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Updated Interim Guidance for Nursing Homes Following the End of the Public Health Emergency

Updated Sections are highlighted in RED.

Summary of Changes to Guidance Since November 4, 2022, Release	
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Applicability

This interim guidance provides guidelines to mitigate the spread of COVID-19 in nursing homes and other long-term care (LTC) facilities that provide skilled personal care services. The guidance in this document is specifically intended for facilities as defined in the Nursing Home Care Act (210 ILCS 45/), 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.

Facilities whose staff **provide non-skilled personal care**, should follow the separate IDPH Interim COVID-19 Guidelines for Assisted Living and Other Higher Risk Community Congregate Living Settings. The CDC definition of non-skilled personal care is provided under Definitions.

Reason for Update

On May 11, 2023, the Illinois COVID-19 Disaster Proclamation ended, aligning with the U.S. Department of Health and Human Services end to the Federal Public Health Emergency (PHE). The response to SARS-CoV-2, the virus that causes COVID-19, remains a public health priority. However, as a result of the concerted efforts of all those involved in ensuring high levels of vaccination, the availability of effective treatments, and use of infection prevention measures, there has been a substantial reduction in the risk for significant COVID-19 illness, hospitalizations, and deaths. Both the nation, and the state of Illinois, are in a better place in the response than three years ago and are prepared to transition away from the emergency phase.

This guidance reflects changes to the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, released May 8, 2023, and the Centers for Medicare and Medicaid Services (CMS) "QSO_23-13-ALL" Guidance for the Expiration of the COVID-19 Public Health Emergency released May 1, 2023.

Included are new provisions regarding COVID-19 metrics, the appropriate use of masking, and the testing of new admissions. The focus remains on minimizing the impact of COVID-19 and other respiratory infections on the residents of nursing homes, who are at higher risks of severe outcomes due to respiratory viral infections.

Continued Focus on County-Level COVID-19 Data: Hospital Admission Data

KEY POINTS

The previous CDC metrics, COVID-19 Community Transmission and Community Levels, are no longer in effect following the expiration of the COVID-19 Public Health Emergency declaration. However, the **CDC COVID-19 Data Tracker will continue to provide relevant data that can be used to guide decision making**.

Facilities should continue to monitor the CDC COVID-19 Data Tracker weekly and implement select infection prevention and control measures (e.g., use of source control) based on the level of new COVID-19 hospital admissions over the past week in their county. This is the same metric that will be utilized by the CDC to issue alerts to the public regarding higher levels of SARS-CoV-2 circulating in the community and the need to take additional protective actions.

- **IDPH is recommending that a COVID-19 new hospital admissions level of 20 per 100,000 population over the past week be used as the measure at which facilities should consider implementing enhanced prevention measures ("HIGH")**
- **If there is a steady increase in hospital admissions for respiratory infections including Flu and RSV over two weeks regardless of the actual rate of admissions, facilities should be vigilant and prepared to implement enhanced measures if necessary.**

Facilities and individuals may choose to implement **additional** protective measures when the **COVID-19 Hospital Admission Rate is lower based on their discretion and taking into account the activity of other respiratory infections such as Flu and RSV.**

The Core Principles of COVID-19 Infection Prevention

1. 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 concentrations and have been proven to decrease COVID-19 transmission.[1] "The lower the concentration, the less likely viral particles can be inhaled into the lungs (potentially lowering the inhaled dose); contact the eyes, nose, and mouth; or fall out of the air to accumulate on surfaces,"[2] according to the CDC.

Improving ventilation practices and interventions can reduce the airborne concentrations and reduce the risk that residents, visitors, and health care personnel (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^2 room with an 11-foot ceiling will require a portable air cleaner labeled for a room size of at least 415 foot^2 (300 × [11/8] = 415)].
- Optimize the use of engineering controls to reduce or eliminate exposures by shielding HCP and other residents from infected individuals. Ensure that barriers are in compliance with the National Fire Protection Agency (NFPA) 101, Life Safety Code (LSC).
- Take measures to limit crowding in communal spaces.
- Encourage social distancing at large gatherings, such as parties or events.
- Explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in resident rooms and all shared spaces.
- 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.

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[1] 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

[2] Centers for Disease Control and Prevention (CDC) (June 2, 2021). Ventilation in Buildings, Available at: https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html. Accessed October 11, 2022.

2. **Vaccinations**

Vaccination remains critically important in reducing risk of hospitalization and death due to COVID-19. Facilities should encourage residents, staff, and families to remain up to date with COVID-19 vaccination, including all eligible booster doses.

3. **Reporting of Staff and Resident COVID-19 Vaccinations and Testing**

- CMS-certified facilities (i.e., facilities that care for residents with Medicare or Medicaid) continue to be required to report SARS-CoV-2 infection and vaccination data to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module. Check the NHSN LTCF COVID-19 Module website for additional information.
- Other forms of communicable disease reporting mandated by state regulations and local health departments are unaffected.

4. **Oral Antivirals, Other Therapeutics for Outpatient Management of COVID-19**

Treatment has been shown to significantly reduce the risk of severe COVID-19 disease and hospitalization, especially in the elderly. **As soon as a resident is diagnosed with COVID-19, contact the resident's medical provider to assess whether treatment is warranted.**

Information is available at:

- National Institutes of Health (NIH) treatment guidelines.
- A clinical decision tree is also available to help clinicians determine if a resident is eligible for treatment and the right choice of treatment.
- Providers/facilities looking to directly administer or provide medications should use the IDPH Therapeutics Request Form.

5. **Screening**

Facilities must ensure a process is in place to inform HCP, residents, and visitors of recommended actions to prevent the transmission of COVID-19 by posting visual alerts (e.g., signs, posters) at entrances and other strategic places. These alerts should include instructions about current IPC recommendations (e.g., when to use source control and perform hand hygiene).

Visitors: Facilities need to ensure visitors are aware that, if they have any of the following three criteria, they should limit or defer non-urgent in-person visitation while they are infectious or potentially infectious or until they have met the health care criteria to end isolation to preserve the safety of residents.

- A positive viral test for SARS-CoV-2,
- symptoms of COVID-19, **or**
- if visitors who have had close contact with someone with SARS-CoV-2 infection or were in another situation that put them at higher risk for transmission, it is safest to defer non-urgent in-person visitation until 10 days after their close contact

Residents: When COVID-19 Hospital Admissions Levels are **HIGH, or if the facility is in outbreak, *all residents, including new admissions,*** should be evaluated at least daily for signs and symptoms of COVID-19.

HCP: Instruct HCP to report a positive viral test, symptoms of COVID-19, **or** close contact with someone with SARS-CoV-2 infection or a higher-risk health care exposure to SARS-CoV-2 to occupational health or another point of contact designated by the facility so these HCP can be properly managed. See below. below

6. **Implement Source Control Measures**

Source control refers to use of respirators or well-fitting face masks to cover a person's mouth and nose to prevent the spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. The overall benefit of broader masking is likely to be the greatest for residents at higher risk for severe outcomes from respiratory virus infection and during periods of high respiratory virus prevalence in the community (as indicated by hospital admissions data). Because nursing home residents are more likely to develop serious illness due to SARS-CoV-2 infection, particular care should be taken to prevent the introduction of the virus into these facilities.

The SARS-CoV-2 virus can be spread from individuals who do not have symptoms. Therefore, when COVID-19 Hospital Admissions Levels are **HIGH**, source control is recommended for staff and visitors in nursing homes and other long-term care facilities when they are in common areas of the facility where they could encounter residents. Facility-wide source control should be considered when there is substantial activity of COVID-19, or other respiratory pathogens like Flu or RSV, in their locale and should seek input from their local health department regarding considerations for other respiratory infections.

Universal use of source control in common areas is also recommended as a mitigation measure during outbreaks of COVID-19 and may be ended once no new cases have been identified for 14 days.

Visitors: Facilities may choose to offer well-fitting masks as a source control option for visitors but should allow the use of a mask or respirator with higher-level protection that is not visibly soiled.

Residents: It is recommended that residents wear a well-fitted mask in common areas when the facility is experiencing an outbreak of COVID-19 or is otherwise recommended by public health. During an outbreak, residents do not have to wear source control in their rooms.

Refer to the section on visitation below for additional discussion regarding source control for visitors.

HCP: Source control options for HCP include:

- A well-fitting mask.
- A NIOSH Approved® particulate respirator with N95® filters or higher.
- A respirator approved under standards used in other countries that are similar to NIOSH Approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH Approved respirator when respiratory protection is indicated).
- A barrier face covering that meets ASTM F3502-21 requirements, including Workplace Performance and Workplace Performance Plus masks.

When used solely for ***source control***, any of the options listed above for HCP could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If used ***during the care of a resident*** for which a NIOSH-approved respirator or well-fitted mask is indicated for personal protective equipment (PPE) they ***should be removed and discarded after the resident care encounter and a new one should be donned.***

HCP could choose not to wear source control when they are in well-defined areas that are restricted from resident access (e.g., staff lounge or meeting rooms). Facility policies should define what areas are considered to be restricted from resident access.

Source control is always recommended for individuals in health care settings who:

- **Have suspected or confirmed SARS-CoV-2 infection** or other respiratory infection (e.g., those with runny nose, cough, sneeze).
- **Had close contact** (residents and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection for 10 days after their exposure.
- **Reside or work on a unit** or area of the facility experiencing a SARS-CoV-2 outbreak.
- Have otherwise had source control recommended by public health authorities.

Residents, visitors, or staff may choose to wear a well-fitted mask at any time, based on their personal preference, when in the common areas of the facility, especially if attending a large gathering and to and from the dining room or activities.

7. Respiratory Protection Program

Employers must establish a respiratory protection program, to ensure that staff members are fit-tested, medically cleared, and trained for any respiratory protection they will need. For more details, see the OSHA Respiratory Protection Standard.

8. Universal PPE for HCP

- Healthcare workers must use proper PPE when exposed to a resident with suspected or confirmed COVID-19 or other sources of SARS-CoV-2. (See OSHA's PPE standards at 29 CFR 1910 Subpart I)[3].

[3] U.S. Department of Labor, Occupational Safety and Health Administration, Coronavirus Disease (COVID-19) Regulations, https://www.osha.gov/coronavirus/standards

- If a resident is suspected or confirmed to have COVID-19, HCP must wear an N95 respirator, eye protection, gown, and gloves.
- **If a facility is experiencing an outbreak** of COVID-19 or other respiratory illnesses, at a minimum, HCP must wear a well-fitted mask **while on the unit or floor experiencing an outbreak**. In addition, facilities should consider requiring an N95 respirator and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) **during all resident care, on the affected unit or floor**.
- For those residents not suspected to have COVID-19 or other respiratory illnesses and who do not reside on a unit experiencing an outbreak, HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis).

- **For COVID-19 specimen collection**
  - PPE requirements vary based on the staff's role in specimen collection and whether they will be at least 6 feet away from the person being tested.
  - Gown, NIOSH-approved N95 equivalent or higher-level respirator, gloves, and eye protection are needed for staff collecting specimens or working within 6 feet of the person being tested.
  - Gloves and mask are needed for staff who will not be directly involved in specimen collection or who will be greater than 6 feet away from person being tested.
  - Consider whether you can minimize the number of staff needed and amount of PPE used by having individuals collect their own specimens while being supervised by health care providers who are at least 6 feet away.

- **HCP PPE Guidance for residents who use CPAP/BIPAP**
  - CPAP/BIPAP (positive pressure ventilation), which is used to treat sleep apnea, are believed to generate aerosols and droplets, and potentially pose a risk of transmitting COVID-19 to HCPs
  - **For residents who are known or suspected of having COVID-19:** HCP must wear an N95 respirator, eye protection, gown and gloves when entering the room during the use of CPAP/BIPAP. If the resident is no longer in the room (for example due to a transfer) an N95 respirator and eye protection should be worn by staff entering the room for 60 minutes post-use of CPAP/BIPAP to allow air contaminants to be removed.
  - **For residents who are NOT suspected of having COVID-19**
    - **If the resident resides on a floor with a COVID-19 outbreak, or the Covid-19 Hospital Admissions Level is HIGH**, the HCP should at a minimum wear a well-fitted mask and should consider an N95 respirator and eye protection.
    - **If the resident does NOT reside on a floor with an outbreak, and the COVID-19 Hospital Admissions Level is LOW,** no additional PPE is required.
  - **The CDC list of aerosol-generating procedures can be found in the FAQ section here.**

- **Broader use of PPE**
  When the potential for encountering asymptomatic persons with SARS-CoV-2 infection also likely increases. In these circumstances, health care facilities should consider implementing broader use of PPE during resident care encounters. For example, facilities should consider having HCP wear N95 respirators and eye protection for the following:

  - HCP working in situations where additional risk factors for transmission are present, such as the resident being unable to use source control and the area being poorly ventilated (e.g., memory care units).

  - If an outbreak is identified and universal respirator use by HCP working in affected areas is not already in place.

9. Testing Plan and Response

The facility must have a written COVID-19 testing plan and response strategy in place based on contingencies informed by the CDC[4] and, as applicable, CMS requirements.

As of publication, facilities may be eligible for no cost direct shipments of BinaxNOW COVID-19 rapid antigen tests from the federal government. To enroll, email the U.S. Department of Health and Human Services (HHS) Binax Team at Binax.Team@hhs.gov and indicate you are a long-term care facility interested in signing-up for the free shipments of BinaxNOW COVID-19 antigen tests. The HHS Binax Team will assist with eligibility and enrollment. Please note, this program may not continue.

COVID-19 testing is required for any of the following:

- **Symptomatic residents or HCP,** even those with mild symptoms of COVID-19, should receive a viral test for SARS-CoV-2 as soon as possible. Implement recommended infection prevention and control (IPC) practices when caring for a resident with suspected or confirmed SARS-CoV-2 infection **(see below)**.
- **Asymptomatic residents and HCP with a close contact or higher-risk exposure** with someone with SARS-CoV-2 infection are recommend to have a **series of three viral tests** for SARS-CoV-2 infection **unless they have recovered from COVID-19 in the prior 30 days**. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) (e.g., PCR) is recommended. This is because some people may remain NAAT positive but not be infectious during this period. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.

[4] Centers for Disease Control and Prevention. COVID-19. Interim Infection Prevention and Control Recommendations for Health care Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, Available at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html Accessed October 11, 2022.

- **Admissions and Residents who Leave the Facility**
  - In general, testing of newly admitted residents with no known exposure to COVID-19 is at the discretion of the facility.
  - However, regardless of whether they are tested, if the COVID-19 Hospital Admissions Levels are **HIGH**, then newly admitted residents should be advised to wear source control for the 10 days following their admission (day 0 is the date of admission).
  - If testing is performed for newly admitted residents, it would be reasonable to test at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 0, day 2, and day 4.
  - Empiric use of Transmission-Based Precautions is generally not necessary for admissions unless they meet criteria described below. Examples of when empiric Transmission-Based Precautions may be considered include:
    - Resident is unable wear source control as recommended for the 10 days.
    - Resident is moderately to severely immunocompromised.
    - Resident is placed on a unit with others who are moderately to severely immunocompromised.
    - Resident is placed on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.
  - Residents who leave the facility for 24 hours or longer should generally be managed as a new admission (as described above).
  - Testing is not required for residents who leave the facility for fewer than 24 hours.

- **Outbreak testing**
  - Facilities can choose to investigate an outbreak using contact tracing or a broad-based approach.
  - A broad-based approach includes the unit, floor, or other specific area of the facility where the positive COVID-19 case was identified (this could be where the resident resides or where the HCP worked). If a facility is unable to conduct contact tracing or contacts cannot be identified, the facility should follow a broad-based approach.
    - **When using the broad-based approach, a facility should continue to test every 3-7 days until there are no more positive cases identified for 14 days.**
    - If additional cases are identified after testing a unit, floor, or specific area of the facility, the facility may expand testing to facility-wide testing if testing and implementation of infection control measures have failed to halt transmission.
  - If contact tracing was completed, test all residents and HCP identified as close contacts or who had a higher-risk exposure unless they have recovered from COVID-19 in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a NAAT (e.g., PCR) is recommended. This is because some people may remain NAAT positive but not be infectious during this period. Test at day 1, day 3, and day 5 (as above).
    - If no additional cases are identified during contact tracing (testing only those residents or staff with a close contact or higher risk exposure) no further testing is indicated.

- If additional cases are identified from testing close contacts or higher-risk exposures, facilities should expand testing as determined by the distribution and number of cases throughout the facility and ability to identify close contacts. This is considered a broad-based approach. **When using the broad-based approach, a facility should continue to test every 3-7 days until there are no more positive cases identified for 14 days.**
- If a facility is unable to perform contact tracing, they should test all residents and HCP on the affected unit(s) using the broad-based approach. Test every 3-7 days until there are no more positive cases identified for 14 days
- If additional cases are identified after testing a unit, floor, or specific area of the facility, the facility may expand testing to facility-wide testing if testing and implementation of infection control measures have failed to halt transmission.
- If facility-wide testing is underway and transmission on a unit, floor, or specific area is interrupted with no new case identified for 14 days, then testing in those specific areas may be discontinued, even if other areas of the facility remain in outbreak.

10. Hand Hygiene

Hand hygiene is a core infection prevention measure and should be performed frequently to reduce the spread of organisms and the virus that causes COVID-19. The facility must train and validate competencies of all staff on hand hygiene. Facilities should encourage persons entering the facility to perform hand hygiene and ensure hand hygiene products are available at the point of care.

11. Environmental Infection Control

- Dedicated medical equipment should be used when caring for a resident with suspected or confirmed SARS-CoV-2 infection. Reusable equipment must be cleaned and disinfected between residents.
- Refer to List N[5] on the U.S. Environmental Protection Agency (EPA) website, for EPA-registered disinfectants that kill SARS-CoV-2; the disinfectant selected should also be appropriate for other pathogens of concern at the facility (e.g., a difficile sporicidal agent is recommended to disinfect the rooms of residents with C. difficile infection).
- Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.
- Once the resident has been discharged or transferred, HCP, including environmental services personnel, should refrain from entering the vacated room without all recommended PPE until sufficient time (approximately 60 minutes) has elapsed for enough air changes to remove potentially infectious particles. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection utilizing routine PPE before it is returned to use.

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

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12. Personal Protective Equipment Supply

Surge capacity refers to the ability to manage a sudden increase in resident volume that would severely challenge or exceed the present capacity of a facility. To help health care facilities plan and optimize the use of PPE in response to COVID-19, CDC has developed a Personal Protective Equipment (PPE) Burn Rate Calculator.

Three general strata have been used to describe surge capacity and can be used to prioritize measures to conserve PPE supplies along the continuum of care:

- **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).

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

Recommended infection prevention and control (IPC) practices when caring for a resident with suspected or confirmed SARS-CoV-2 infection or a close contact of someone with confirmed COVID-19 infection.

Duration of Empiric Transmission-Based Precautions for ***Symptomatic Residents being Evaluated for SARS-CoV-2 infection***:

- The decision to discontinue empiric Transmission-Based Precautions by excluding the diagnosis of current SARS-CoV-2 infection for a resident with symptoms of COVID-19 can be made based upon having negative results from at least one NAAT (e.g., PCR) viral test.
- If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining Transmission-Based Precautions and confirming with a second negative NAAT or second negative antigen test taken 48 hours after the first negative test.
- If a resident is suspected of having SARS-CoV-2 infection is never tested, the decision to discontinue Transmission-Based Precautions can be made based on time from symptom onset as described in the Isolation section below.
- Ultimately, clinical judgement and suspicion of SARS-CoV-2 infection determine whether to continue or discontinue empiric Transmission-Based Precautions.
- Facilities should consult with residents' health care providers to rule out other respiratory infections before discontinuing Empiric Transmission-Based Precautions.

Duration of Empiric Transmission-Based Precautions for ***Asymptomatic Residents following Close Contact*** with Someone with SARS-CoV-2 Infection

- Asymptomatic residents do not require Empiric Transmission-Based Precautions while being evaluated for COVID-19 following a close contact with someone with COVID-19 infection.
  - Testing is not recommended for those recovered from COVID-19 in the **prior 30 days**.
  - Testing should be considered for those who have recovered in the **prior 31-90 days**.
  - These residents should wear source control when out of their rooms.

- Empiric Transmission-Based Precautions following ***close contact*** may be considered when:
  - Resident is unable to be tested or wear source control for 10 days following exposure.
  - Resident is moderately to severely immunocompromised.
  - Resident resides on a unit with others who are moderately or severely immunocompromised.
  - Resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

If residents are placed in Transmission-Based Precautions for any reason listed above:

- Residents can be removed from Transmission-Based Precautions after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing as described for asymptomatic individuals following close contact is negative.
- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.
  - This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
- If viral testing is not performed, residents can be removed from Transmission-Based Precautions after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms.

13. Management of Residents

COVID-19 Unit

- Facilities are not required to have a dedicated COVID-19 unit unless the number of positive residents would warrant such a unit. If residents can be safely managed in the general population, a facility can place a COVID-19 positive resident in a single room with appropriate isolation signage, and staff wearing N95 respirator, eye protection, gown, and gloves upon entry to the room.
- Facilities could consider designating entire units within the facility, with dedicated HCP, to care for residents with SARS-CoV-2 infection when the number of residents with SARS-CoV-2 infection is high.
  - When feasible, dedicate HCP to the COVID-19 area or unit (including environmental services or housekeeping staff). Dedicated means that HCP are assigned to care only for these residents during their shifts. Dedicated units and/or HCP might not be feasible due to staffing shortages or a small number of residents with SARS-CoV-2 infection.

- Consideration should be given to assigning staff who are up to date with COVID-19 vaccination or have recently recovered from COVID-19 infection to care for residents in the dedicated area or unit.

Resident Placement if not using a COVID-19 Unit

- Place a resident with suspected or confirmed SARS-CoV-2 infection in a single-person room using Transmission-Based Precautions (isolate). The door should be kept closed (if safe to do so). Ideally, the resident should have a dedicated bathroom.
- If limited single rooms are available or if numerous residents are simultaneously identified to have known SARS-CoV-2 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.
- If cohorting, only residents with the same respiratory pathogen should be housed in the same room. Multidrug-resistant organisms (MDRO) colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
- Limit transport and movement of the resident outside of the room to medically essential purposes.
- Communicate information about residents with suspected or confirmed SARS-CoV-2 infection to appropriate personnel before transferring them to other departments in the facility and to other health care facilities.

Residents with Confirmed COVID-19

- Resident placement: single room with door closed if safe to do so. Dedicated bathroom if possible.
- If limited single rooms are available or if numerous residents are simultaneously identified to have COVID-19, residents can remain in their current location with appropriate signage and PPE use. Cohorting may occur with other positive COVID-19 residents.
- Isolate using Transmission-Based Precautions (see duration of TBP below).
- Discuss treatment options with resident or their decision maker to prevent hospital admissions.
- Monitor the resident every four hours for clinical worsening. Include an assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam to identify and to quickly manage serious infections.
- Residents should report any symptoms to HCP. If symptoms recur (e.g., rebound), these residents should be placed back into isolation until they again meet the health care criteria below to discontinue Transmission-Based Precautions for SARS-CoV-2 infection unless an alternative diagnosis is identified.
- In general, residents who are hospitalized for SARS-CoV-2 infection should be maintained in Transmission-Based Precautions for the time period described for residents with severe to critical illness.

- In general, residents should continue to wear source control until symptoms resolve or, for those who never developed symptoms, until they meet the criteria to end isolation below. Then they should revert to usual facility source control policies for residents.
- Use dedicated medical equipment.
- Staff must wear full PPE (N95 respirator, gown, gloves, eye protection) when providing care.
- Residents with confirmed COVID-19 should have in-room meals and activities until recovered.
- Follow the Environmental Infection Control section listed above in this guidance.
- Visitation may occur following guidance in the visitation section.

Duration of Transmission-Based Precautions for residents with COVID-19:

1) **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).
2) **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.

Residents who were ***asymptomatic throughout their infection*** and are not moderately to severely immunocompromised should be maintained on Transmission-Based Precautions until:

- At least 10 days have passed since the date of their first positive viral test.

Note: The test-based strategy while not recommended could be used to inform the duration of isolation for those residents who are moderately to severely immunocompromised. Refer to CDC recommendation.

Residents Suspected to have COVID-19

- Test symptomatic residents.
- In general, **asymptomatic residents** do not require empiric use of Transmission-Based Precautions while being evaluated (tested) for COVID-19 ***following close contact*** with someone with SARS-CoV-2 infection.
- Resident placement: single room with door closed if safe to do so. Dedicated bathroom when possible.
- 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. However, these residents should NOT be cohorted with residents with confirmed SARS-CoV-2 infection unless they are confirmed to have SARS-CoV-2 infection through testing.

- Isolate empirically using Transmission-Based Precautions until results of tests are known.
- Monitor residents at least daily.
  - Screening for signs and symptoms of COVID-19.
  - Actively monitoring temperature.
  - Assessing respiratory status with pulse oximetry.
  - ***If residents have a fever or symptoms consistent with COVID-19, increase the monitoring to every four hours.*** Include an assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam to identify and to quickly manage serious infection.
- Use dedicated medical equipment.
- Staff must wear full PPE (N95 respirator, gown, gloves, eye protection) when providing care.
- Follow the Environmental Infection Control section listed above in this guidance.
- Residents with suspected COVID-19 should have in-room meals and activities until recovered.
- Visitation may occur following guidance in the visitation section.

14. Resident Activities

When COVID-19 Hospital Admission Levels are **HIGH**, it is best practice for facilities to take extra precautions during communal dining and group activities. For instance, these measures may include limiting the size of groups and staggering meals to reduce crowding in communal spaces. Facilities are also encouraged to utilize these extra precautions when there is significant activity of other respiratory infections like Flu and RSV in their locality or based on recommendations from their local health department.

Beauty Salons and Barber Shops

- Residents are allowed to receive services in beauty salons and barber shops unless suspected or confirmed positive for COVID-19. Residents on Transmission-Based Precautions should not participate.
- Residents should consider wearing source control in the beauty salon when COVID-19 Hospital Admission Levels are **HIGH.**
- It is recommended that the beautician or barber wear source control while in the beauty salon when residents are present when COVID-19 Hospital Admission Rates are **HIGH**.

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

- Residents are allowed to participate in indoor performances or religious services unless suspected or confirmed positive for COVID-19. Residents on Transmission-Based Precautions should not participate in these gatherings.
- Residents should consider wearing source control during the performance or service when COVID-19 Hospital Admission Levels are **HIGH** while indoors. Physical distancing is not required.
- It is recommended that performers wear source control while performing indoors when COVID-19 Hospital Admission Levels are **HIGH**.

- Performers who play wind instruments can use bell/end coverings or face coverings with a slit when COVID-19 Hospital Admission Levels are **HIGH**.
- When in outbreak, individual serving packets of wafer and juice/wine are preferred for communion.
- Residents should consider source control and physical distancing if attending a large gathering (e.g., festivals, fairs, and parades), especially if immunocompromised and COVID-19 Hospital Admission Levels are **HIGH**.

15. 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)).

For the safety of the visitor, in general, residents should be encouraged to limit in-person visitation while they are infectious. However, facilities should adhere to local, state, and federal regulations related to visitation. Additional information about visitation from the CMS is available at Policy & Memos to States and Regions | CMS.

- Counsel residents and their visitor(s) about the risks of in-person visits.
- Facilities should provide instruction before visitors enter the resident's room on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy.
- When the resident is in Transmission-Based Precautions for suspected or confirmed COVID-19, or other respiratory illness, visits should occur in the resident's room.

Compassionate Care Visits

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 the COVID-19 Hospital Admission Levels, or an outbreak.

16. Managing Health Care Personnel with COVID-19 Infection or Exposure

(See Tables 2 and 3 in Appendix A below for Details)

HCP with higher risk exposure

In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction if they do not develop symptoms or test positive for SARS-CoV-2.

Following a higher-risk exposure, HCP should be managed as follows:

- Have a series of three viral tests for SARS-CoV-2 infection.
- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.
    - ***This will be at day 1 (where day of exposure is day 0), day 3, and day 5.***

- Due to challenges in interpreting the result, **testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days.**
- Testing should be considered for those who have recovered **in the prior 31-90 days;** however, an antigen test instead of NAAT is recommended. This is because some people may remain NAAT positive but not be infectious during this period.
- Follow all recommended infection prevention and control practices, **including wearing well-fitting source control, monitoring themselves for fever or symptoms consistent with COVID-19, and not reporting to work when ill or if testing positive for SARS-CoV-2 infection.**
- Any HCP who develops fever or symptoms consistent with COVID-19 should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
- While work restriction is not necessary for most asymptomatic HCP following a higher-risk exposure, ***examples of when work restriction may be considered include:***
    - HCP is unable to be tested or wear source control as recommended for the 10 days following their exposure.
    - HCP is moderately to severely immunocompromised.
    - HCP cares for or works on a unit with residents who are moderately to severely immunocompromised.
    - HCP works on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions.

The specific factors associated with these exposures should be evaluated on a case-by-case basis to determine if a higher-risk exposure occurred. CDC guidance is found at evaluating an exposure. Exposures that might require testing and/or restriction from work can occur both while at work and in the community. Higher-risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure without appropriate PPE.

HCP with SARS-CoV-2 Infection--Return to Work Criteria

- HCP with confirmed COVID-19 should be excluded from work.
    - After returning to work, HCP should self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.
    - If symptoms recur (e.g., rebound), these HCP should be restricted from work and follow recommended practices to prevent transmission to others (e.g., use of well-fitting source control) until they again meet the health care criteria below to return to work unless an alternative diagnosis is identified.

- The following are criteria to determine when HCP with SARS-CoV-2 infection could return to work and are influenced by severity of symptoms and presence of immunocompromising conditions.

- **HCP with mild-to-moderate illness** who are not moderately-to-severely immunocompromised could return to work after all of the following criteria have been met:
  - At least seven days have passed since symptoms first appeared if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).
  - At least 24 hours have passed since last fever without the use of fever-reducing medications.
  - Symptoms (e.g., cough, shortness of breath) have improved.

- **HCP who was asymptomatic throughout their infection** and are not moderately to severely immunocompromised could return to work after the following criteria have been met:
  - At least seven days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).
  - Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later.

- **HCP with severe to critical illness** who are not moderately-to-severely immunocompromised could return to work after all of the following criteria have been met:
  - At least 10 days and up to 20 days have passed since symptoms first appeared.
  - At least 24 hours have passed since last fever without the use of fever-reducing medications.
  - Symptoms (e.g., cough, shortness of breath) have improved.

- **HCP who are moderately-to-severely immunocompromised** may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. The test-based strategy as described below for contingency staffing can be used for moderately-to-severely immunocompromised HCP and inform the duration of work restriction.

- **When contingency staffing strategies are used, HCP with SARS-CoV-2 infection must be well enough and willing to return to work. When following contingency staffing strategies:**
  - HCPs with mild-to-moderate illness who are not moderately-to-severely immunocompromised:
    - At least five days have passed since symptoms first appeared (day 0).
    - At least 24 hours have passed since last fever without the use of fever-reducing medications
    - Symptoms (e.g., cough, shortness of breath) have improved.

        - Health care facilities may choose to confirm resolution of infection with a negative nucleic acid amplification test (NAAT) or a series of two negative antigen tests taken 48 hours apart*.
    - An HCP who was asymptomatic throughout their infection and are not moderately-to-severely immunocompromised:
        - At least five days have passed since the date of their first positive viral test (day 0).
        - Health care facilities may choose to confirm resolution of infection with a negative NAAT (molecular) or a series of two negative antigen tests taken 48 hours apart*.

* Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred if testing asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days.

17. Staffing and Other Personnel

- **Staffing**
  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. If a facility is allowing HCP who are positive to work, they must be willing and well enough to work. For additional strategies refer to CDC website Mitigation Strategies for Staffing Shortages.

- **Essential Caregivers**
  Facilities should encourage visits by essential caregivers (ECs) in nursing homes and other long-term care facilities (LTCF). Essential caregivers are not general visitors. These individuals participate in resident care by meeting an essential need of the resident, by assisting with activities of daily living, or positively influencing the behavior of the resident. Utilize the EC to provide care and emotional support in the same manner as prior to the pandemic or in whatever manner would best support current needs as resident health care or psychological conditions may have changed.

  It is important to ensure residents can receive individualized person-centered care while preventing the transmission of pathogens that cause disease. For this reason, ECs should follow all regulatory and facility requirements related to infection prevention and control that apply to LTCFs. The basic elements of an infection prevention and control program are designed to prevent the spread of infection in health care settings. When these

elements are present and practiced consistently, the risk of infection among residents and health care personnel is reduced[6],[7].

18. Essential Caregivers Guidance

- Facilities should encourage participation by ECs and communicate the role of the EC with ECs, residents, and families.
- Facilities should establish policies and procedures for designating and utilizing ECs that include a process and parameters for training ECs on infection prevention and control measures.
- ECs must be screened, tested, offered vaccination, and provided PPE in accordance with the health care personnel guidance in the facility's COVID-19 plan. ECs will be subject to the same standards for testing, quarantine, and isolation based on their vaccination status as for health care personnel at the facility.
- The facility must document that it has trained the EC on proper infection control, including hand hygiene and appropriate use of PPE, and include the ECs in hand hygiene and PPE use audits. This training should occur at least annually.
- The administrator, infection preventionist, or director of nursing should determine if EC participation is appropriate or can be considered under compassionate care if a resident has tested positive or is symptomatic for COVID-19, other respiratory infections, or MDROs.
- The facility should permit flexibility in scheduling EC participation, such as allowing evening and weekend visits, to accommodate the needs of the resident and the EC. This is consistent with Centers for Medicare and Medicaid Services (CMS) and Illinois Department of Public Health (IDPH) guidance related to residents' rights and visitation.[8]
- Residents may designate more than one EC based on needs (e.g., more than one family member may split time to provide care for the resident).

19. State-Authorized Personnel

IDPH grants authorization for entry to sState-authorized personnel. They should **not** be classified as visitors. 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-

[6] Stall, N. M., Johnstone, J., McGeer, A. J., Dhuper, M., Dunning, J., & Sinha, S. K. (2020). Finding the right balance: An evidence-informed guidance document to support the re-opening of Canadian nursing homes to family caregivers and visitors during the coronavirus disease 2019 pandemic. Journal of the American Medical Directors Association, 21(10), 1365-1370.

[7] Mody, L., Akinboyo, I. C., Babcock, H. M., Bischoff, W. E., Cheng, V. C. C., Chiotos, K., ... & Anderson, D. J. (2021). Coronavirus disease 2019 (COVID-19) research agenda for health care epidemiology. Infection Control & Hospital Epidemiology, 1-11.

[8] Centers for Medicare & Medicaid Services. State Operations Manual, Resident Rights and Visitation, pgs. 26-29. Available at: https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf. Accessed October 11, 2022.

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 facilities 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.

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. These personnel should adhere to the core principles of COVID-19 infection prevention.

20. Definitions

Close Contact
a) Being within 6 feet of a person with confirmed SARS-CoV-2 infection.
b) Having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.

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.

Essential Caregiver (EC)
Essential caregivers are not general visitors. These individuals meet an essential need of the resident by assisting with activities of daily living or positively influencing the behavior of the resident. The goal of such a designation is to help ensure high-risk residents continue to receive individualized, person-centered care. The plan of care should include services provided by the EC. (This language is not new and is incorporated here from the separate EC guidance which has been archived).

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 1)HCP was not wearing a respirator (or if wearing a face mask, the person with SARS-CoV-2 infection was not wearing a cloth mask or face mask), 2) 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, 3) HCP was not wearing eye protection if the individual with COVID-19 was not wearing a face covering or mask, 4) 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.

Non-skilled personal care
CDC defines non-skilled personal care as consisting of any non-medical care that can reasonably and safely be provided by non-licensed caregivers, such as help with daily activities like bathing and dressing; it may also include reminders for the kind of health-related care that most people do themselves, like taking oral medications. In some cases where care is received at home or a residential setting, care can also include help with household duties such as cooking and laundry.

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
Staff (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.

Table 1: COVID-19 Testing Summary		
Testing Trigger	**Staff (HCP)**	**Residents**
Symptomatic individual identified.	All staff with signs or symptoms should receive a viral test for SARS-CoV-2 as soon as possible.	All residents with signs or symptoms should receive a viral test for SARS-CoV-2 as soon as possible.
Higher-risk exposure or close contact with an individual who tested positive for COVID-19 that occurs within the facility.	Asymptomatic HCP with a close contact or higher-risk exposure with someone with SARS-CoV-2 infection should have **a series of three viral tests** for SARS-CoV-2 infection **unless they have recovered from COVID-19 in the prior 30 days.** **Testing should be considered for those who have recovered in the prior 31-90 days;** however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test**. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.**	Asymptomatic residents with a close contact or higher-risk exposure with someone with SARS-CoV-2 infection should have **a series of three viral tests** for SARS-CoV-2 infection **unless they have recovered from COVID-19 in the prior 30 days.** **Testing should be considered for those who have recovered in the prior 31-90 days;** however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. This is because some people may remain NAAT positive but not be infectious during this period. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. **This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.**
Higher risk exposure or close contact with individual positive with COVID-19 that occurs outside the facility.	Follow guidance listed above. In general, HCP who have had prolonged close contact **with someone with SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures above.**	Follow guidance listed above.
New admissions, readmissions, or those out of the facility for more than 24 hours.	Not applicable	Testing of newly admitted residents with no known exposure to COVID-19 is at the discretion of the facility. If the COVID-19 Hospital Admission Levels are **HIGH**, newly admitted residents should be advised to wear source control for the 10 days following their admission (day 0 is the date of admission). If testing is performed for newly admitted residents, it would be reasonable to test at admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 0, day 2, and day 4. Residents who leave the facility for 24 hours or longer, should be managed as a new admission.

Table 2: Work Exclusions and Restrictions for HCP with COVID-19 Infection			
Vaccination Status	**Conventional**	**Contingency**	**Crisis (Must notify LHD and OHCR)[2]**
	Work Exclusion and Required Testing	**Work Exclusion and Required Testing**	**Work Exclusion and Required Testing**
Vaccination status does not affect work exclusions or restrictions	Ideally, HCP should be excluded from work for 10 days . HCP can return to work after day 10 following the exposure (day 0) if they do not develop symptoms. No testing required to return to work if off work for 10 days. . **OR** A facility may choose to exclude the HCP from work for seven days with required testing. • May return to work seven days ***after exposure*** (day 0) if they do not develop symptoms and all viral testing is negative. • At least seven days have passed since ***symptoms*** first appeared if a negative viral test* is obtained within 48 hours prior to returning to work and • at least 24 hours have passed since last fever without the use of fever-reducing medications, and symptoms (e.g., cough, shortness of breath) have improved. HCP who **was asymptomatic throughout their infection** and are not moderately-to-severely immunocompromised could return to work after the following criteria have been met: ○ At least seven days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7). *Either a NAAT (molecular) or antigen test may be used. If using an antigen test, HCP should have a negative test obtained on day 5 and again 48 hours later	HCP may return if at least five days have passed since the date of their first positive viral test (day 0). May return after five days if asymptomatic or have mild to moderate symptoms that are improving and fever-free for 24 hours. Health care facilities may choose to confirm resolution of infection with a negative NAAT (molecular) or a series of two negative antigen tests taken 48 hours apart*. Antigen testing is preferred if testing asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days due to PCR sensitivity.	Allowed to work but should have duties prioritized. No additional testing is required to return to work.
[1]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. **[2]LHD – Local Health Department, OHCR = IDPH Office of Health Care Regulation**			

Table 3: Work Exclusions and Restrictions for Asymptomatic HCP with Exposures		
Conventional	**Contingency**	**Crisis (Must notify LHD and OHCR)**
Work Exclusion and Required Testing	**Work Exclusion and Required Testing**	**Work Exclusion and Required Testing**
Allowed to work with no testing if has recovered from COVID-19 in the prior 30 days and are asymptomatic. **Allowed to work with a series of three viral tests if recovered from COVID-19 in the prior 31-90 days.** Testing: Use an antigen test instead of a NAAT (e.g., PCR). Test immediately (not earlier than 24 hours after exposure), and if negative, again 48 hours after the first negative test, and if negative, again 48 hours after the second negative test. **Typically, this will be day 1 (where day of exposure is day 0), day 3, and day 5.**	Allowed to work **Must be asymptomatic** No additional testing is required to return to work, but the facility may need to include the returning HCP in outbreak testing if additional cases were identified from the testing of close contacts or other higher-risk exposures during the original outbreak investigation. Outbreak testing must be completed every 3-7 days until there are no more positive cases identified for 14 days. Testing would not be necessary if HCP had COVID-19 infection in prior 30 days. Facility should include HCP in testing if recovered in prior 31-90 days. No additional testing is required if no cases were identified from the testing of the close contacts or higher-risk exposures during the initial outbreak investigation.	Allowed to work **Must be asymptomatic** No additional testing is required to return to work, but the facility may need to include the returning HCP in outbreak testing if additional cases were identified from the testing of close contacts or other higher-risk exposures during the original outbreak investigation. Outbreak testing must be completed every 3-7 days until there are no more positive cases identified for 14 days. Testing would not be necessary if HCP had COVID-19 infection in prior 30 days. Facility should include HCP in testing if recovered in prior 31-90 days. No additional testing is required if no cases were identified from the testing of the close contacts or higher-risk exposures during the initial outbreak investigation.