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

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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 new State of Illinois Executive Order**

On February 2, 2022, the Centers for Disease Control and Prevention (CDC) updated the [Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes](#) to incorporate “up to date” as the preferred description of an individual’s vaccination status, and shortened the time required for quarantine.

The Governor’s Executive Order on February 4, 2022 (Executive Order 2022-05) reissued previous COVID-19 executive orders and is applicable to nursing homes and other long-term care (LTC) facilities.

Notably, [Executive Order 2022-05](#) revised the state requirement for vaccination of health care workers to require that, beginning March 15, 2022, all health care workers<sup>1</sup> at skilled nursing and intermediate care facilities licensed under the Nursing Home Care Act, facilities licensed under the ID/DD Community Care Act, and facilities licensed under the MC/DD Act, must be up-to-date on COVID-19 vaccinations in order to be considered fully vaccinated against COVID-19.

An individual is considered “up to date” on COVID-19 vaccinations when they have received all CDC-recommended COVID-19 vaccines, including any booster dose(s) when eligible. Additionally, IDPH revised its emergency rules to provide that staff at these facilities who are not up to date must undergo testing for COVID-19 twice weekly, with tests administered at least three days apart ( 77 Ill. Admin. Code 300.698; 77 Ill. Admin. Code 600.759; 77 Ill. Admin Code

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<sup>1</sup> Health Care Worker, as defined in Executive Order 2021-22, means any person who (1) is employed by, volunteers for, or is contracted to provide services for a Health Care Facility, or is employed by an entity that is contracted to provide services to a Health Care Facility, and (2) is in close contact (fewer than 6 feet) with other persons in the facility for more than 15 minutes at least once a week on a regular basis as determined by the Health Care Facility. The term “Health Care Worker” does not include any person who is employed by, volunteers for, or is contracted to provide services for any State-owned or operated facility. The term “Health Care Worker” also does not include any person who is present at the Health Care Facility for only a short period of time and whose moments of close physical proximity to others on site are fleeting (e.g., contractors making deliveries to a site where they remain physically distanced from others or briefly entering a site to pick up a shipment).

350.769). Other requirements related to vaccination and testing in Executive Order 2021-22 (as amended by Executive Order 2021-23, Executive Order 2021-27, and Executive Order 2022-01) remain in effect.

## Introduction/Background

“Older adults living in congregate settings are at high risk for infection by respiratory and other pathogens, such as SARS-CoV-2,” the CDC stated February 2, 2022. “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.”<sup>2</sup>

This IDPH guidance document draws on current best practice recommendations. IDPH will revise and update this document as needed, based on accrued experience, new information, and future guidance from Centers for Medicare and Medicaid Services (CMS) and CDC.

### The 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 and engineering controls to improve air quality
- 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 [up to date](#) on their COVID-19 vaccinations, making it possible for them to still become infected by visitors **and through interactions in the community**. In addition, individuals can spread COVID-19, including new variants, even if they are vaccinated **and up to date with COVID-19 vaccinations**. Having a strong IPC program is critical to protect both residents and health care personnel (HCP).

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<sup>2</sup> Centers for Disease Control and Prevention (CDC). Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes. February 2, 2022. <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

## Use of Engineering Controls and Indoor Air Quality

When indoors, improving ventilation and increasing the number of times fresh or filtered air enters a room can help reduce viral particle concentration and have been proven to decrease COVID-19 transmission.<sup>3</sup> “The lower the concentration, the less likely viral particles can be inhaled into the lungs (potentially lowering the inhaled dose); contact eyes, nose, and mouth; or fall out of the air to accumulate on surfaces,<sup>4</sup>” according to the CDC.

Improving ventilation practices and interventions can reduce the airborne concentrations and reduce the risk that residents, visitors, and HCP come in contact with viral particles.

Approaches include:

- Increasing the introduction of outdoor air.
- Ensuring ventilation systems are operating properly as defined by [ASHRAE Standard 62.1](#).
- Optimizing the use of engineering controls to reduce or to eliminate exposures.
- Exploring options to improve ventilation delivery and indoor air quality in all shared spaces. The higher number of air exchanges per hour will result in better results with respect to purging airborne contaminants. Refer to the CDC suggested options for [Air Changes per Hour \(ACH\)](#).
- Using portable **room air cleaners with a high efficiency particulate air (HEPA) filter** to enhance air cleaning. **Air cleaners** need to have the appropriate CADR (Clean Air Delivery Rate) rating for the room size [e.g., a 300-foot<sup>2</sup> room with an 11-foot ceiling will require a portable air cleaner labeled for a room size of at least 415 foot<sup>2</sup> (300 × [11/8] = 415)]<sup>3</sup>. [CDC FAQ #5](#).
- The following resources provide evidence-based guidance:
  - [CDC Ventilation in Buildings](#) (June 2, 2021)
  - CDC/HICPAC [Guidelines for Environmental Infection Control in Health Care Facilities](#) (2003)
  - American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), which provides [COVID-19 technical resources](#) for health care settings.

## Vaccinations - Updated

LTC facilities must ensure that staff are vaccinated and tested in accordance with **the February 4, 2022 amendment and revision to Executive Order 2021-22, [Executive Order 2022-05](#), and the Illinois Administrative Codes applicable to each respective licensure found at [this link](#).**

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<sup>3</sup> Efficacy of Portable Air Cleaners and Masking for Reducing Indoor Exposure to Simulated Exhaled SARS-CoV-2 Aerosols — United States, 2021 MMWR Morb Mortal Wkly Rep / July 9, 2021 / 70(27);972–976 DOI: <http://dx.doi.org/10.15585/mmwr.mm7027e1>

<sup>4</sup> Centers for Disease Control and Prevention (CDC) (June 2, 2021). Ventilation in Buildings, retrieved from <https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html>

[Executive Order 2022-05](#) revised the state requirement for vaccination of health care workers to require that, beginning March 15, 2022, all Health Care Workers<sup>5</sup> at skilled nursing and intermediate care facilities licensed under the Nursing Home Care Act, facilities licensed under the ID/DD Community Care Act, and facilities licensed under the MC/DD Act, must be **up to date** on COVID-19 vaccinations in order to be considered fully vaccinated against COVID-19. An individual is considered “up to date” on COVID-19 vaccinations when they have received all CDC recommended COVID-19 vaccines, including any booster dose(s) when eligible.

Additionally, IDPH revised its emergency rules to provide that **staff at these facilities who are not up to date must undergo testing for COVID-19 twice weekly**, with tests administered at least three days apart (77 Ill. Admin. Code 300.698; 77 Ill. Admin. Code 600.759; 77 Ill. Admin. Code 350.769). Other requirements related to vaccination and testing in Executive Order 2021-22 (as amended by Executive Order 2021-23, Executive Order 2021-27, and Executive Order 2022-01) remain in effect.

IDPH will also enforce the vaccination requirements for CMS certified facilities in compliance with [QSO-22-07-ALL](#), released on December 28, 2021.

CDC guidance for [up to date vaccination](#), including booster doses for visitors, is always preferred and should be encouraged.

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 the city of Chicago, contact your local health department or email [dphltctesting@illinois.gov](mailto: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](mailto: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](#).

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

**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 IDPH 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.

### **Oral Antivirals, Other Therapeutics for Outpatient Management of COVID-19 - Updated**

Current options for outpatient management of Covid-19 include Pre exposure and Post exposure prophylaxis in addition to treatment. Treatments are currently in the form of oral medications as well as non-oral forms such as intravenous, subcutaneous or intramuscular injections. The choice of agent varies based on the current dominant variant in circulation as well as a patient's duration of symptoms and comorbid conditions. The therapeutics are available through LTC assigned pharmacies as well as at retail pharmacies. To determine if your patient is eligible for treatment, refer to the National Institutes of Health ([NIH](#)) [treatment guidelines](#). [A clinical decision tree](#) is also available to help clinicians determine if a patient is eligible for treatment and the right choice of treatment,

- **Pre-exposure prophylaxis (PreP)**  
[Pre-exposure prophylaxis](#) is available for those residents who are not expected to mount a response to vaccination due to their immunosuppressed state or have a contraindication to receiving the vaccine. Vaccines still remain the most effective form of prevention and PreP is not intended to replace vaccination.
- **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 monoclonal antibody (mAb) treatment, **regardless of vaccination status**.

Treatment 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 treatment should be administered and the type of treatments accessible.**

**Consider circulating variants and whether the available treatment will be effective active against them.** If mAb cannot be administered on site, it is important to transport residents for the one-time infusion or injection treatments. Links below have information on mAb treatment, and effectiveness against circulating strains.

- **Post-exposure Prophylaxis (PEP)**  
PEP 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, in those

who are not **up to date with COVID-19 vaccinations for which they are eligible** or who are not expected to develop immunity from vaccination (for example, people with immunocompromising conditions, including those taking immunosuppressive medications). **During supply shortages, treatment should be prioritized over PEP.**

### **Therapeutics Allocation and Distribution Process**

Long-term care facilities should contact their usual pharmacy provider for more information on residents receiving monoclonal antibodies or oral therapeutics or visit the [IDPH therapeutic locator webpage](#) to identify other locations where these therapeutics are available.

In the situation of an urgent need for treatment (i.e., positive residents and contacts) by a facility that does not usually provide COVID-19 therapeutics, use the [matchmaker function](#) to locate doses nearest to you or email IDPH at [dph.mabtherapy@illinois.gov](mailto:dph.mabtherapy@illinois.gov).

- **Providers/facilities looking to directly administer or provide medications should use the [IDPH Therapeutics Request Form](#).**

### **Source Control and Physical Distancing Recommendations**

It is safest for residents and visitors to wear source control and physically distance, particularly if either are at risk for severe disease or are **not up to date** with COVID-19 vaccinations.

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 personal protective equipment (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](#)) reissued February 4, 2022, "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." **During visitations**, face coverings may be removed temporarily while actively eating or drinking while maintaining 6 feet of distance from others.

### **Universal PPE for HCP - Updated**

- **If a resident is suspected or confirmed to have COVID-19 or is **not up to date** with COVID-19 vaccinations, and the resident is 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 **up to date** with COVID-19 vaccinations, 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***
    - **At a minimum**, HCP must wear a well-fitted mask **at all times** and eye protection while present in resident care areas.
    - **Facilities might consider having HCP wear N95 respirators at all times while in the facility.**
    - HCP are not required to wear eye protection for COVID-19 when working in non-resident care areas (e.g., offices, main kitchens, maintenance areas) when there are substantial or high community COVID-19 transmission levels. HCP should wear eye protection when entering the resident care areas.
  - **When community transmission levels are *low-to-moderate***  
HCP must wear a well-fitted face mask.
- **For COVID-19 specimen collection:** HCP must wear an 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 an N95 respirator and eye protection **when entering the room of a resident with CPAP/BIPAP**.
  - 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: Continued Focus on County Level COVID-19 Transmission**

CDC's new COVID-19 Community Levels recommendations do not apply in health care settings, such as hospitals and nursing homes. Instead, health care settings should continue to use [community transmission rates](#) and continue to follow CDC's infection prevention and control recommendations for health care settings.<sup>2</sup>

#### **KEY POINTS**

- **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.

**Testing of HCP, PPE use, and licensed LTC facility response to a positive case(s).**

- As part of [Executive Order 2022-05](#) and the most recent [emergency rules](#) (Sections 300.698, 350.769, and 390.759) **effective February 14, 2022, skilled nursing facilities, ICF/DD facilities, and MC/DD facilities must test HCP that are not up to date with COVID-19 vaccination at a minimum of twice a week** (See Table 1).
- In accordance with [Executive Order 2021-22](#) and per the most recent emergency rules (77 Ill. Admin Code Sections 295.4047, 330.794, 370.4, and 380.643), **assisted living and shared housing facilities, sheltered care facilities, community living facilities, and SMRFs must test staff who are not fully vaccinated at a minimum of weekly or twice weekly based on the community transmission level.** (See Table 2).
- **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,** the facility must test staff at the frequency shown in the tables 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 tables below.
- **For HCPs who work infrequently (less than weekly),** test within 72 hours of the next scheduled shift.
- Local health departments may have more stringent testing requirements.

**Table 1: Routine Testing Intervals of Staff who work in facilities licensed under Ill. 77 Adm. Codes 300, 350, and 390 who are Not Up to Date with COVID-19 Vaccinations by Community Transmission Levels**

Community Transmission Level	Minimum Testing Frequency of Staff Who Are Not Up to Date with COVID-19 Vaccinations *
<b>LOW</b>	Per <a href="#">emergency rules</a> (Sections 300.698, 350.769, and 390.759) effective February 14, 2022, testing is required at a minimum of <a href="#">twice a week</a> .
<b>MODERATE</b>	<a href="#">Twice a week</a>
<b>SUBSTANTIAL</b>	Twice a week
<b>HIGH</b>	Twice a week

\*Up to date staff do not need to be routinely tested.

**Table 2: Routine testing intervals of staff who work in facilities licensed under Ill. 77 Adm. Codes 295, 330, 370, 380, who are not fully vaccinated by community transmission levels**

Community Transmission Level	Minimum Testing Frequency of Staff who are not Fully Vaccinated*
LOW	Per Illinois eemergency rule (Sections 295.4047, 330.794, 370.4, and 380.643) testing is required at a minimum of once a week
MODERATE	Once a week
SUBSTANTIAL	Twice a week
HIGH	Twice a week

\*Fully vaccinated staff do not need to be routinely tested.

### Case status in the facility

A facility must continue to test and to monitor for new facility-onset and facility-associated cases and, if found, must 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.<sup>6</sup> Refer to CDC website [Mitigation Strategies for Staffing Shortages](#). See page 15 for additional discussion.

### Hand hygiene

The facility must train and validate competencies of all staff on hand hygiene. Everyone entering the facility must perform hand hygiene.<sup>7</sup>

### Cleaning and disinfection supplies

Ensure that any disinfectants used in the facility are included on the U.S. Environmental Protection Agency (EPA) "List N"<sup>8</sup> as effective against coronavirus (COVID-19). Cleaning and disinfectant 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).

<sup>6</sup> 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>

<sup>7</sup> 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>

<sup>8</sup> U.S. Environmental Protection Agency (EPA) <https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19>

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 respirators, face masks, or gowns are reused, the facility is operating at a crisis level. Based upon availability, facilities should not be operating at a crisis level for PPE utilization.<sup>9</sup> Utilize CDC [PPE optimization strategies](#).

### 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) persons who meet 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)** should report any of the above criteria, regardless of vaccination status. Symptomatic HCP should be restricted from work until they have been evaluated.
- **Visitors** meeting any of the above criteria should be restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively<sup>10</sup>. Visitors must follow the quarantine and isolation guidance for LTC residents; the shortened CDC time periods for the general public do not apply.
  - This means that a visitor should not visit for **10 full days** after a **positive test** regardless of their vaccination status.
  - Visitors who are **up to date** with COVID-19 vaccinations and had **close contact** with a positive case are allowed to visit as long as they remain asymptomatic.
  - Visitors who are **not up to date** with COVID-19 vaccinations and had contact with a positive case should not visit for **10 full days** following the last exposure.
  - Visitors who have had COVID-19 in the prior 90 days are allowed to visit.

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<sup>9</sup> 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>

<sup>10</sup> 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>

## Testing Plan and Response Strategy

The facility must have a written COVID-19 testing plan and response strategy in place based on contingencies informed by the CDC<sup>11</sup> and, as applicable, CMS requirements.<sup>12</sup> 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 test 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).
- **Visitor testing:** While not required, facilities in counties with substantial or high levels of community transmission are encouraged to offer testing to visitors, if feasible. If facilities do not offer testing, they should encourage visitors to be tested on their own before coming to the facility (e.g., within 2–3 days).
- **Visitor vaccination information:** Facilities may ask about a visitor's vaccination status; however, visitors are not required to be tested or vaccinated (or show proof of such) as a condition of visitation.
- **Provisions for the facility to submit the testing and response plan** to IDPH, CMS, or local health department personnel upon request.
- **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](#). Testing is also available, at no cost to the facility, through the [Midwest Coordination Center \(MCC\)](#).
- **Provisions for point-of-care testing, if applicable.** 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** (Table 3 in Appendix A summarizes this information)

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.

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<sup>11</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html> ;  
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

<sup>12</sup> <https://www.federalregister.gov/documents/2020/09/02/2020-19150/medicare-and-medicaid- programs-clinical-laboratory-improvement-amendments-clia-and-patient>

- Increase monitoring and screening of all residents and HCP for signs and symptoms of COVID-19 from daily to each shift to detect more rapidly those with new symptoms **until there are no more positive cases for 14 days.**
- **IDPH recommends contact tracing be completed in order to assure that all high-risk exposures or potential close contacts are identified and tested.**
- There are two options for outbreak investigations. 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 unit-based approach** involves contact tracing to identify any high-risk exposures in HCP or close contacts in residents AND requires testing to be done on all residents and HCP working on the unit or department where the new case was identified. Additional testing and contact tracing may be warranted if the investigation expands beyond the affected unit/department.
  - A **broad-based approach** involves contact tracing to identify any high-risk exposures in HCP or close contacts in residents AND testing is completed on all residents and HCP in the facility.
- **IDPH will require, at a minimum, a unit-based approach in addition to contact tracing.**
- If a facility is not able to perform contact tracing, then all residents who are not up to date must be placed into quarantine.
- **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 24 hours 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.
- 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 immediately, but not sooner than 24 hours, and then on day 5 – 7 if negative.
- Testing must continue every 3-7 days until there are no more positive cases for 14 days.
- While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility.
- Visitors should be made aware of the potential risk of visiting during an outbreak and adhere to the core principles of infection prevention and control.
- If residents or their representative would like to visit during an outbreak, they should wear a well-fitting mask during the visit, regardless of vaccination status. Visits should ideally occur outdoors or in the resident's room, unless it is a shared room and the resident's roommate is unvaccinated, **not up to date** with COVID-19 vaccinations, or immunocompromised (regardless of vaccination status).
- 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 of 48 hours prior to symptoms onset or 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. This approach can also be used when resources are not available to conduct contact tracing.

- If feasible, perform contact tracing on the unit or department where the new case was identified to determine if, during the prior 48 hours, there were any higher risk exposures to other HCP or close contacts with residents. Expand contact tracing as warranted based upon investigation findings.
- Conduct facility-wide testing of all residents and HCP immediately (but not earlier than 24 hours after exposure), regardless of vaccination status. Test every 3-7 days until there are no more positive cases for 14 days since the last positive. There is no need to test individuals who have had COVID-19 in the prior 90 days if they remain asymptomatic.
- If a facility is using the broad-based approach and have not completed contact tracing, the facility should quarantine and restrict residents who are not up to date with COVID-19 vaccinations to their rooms even if they test negative. Residents should remain in quarantine until there are no more positive cases for 14 days since the last positive. HCP should wear full PPE when providing care to these residents. These residents should not participate in communal dining or group activities.
- While it is safer for visitors not to enter the facility during an outbreak, visitors must still be allowed in the facility.

- Visitors should be made aware of the potential risk of visiting during an outbreak and adhere to the core principles of infection prevention and control.
- If residents or their representative would like to have a visit during an outbreak, they should wear a well-fitting mask during the visit, regardless of vaccination status, and visits should ideally occur outdoors or in the resident room unless it is a shared room and the resident's roommate is **not up to date** with COVID-19 vaccinations, or immunocompromised (regardless of vaccination status).

**Management of HCP with higher risk exposures or COVID-19 infections**  
**([CDC Guidance Managing Health Care Personnel with COVID-19 Infection or Exposure](#))**  
**(See Tables 4 and 5 in Appendix A for Details)**

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, have been updated to enhance protection for HCP, residents, and visitors and to address concerns about potential impacts on the health care system given a surge of COVID-19 infections. Updates to CDC guidance are found at CDC ([evaluating an exposure](#)).<sup>13</sup>

If conventional strategies cannot be sustained during a surge in cases, facilities may consider implementing contingency strategies, then crisis strategies, in an incremental manner. Facilities are best positioned to evaluate their own needs as to whether conventional, contingency, or crisis strategies are most appropriate at a given time. **IDPH generally does not support HCP working while ill, as sickness presenteeism, or working while ill, increases risk of errors and COVID-19 transmission.<sup>12</sup> If a facility is allowing HCP who are positive to work, they must be willing and well enough to work.**

**Notes:** This guidance is for HCP and does not apply to residents or the general public.

- HCP who are moderately to severely immunocompromised regardless of vaccination status 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.
- HCP who have had prolonged, continued close contact with someone with COVID-19 in the home, regardless of vaccination status, must test immediately, but not earlier than 24 hours, between days 5-7, and weekly for two weeks after the last exposure date.

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<sup>12</sup> Kinman G, Grant C. Presenteeism during the COVID-19 pandemic: risks and solutions. *Occup Med (Lond)*. 2021;71(6-7):243-244. doi:10.1093/occmed/kqaa193

- Facilities must notify the local health department and the IDPH Office of Health Care Regulation (OHCR) if they are moving to crisis staffing. For reporting of crisis status, facilities should report to OHCR in the same manner used to report serious incidents or accidents.

**Mitigation Strategies for Staffing Shortages – Reminder - updated**  
**(This section was published in previous editions, and has been updated)**  
**(Definitions for vaccination status are at the end of this document)**  
[\(CDC strategies to mitigate staffing shortages\)](#)

IDPH does not support staff working while ill. HCPs should be asymptomatic and well enough to work, as sickness presenteeism, or working while ill, increases risk of errors and transmission.<sup>12</sup> **Mitigation strategies listed below are intended to be used in the order that they appear.**

**Contingency Capacity Strategies to Mitigate Staffing Shortages**

When staffing shortages are anticipated, health care facilities and employers, in collaboration with human resources and occupational health services, should use contingency capacity strategies to plan and to prepare for mitigating this problem. Crisis level staffing mitigation strategies are discussed in a separate section below. Contingency mitigation strategies include:

- Attempt to hire additional staff; rotate staff; offer overtime, bonus, or hazard pay to support resident care activities.
- Contact staffing agencies to identify additional health care personnel (staff) to work in the facility. Be aware of Illinois-specific emergency waivers or changes to licensure requirements or renewals for select categories of staff.
- Determine if there are alternate care sites with adequate staffing to care for residents with COVID-19 (e.g., sister facilities in same network or other COVID-19 designated facilities where residents could be transferred to for care).
- Reach out to Illinois Helps for staffing assistance (<https://illinoishelps.net/>).
- As appropriate, consider requesting that staff postpone elective time off from work.
- If shortages continue despite other mitigation strategies, consider allowing asymptomatic staff with higher risk exposures to return to work (Table 5). **If HCP develop symptoms at any point, they should immediately isolate and undergo testing and evaluation to determine if they have COVID-19.**

- Consider allowing staff with COVID-19 infection who are asymptomatic or have mild-to-moderate (but improving) symptoms, and no fever within 24 hours, to return to work with a shortened, five-day isolation period (Table 4). **HCP should wear an N95 respirator at work until 10 full days after they developed symptoms or had a positive test.**
- Facilities should **prioritize job duties** for HCP who have COVID-19 and are returning to work sooner under shortened isolation guidelines.

### Care Strategies

- Bundle care activities or determine if tasks could be postponed, offered every other day, or on an alternate schedule (e.g., showers given every other day unless necessary to maintain skin integrity). Resume routine care activities as soon as staffing allows.
- Reassign staff who work in non-clinical areas to support resident care activities. Facilities will need to ensure these staff have received appropriate orientation, appropriate and adequate PPE, and training to work in areas that are new to them.

**NOTE: Document all attempts to augment staffing needs (date, time, and effort made)**

### Crisis Capacity Strategies to Mitigate Staffing Shortages

When staffing shortages are occurring, health care facilities and employers (in collaboration with their local health department, human resources, and occupational health services) may need to implement crisis capacity strategies to continue to provide resident care. When there are no longer enough staff to provide safe resident care:

- Implement regional plans to transfer residents with COVID-19 to designated health care facilities or alternate care sites with adequate staffing.
- The facility has activated its contingency staffing plan and has exhausted all options to address staffing needs, triggering a crisis level of staffing.
- The facility has exhausted all options to cohort COVID-19-positive residents internally or transfer positive residents to COVID-19 care sites.
- If shortages continue despite other mitigation strategies, consider allowing asymptomatic HCP with higher risk exposures to return to work (Table 5). **If HCP develop symptoms at any point, they should immediately isolate and undergo testing and evaluation to determine if they have COVID-19.**

- Consider allowing HCP with COVID-19 infection who are asymptomatic or have mild-to-moderate (but improving) symptoms and no fever within 24 hours, to return to work with a shortened isolation period (Table 4). **HCP should wear an N95 respirator until 10 full days after they developed symptoms or had a positive test.**
- **Facilities should [prioritize job duties](#) for HCP who have COVID-19 and are returning to work sooner under shortened isolation guidelines.**

Additional information is available: *Strategies to Mitigate Health Care Personnel Staffing Shortages* can be found at the following CDC website: <https://www.cdc.gov/coronavirus/2019-ncov/Staff/mitigating-staff-shortages.html>

### **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
- Discuss treatment options with patient or their decision maker, to prevent hospital admissions
- Monitor the resident every four hours for clinical worsening
- 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
  - While not recommended, residents who are on transmission-based precautions (TBP) can still receive visitors and visits from ombudsmen. In these cases, visits should occur in the resident's room and the resident should wear a well-fitting mask. Counsel visitors about risks of COVID-19.
  - Before visiting residents, who are on TBP, visitors and ombudsmen should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors and ombudsmen must wear PPE as indicated by the type of transmission-based precaution. For COVID-19 this includes a well-fitting mask (for visitors), gown, gloves, and eye protection if providing direct care.
  - Visitors and ombudsmen should adhere to the core principles of infection prevention and control, **which includes hand hygiene, well-fitting face covering, appropriate physical distancing, and PPE.**
  - Facilities should offer well-fitting mask or other appropriate PPE, **including KN95 masks (if available).**<sup>13,14</sup> Visitors should not wear facility provided N95s, however, they may **bring and** wear their own **N95s.**

- **Visitors** who are not up to date with COVID-19 vaccinations and choose to visit a COVID-19 positive resident need to wear appropriate PPE and maintain a distance of 6 feet or more away from the resident while visiting. Visitors who are closer than 6 feet for a cumulative total of 15 minutes or more over a 24-hour period without wearing appropriate PPE are considered EXPOSED or a close contact to a positive case. If the visitor was wearing appropriate PPE and was 6 feet or more away from the resident, then the visitor is NOT considered to be exposed.
- Visitors who are **not up to date with COVID-19 vaccinations will be considered exposed** to a positive case (even if the positive case is the resident they were visiting) **and should quarantine per community guidance and not visit a long-term care facility for 10 full days from the last exposure (with the date of the last visit being day 0).**
- Visitors who are up to date with COVID-19 vaccinations or within 90 days of a COVID-19 infection, do not need to quarantine and are allowed to enter long-term care facilities.
- Communal dining – Dining for persons confirmed to have COVID-19 is not allowed in communal areas. Dining should occur in the 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 enter wearing appropriate PPE for the terminal cleaning.

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

- Test symptomatic residents regardless of vaccination status.
- Resident 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.
- Monitor residents at least daily.
- Use dedicated medical equipment.
- Staff wear full PPE (N95 respirator, gown, gloves, eye protection).
- Visitation - Follow visitation guidance listed above for "Residents with confirmed COVID-19."
- Communal dining –Dining for persons confirmed to have COVID-19 is not allowed in communal areas. Dining should occur in the resident room.
- Group activities – residents suspected of having COVID-19 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. HCP must not enter to remove equipment or terminally clean the room for at least 60 minutes after discharge unless they are wearing full PPE. After 60 minutes, they can enter wearing appropriate PPE for the terminal cleaning.
- 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 a 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**

- Testing is not recommended for residents who have had COVID-19 in the last 90 days if they remain asymptomatic.
- **Regardless of vaccination status**, a resident should have a series of two tests (PCR or POC antigen) for COVID-19. The tests should be done immediately (but not earlier than 24 hours 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 and treat as suspected COVID-19 case (see above guidance).
  - If the resident is **asymptomatic and up to date** with COVID-19 vaccinations, no need to quarantine or restrict the resident to their room, but the resident should wear source control for **10** days post exposure **when out of their room**.
  - If the resident is **asymptomatic and not up to date** with COVID-19 vaccinations, quarantine for **10** days even if testing negative. HCP should wear full PPE.
  - If the resident is asymptomatic and **has had COVID-19 within last 90 days**, there is no need to quarantine; resident should wear source control for **10** days post exposure.
  - If the resident is **moderate-to-severely immunocompromised**, consider quarantine. Consult with the resident's health care provider to determine if quarantine is necessary.
  - Residents can be removed from transmission-based precautions (TBP) after day **10** following the exposure (day 0) if they do not develop symptoms.

- If the resident develops symptoms, the need for TBP begins again with the date the symptoms started (now considered day 0) and TBP should extend to day 10 using this symptom onset date.
- Determine if post exposure prophylaxis is appropriate based on circulating variants and duration of exposure.
- Visitation, dining, and group activities
  - Visitors should be counseled on the risks of COVID-19.
  - Indoor visits are allowed, but only in the resident's room. Both the resident and the visitor should wear source control and maintain physical distancing.
  - Residents who are **NOT up to date** with COVID-19 vaccinations, but are identified to have had a close contact, **should be placed in quarantine (above)**.
    - Residents should not participate in communal dining during quarantine and should dine in their room.
    - Residents should not participate in group activities during quarantine.
  - Residents who **ARE up to date** with COVID-19 vaccinations, but are identified to have had a close contact, **do not have to be restricted to their rooms**.
  - Residents who **ARE up to date** with COVID-19 vaccinations **can participate in indoor visits** in their rooms, in common areas, or in designated visitation spaces. Outdoor visits are also allowed. Both the resident and the visitor should wear source control and maintain physical distancing for both indoor and outdoor visits.
  - Residents who **ARE up to date** with COVID-19 **may participate in communal dining** but should wear source control to and from the dining hall and when not eating or drinking.
  - Residents who **ARE up to date** with COVID-19 **may participate in group activities** but should wear source control during the activity.

### **New Admissions or Readmissions**

- 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).
- **New Admissions or Readmissions – see Table 2 below**
  - 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; however, POC antigen testing is acceptable.
- **New admissions or readmissions that are NOT up to date** with COVID-19 vaccinations need to quarantine for **10** days and complete the testing listed above.
- **New admissions or readmissions that ARE up to date** with COVID-19 vaccinations do not need to quarantine if 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 HCP to provide care to all 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 involved in an outbreak must consider the criteria listed above, the extent of the outbreak, and consult with their local health department before accepting new admissions.**

#### **Residents who leave the facility - see table below**

**Facilities must permit residents to leave the facility as they choose.** Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident, to wear a well-fitting mask, physically distance, and perform frequent hand hygiene, and to encourage those around them to do the same.

- Screen residents upon return for signs or symptoms of COVID-19.
  - If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, test the resident for COVID-19, regardless of vaccination status and follow the guidance for “Resident Identified as a Close Contact of Someone with COVID-19 (above).”
  - If the resident develops signs or symptoms of COVID-19 after the outing, test the resident for COVID-19, regardless of vaccination status, and follow the guidance for “Residents Suspected of Having COVID-19 (above).”
- Quarantine is not recommended for residents who are **not up to date** with COVID-19 vaccinations who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) if they have not had 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**.

<b>Table 3: New Admission/Readmissions and Residents who Leave the Facility</b>			
<b>Resident vaccination status</b>	<b>Is quarantine of resident necessary?</b>	<b>Is testing of the resident necessary?</b>	
		<b>Low-to-moderate community transmission</b>	<b>Substantial-to-high community transmission</b>
Not up to date with COVID-19 vaccinations resident out for less than 24 hours	No	No	No
Not up to date with COVID-19 vaccinations, resident out for 24 hours or more	Yes	No	Yes, test as readmission
Up to date with COVID-19 vaccinations, resident out for less than 24 hours	No	No	No
Up to date with COVID-19 vaccinations resident out for 24 hours or more	No	No	Yes, test as readmission

### Visitation

Residents have the right to receive visitors of their choosing at the time of their choosing and in a manner that does not impose on the rights of another resident, such as a clinical necessity or safety restriction (see 42 CFR § 483.10(f)(4)(v)). Nursing homes 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.

Adherence to the core principles of infection prevention and control is an evidence-based way to reduce the risk of COVID-19 transmission. Residents have the right to make choices about aspects of their lives in the facility that are significant to their well-being.

- Facilities must screen all visitors entering the facility, regardless of their vaccination status, for the following criteria: a positive viral test for COVID-19, symptoms of COVID-19, or if they have had close contact with someone with COVID-19 infection.
- **Visitors should follow the same isolation and quarantine guidance as residents** and should not visit for 10 days if they are a close contact of a positive case or have had a positive viral test. Community guidance for isolation and quarantine does not apply to individuals visiting long-term care facilities.
- Facilities must allow indoor visitation at all times and for all residents as required under the CMS visitation rules ([QSO-20-39-NH](#)).

- Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of infection prevention and control and does not increase COVID-19 infection risk to other residents.
- 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.
- Nursing homes may take additional measures to make visitation safer, while ensuring visitation can still occur. This includes requiring that, during visits, residents and visitors wear masks that are well-fitting and preferably those with better protection, such as surgical masks or KN95s. While not required, facilities may offer visitors surgical masks or KN95s to replace a cloth face covering or mask.
- Visitors who are unwilling or unable to adhere to the core principles of COVID-19 infection prevention and control should not be permitted to visit or should be asked to leave.
- If a resident's roommate is **not up to date** with COVID-19 vaccinations or immunocompromised (regardless of vaccination status), visits should not be conducted in the resident's room, if possible.
- [Executive Order 2022-06](#) **lifted the universal face covering requirement for the general public effective February 28, 2022. However, all individuals regardless of vaccination status shall continue to be required to wear a face covering in health care facilities such as long-term care facilities.**
- **Face coverings or masks are still required indoors for visitors to long-term care facilities. If the resident and all their visitor(s) are up to date with all recommended COVID-19 vaccine doses, the resident can choose not to wear source control while in the resident's room and may choose to have physical contact.**
- 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 present unless moving roommate is not possible)
  - Multipurpose rooms
  - Dining areas
  - Designated visitation rooms
  - Outdoors

#### **Indoor Visitation During an Outbreak -**

- While it is safer for visitors not to enter the facility during an outbreak, visitors must still be allowed in the facility.
- Visitors should be made aware of the potential risk of visiting during an outbreak and adhere to the core principles of infection prevention.

- If residents or their representative would like to have a visit during an outbreak, they should wear well-fitting masks during visits regardless of vaccination status.
- Visits should occur in resident rooms rather than public areas on the affected unit(s).
- Local health departments may provide further guidance or direction to a facility to reduce the risk of COVID-19 transmission during an outbreak.
- There may be times when the scope and severity of an outbreak warrants the local health department to recommend a pause or limitations on visitation as a temporary, short-term intervention (e.g., 14 days). These situations are expected to be **extremely rare** and only occur after the facility has been working with the local health department to manage and prevent escalation of the outbreak. **If the outbreak is severe enough to warrant pausing visitation, it would also warrant a pause on accepting new admissions** (as long as there is adequate alternative access to care for hospital discharges).<sup>14</sup> Facilities must document the outbreak control measures taken, including consultations with the local health department, that preceded the decision to limit visitation.

### **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 circumstances.

**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).

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<sup>14</sup> CMS Nursing Home Frequently Asked Questions. <https://www.cms.gov/files/document/nursing-home-visitation-faq-1223.pdf>

## Essential Caregivers

Facilities should encourage visits by essential caregivers. Refer to the [IDPH Essential Caregiver Guidance for Long-term Care Facilities Guidance](#).

### Communal Dining and Group activities

#### Communal Dining

- Residents should wear a mask to and from dining hall or activity room.
- Residents, regardless of vaccination status or community transmission levels, should wear source control in public areas of the facility when not actively eating or drinking.
- Residents who are **not up to date** with COVID-19 vaccinations must maintain 6 feet distance from other residents and HCP.

#### 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 other residents and visitors when outdoors.
  - **Performers are not** required to wear source control while performing outdoors provided they can maintain 6-9 feet of distance from the audience. If this is not possible, source control must be worn.
  - **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).
  - 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.
  - **Vaccinated** residents do not have to physically distance from one another when wearing source control as long as they do not have symptoms of COVID-19.
  - **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).

**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 should wear source control to, from, and in the beauty salon.
- **The beautician or barber**, regardless of vaccination status, should 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 of 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 Medicare and Medicaid-certified nursing homes provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident

Representatives of the Office of the State Long-Term Care Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If the resident or the ombudsman program requests alternative communication in lieu of an in-person visit, 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 must be permitted entry into facilities unless they exhibit signs or symptoms of COVID-19. Consistent with [QSO-20-39-NH](#), LTC facilities are not permitted to restrict access to surveyors based on vaccination status, nor ask a surveyor for proof of his or her vaccination status as a condition of entry. Surveyors must adhere to the core principles of COVID-19 infection prevention.

### **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 - Updated**

### **Contingency staffing**

Staffing shortages are imminent and, if action is not taken, will interrupt care functions. Contingency strategies are used to mitigate staffing shortages.

### **Crisis staffing**

Staffing shortages already exist and crisis strategies are used in order to continue to provide resident care.

**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 or other congregate care setting 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](#)).

**Higher-risk exposure:** HCP who had prolonged close contact\* with a resident, visitor, or HCP with confirmed COVID-19, and

- HCP was not wearing a respirator when caring for a person with known COVID-19.
- HCP was wearing a surgical or procedure mask, and the individual later identified to have COVID-19 was not wearing a face covering or mask.
- HCP was not wearing eye protection if the individual with COVID-19 was not wearing a face covering or mask.
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure.

\*Prolonged close contact is within 6 feet for 15 minutes or longer during a 24-hour period, or for any duration during an aerosol generating procedure.

**Source control** 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.

**Staff: (CDC) also known as health care personnel (HCP) or health care worker (HCW)** 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 resident 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.

### **Vaccination status**

- **Boosted:** Have received all COVID-19 vaccine doses, including eligible booster dose(s).
- **Up to date:** An individual has received the primary series of COVID-19 vaccine (either two doses or one dose, depending on the vaccine), and has received all additional and booster doses for which they are eligible as recommended by the CDC. ([CDC up to date recommendations for COVID-19 vaccines](#))
- **Not up to date:** An individual has not received all COVID-19 vaccinations for which they are eligible, as outlined under “up to date.”
- **Fully vaccinated:** Two weeks have passed since an individual received the second dose of a two-dose primary series, or one dose of a single dose vaccine. These individuals have NOT received a booster dose.
- **Unvaccinated:** Have NOT received all primary COVID-19 vaccine doses.

APPENDIX A: SUMMARY TABLES

Testing Trigger	Staff (HCP)	Residents
Symptomatic individual identified.	All staff with signs or symptoms must be tested, regardless of vaccination status.	All residents with signs or symptoms must be tested, regardless of vaccination status.
Higher-risk exposure or close contact with an individual who tested positive for COVID-19 that occurs within the facility.	Follow testing requirements listed in <b>Table 5: Work Exclusions &amp; Restrictions for Asymptomatic HCP with Exposures</b>	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), unless within 90 days of COVID-19 infection.  Test immediately, but not earlier than 24 hours 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.	Follow testing requirements listed in <b>Table 5: Work Exclusions &amp; Restrictions for Asymptomatic HCP with Exposures</b>	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), unless within 90 days of COVID-19 infection.  Test immediately, but not earlier than 24 hours 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.  <b>Testing is not required for individuals who are within 90 days of a COVID-19 infection.</b>		If <b>community transmission levels are substantial or high</b> , 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 <b>community transmission levels are low-to-moderate</b> , do not need to be tested on admission.

Vaccination Status	Conventional		Contingency		Crisis (Must notify LHD and OHCR) <sup>2</sup>	
	Work Exclusion	Required Testing	Work Exclusion	Required Testing	Work Exclusion	Required Testing
<b>Up to date and Not up to date</b>	10 days off (ideal)	No testing required to return to work	5 days off	May return after 5 days if asymptomatic or have mild to moderate symptoms that are improving and fever-free for 24 hours. <b>Must have one negative test<sup>1</sup></b> completed within 48 hours before work shift begins or rapid antigen test prior to shift.	Allowed to work except, should have duties prioritized	No additional testing required to work
	<b>OR</b> 7 days off	May return to work after 7 days if asymptomatic or have mild to moderate symptoms that are improving and fever-free for 24 hours. <b>Must have one negative test<sup>1</sup></b> completed within 48 hours before work shift begins or rapid antigen test prior to shift				
<sup>1</sup> Either an antigen test or NAAT can be used as a clearance test to return to work; however, antigen testing is preferred because a NAAT test may remain positive for some time following infection. <sup>2</sup> LHD – Local Health Department, OHCR = IDPH Office of Health Care Regulation						

APPENDIX A: SUMMARY TABLES

**Table 6: Work Exclusions & Restrictions for *Asymptomatic HCP with Exposures* - Updated**

Vaccination Status	Conventional		Contingency		Crisis (Must notify LHD and OHCR)	
	Work Exclusion	Required Testing	Work Exclusion	Required Testing	Work Exclusion	Required Testing
<p><b>Up to Date</b></p> <p>Screen for symptoms twice per shift for 10 days</p>	<p>Allowed to work with testing</p> <p><b>Must be asymptomatic</b></p>	<p>Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection.</p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, must additionally test weekly for two weeks after the last exposure date.</p>	<p>Allowed to work</p> <p><b>Must be asymptomatic</b></p>	<p>No additional testing required to work <b>but include HCP in outbreak testing completed every 3-7 days</b>, unless within 90 days of COVID-19 infection</p>	<p>Allowed to work</p> <p><b>Must be asymptomatic</b></p>	<p>No additional testing required to work <b>but include HCP in outbreak testing completed every 3-7 days</b>, unless within 90 days of COVID-19 infection.</p>
<p><b>Not Up to Date</b></p> <p>Screen for symptoms twice per shift for 10 days</p>	<p>10 days off (ideal)</p>	<p>If excluded from work for 10 days, no testing is required to return to work.</p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection, must additionally test weekly for two weeks after the last exposure date.</p>	<p>Allowed to work with <b>negative testing*</b></p> <p><b>Must be asymptomatic</b></p>	<p>Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection.</p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection., must additionally test weekly for <b>two weeks after the last exposure date</b>.</p>	<p>Allowed to work with <b>negative testing*</b></p> <p><b>Must be asymptomatic</b></p>	<p>Allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 infection.</p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, are allowed to work with negative test completed on days 1* and 5-7 post exposure, unless within 90 days of COVID-19 for <b>two weeks after the last exposure date</b>.</p>
	<p>OR</p> <p>7 days off</p> <p><b>Must be asymptomatic</b></p>	<p>May return after 7 days with <b>one negative test*</b></p> <p>Note: HCP with <i>prolonged, continued exposure in the home</i>, are allowed to work following testing cadence noted above under 10 days off.</p>				
<p><b>NOTE: Asymptomatic Exposed HCP must complete required testing listed above and should be included in the facility's routine testing for unvaccinated HCP and outbreak testing every 3-7 days until there are no more positive results for 14 days.</b></p>						
<p><b>* Negative test result must be within 48 hours of returning to work. Either an antigen test or NAAT can be used, as a clearance test to return to work; however, antigen testing is preferred because a NAAT test may remain positive for some time following infection.</b></p>						
<p>* For calculating day of test:                      1) for infection consider day of symptomatic onset or first positive test if asymptomatic, as day 0                      2) for exposure consider day of exposure as day 0</p>						