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COVID-19

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Updated Interim Guidance for Nursing Homes and Other Long-Term Care Facilities Incorporating COVID-19 Vaccination

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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 – Vaccination Allows for Increased Social Interactions

On April 27, 2021 the Centers for Disease Control and Prevention (CDC) issued updated guidance for long-term care facilities, which has been adopted by the Centers for Medicare and Medicaid Services (CMS).[1] The CDC update allows for increased social interactions for residents of long-term care facilities based upon their vaccination status. Those recommended changes have been incorporated into this guidance.

Background

Safe and effective COVID-19 vaccines received Emergency Use Authorization from the U.S. Food and Drug Administration (FDA) in December 2020. Since then, more than 326,000 COVID-19 vaccinations have been administered to residents and staff at nearly 1,600 long-term care facilities in Illinois through the work of the Federal Pharmacy Partnership Program, Illinois Department of Public Health (IDPH), and local health departments. Similar programs ensuring the vulnerable residents of long-term care facilities receive COVID-19 vaccinations have been offered in every state.

Encouraged by the decline of COVID-19 cases across the country, and the availability of vaccines, CMS, in conjunction with the CDC, released expanded nursing home visitation guidance on March 10, 2021 and revised on April 27, 2021 (QSO-20-39-NH revised). Separation from family and other loved ones has taken a physical and emotional toll on residents, and the revised guidance is a step towards reducing that burden.

Continuing to take precautions to reduce the risk of transmission of COVID-19, however, remains vitally important. At this time, not all nursing home residents and staff are fully vaccinated making it possible for them to still become infected by visitors. In addition, the CDC

[1] Centers for Disease Control and Prevention. Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination. April 27, 2021. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

and public health experts are evaluating if individuals can spread COVID-19, including new variants, even if they are vaccinated.

Therefore, the CDC still recommends maintaining the infection prevention practices that reduce the spread of COVID-19, such as wearing a face mask, performing hand hygiene, and maintaining 6 feet of physical distance from others, especially for unvaccinated persons in congregate care settings.

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

Definitions

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

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

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

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

1. Staff member not wearing either face mask or respirator.

2. Staff not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or face mask.

3. Staff member not wearing full personal protective equipment (PPE) (gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure.

Round of Testing (New): The first round of testing refers to having one test performed for all residents and staff, which should be completed within three days.

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

State-authorized personnel: State-authorized personnel include, but are not limited to representatives of the Office of the State Long-Term Care Ombudsman Program, the Office of State Guardian, IDPH Office of Health Care Regulation, and the Legal Advocacy Service; and community-service providers, social-service organizations, prime agencies, or third parties serving as agents of the state for purposes of providing telemedicine, transitional services to community-based living, and any other supports related to existing consent decrees and court-mandated actions, including, but not limited to, the prime agencies and sub-contractors of the Comprehensive Program serving the *Williams* and *Colbert* Consent Decree Class Members.

Source Control: Source control refers to 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.

Core Principles of COVID-19 Infection Prevention

- **Vaccination** for COVID-19 has been shown to be highly effective.

- **Screen** all who enter the facility for signs and symptoms of COVID-19, including temperature checks, and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status).

- **Perform hand hygiene** with the use of alcohol-based hand rub, which is preferred to soap and water, unless hands are visibly soiled.

- **Require face covering** or mask (covering mouth and nose), in accordance with CDC guidance and FDA guidance.

- **Employ physical distancing** at least 6 feet between persons, in accordance with CDC guidance.

- **Provide instructional signage** throughout the facility and visitor education on COVID-19 signs and symptoms, infection control precautions, and other applicable facility practices (e.g., use of cloth face mask or face covering, specified entries, exits and routes to designated areas, hand hygiene).

- **Clean and disinfect** high-touch surfaces in the facility often, and designated visitation areas after each visit.

- Ensure appropriate staff use of **PPE.**

- **Effective cohorting** of residents (e.g., separate areas dedicated to COVID-19 care).

- **Resident and staff testing** as required.

Continued Monitoring of Essential Measures

Facilities are no longer required to attest to meeting eligibility criteria to reopen; however, facilities should continue to monitor criteria to ensure they can provide safe care and respond to outbreak situations. The CMS Reopening Phases no longer apply.

Case status in the community

The state is divided into 11 geographic Illinois COVID-19 regions for the purpose of monitoring and mitigating resurgence of COVID-19. Indicators are calculated daily for each region and compared to pre-established threshold values for: (a) test positivity rate and (b) a composite metric of COVID-19 hospital admissions and hospital resource capacity.[2]

Note: If health metrics indicate a resurgence of COVID-19 within one of the 11 defined Illinois COVID-19 regions, then IDPH will consider mitigation options for various settings within that region from a tiered menu. See the end of this document for details.

Case status in the facility

A facility must continue to test and to monitor new facility-onset and facility-associated cases and implement facility-wide testing per testing plan.

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[2] https://www.dph.illinois.gov/regionmetrics

Staffing level
IDPH does not support staff working while ill. However, should shortages occur, facilities should utilize mitigation strategies as defined by CDC.[3] Refer to "Mitigation Strategies for Staffing Shortages" section below.

Hand hygiene
The facility must train and validate competencies of all staff on hand hygiene.[4] Everyone entering the facility must perform hand hygiene.

Cleaning and disinfection supplies
Ensure that any disinfectants used in the facility are included on the U.S. Environmental Protection Agency (EPA) "List N"[5] as effective against coronavirus (COVID-19)**.** Cleaning and disinfecting products should be readily available for use at the point of care.

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

Facilities can consider crisis capacity strategies when the available supply is not able to meet the facility's current or anticipated utilization rate. CDC's optimization strategies for PPE offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted. KN95 masks are not considered NIOSH-approved N95 respirators and are considered a crisis level strategy option.

As specified in the guidance for PPE, a NIOSH-approved N95 equivalent or higher-level respirator is recommended when caring for suspected or confirmed patients with COVID-19.[6] Facilities would be considered in crisis capacity, if their supply of N95s does not meet the anticipated demand as calculated by the CDC Burn Rate Calculator

As PPE availability returns to normal, health care facilities should promptly resume standard practices.[7]

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[3] https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
[4] https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

[5] https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19
[6] https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/ ; https://www.cms.gov/files/document/qso-20-39-nh.pdf
[7] https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/

The facility may operate at contingency PPE capacity. If the facility has sufficient PPE, it is not operating at crisis capacity, as defined by CDC.[8] All staff must wear appropriate PPE when indicated. Also refer to the PPE Capacity Categories section below.

Everyone entering the facility must wear a face mask or respirator, as appropriate. All residents must wear a cloth face mask or face covering, if possible, when outside of their rooms and when staff enter their rooms.

- If, due to a medical condition or disability, a resident cannot tolerate or is unable to remove a cloth face covering, then a face shield may be substituted as a second-best alternative.

- If, due to a medical condition or disability, a staff member cannot tolerate a face mask, and the staff member requests a reasonable accommodation under the Americans with Disabilities Act or the Illinois Human Rights Act, then the employer will determine whether such an accommodation can be provided while fully protecting the health and safety of that employee, other staff members, and residents of the facility, and without causing an undue hardship to the employer.

Universal screening

The facility must have a written policy that states where, when, how, and by whom screening will be performed and recorded. The facility must use a checklist-based screening protocol, recorded in written or electronic format, for each person entering the facility, including all staff, visitors, and other persons. Face-to-face screening of visitors and staff is no longer required. Visitors and staff may complete screening protocols independently if reviewed by a staff member prior to entry. Visitors or staff meeting any of the exclusion criteria should be restricted from visiting or working. Screening must check for each of these exclusion criteria:

- measured body temperature of 100.0 degrees Fahrenheit or more;[9]
- symptoms of COVID-19, as listed by CDC;[10]
- diagnosis of COVID-19 before completing the appropriate period of isolation;[11] or
- those who have had close contact with someone with COVID-19 infection in the prior 14 days (applies only to visitors) regardless of their vaccination status).[12]

All residents are to be screened for elevated body temperature, pulse oxygen level, and symptoms of COVID-19, as listed by CDC, at least daily.

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[8] https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
[9] https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
[10] https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html
[11] https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
[12] https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

The facility must retain screening records according to the facility's record retention policy, but not for less than 30 days.

Testing Plan and Response Strategy

The facility should have a written COVID-19 testing plan and response strategy in place, based on contingencies informed by the CDC[13] and, as applicable, CMS requirements.[14]

- The testing plan must specify the method(s) and locations of testing (laboratory and/or point-of-care).

- The testing plan should include:

  - Initial testing of all residents and staff ("facility-wide baseline testing") if this has not been done previously during the COVID-19 pandemic.

  - Immediate testing of residents or staff with signs/symptoms of COVID-19 regardless of vaccination status.

  - Asymptomatic staff with a higher-risk exposure and patients or residents with prolonged close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, **should have a series of two viral (antigen or Nucleic Acid Amplification Test [NAAT]) tests for SARS-CoV-2 infection**. **In these situations, testing is recommended immediately and 5–7 days after exposure.**

  - People with SARS-CoV-2 infection in the last 90 days do not need to be tested if they remain asymptomatic, including those with a known contact.

  - A policy for addressing residents and staff that refuse testing in each of the following situations: (a) symptomatic or (b) asymptomatic.

  - Timely reporting of testing results to IDPH and the certified local health department in accordance with applicable regulations; records are retained according to the facility's record retention policy.

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

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

- Provisions for designating resident care areas with dedicated staff if residents become symptomatic ("PUI unit") or test positive for COVID-19 (COVID-19 unit).[15] [16]

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

- **Response to a positive test**: If there is an outbreak, a single facility-onset COVID-19 infection in a resident, or a single new case of facility-associated COVID-19 infection in a staff member, the first round of testing should include all previously negative residents and staff **regardless of vaccination status.**

  - Repeated retesting continues, generally every 3-to-7 days, until no new cases of COVID-19 infection are identified among residents or staff for a period of at least 14 days **regardless of vaccination status.**

  - When the positive case is identified in a staff member that rotates on multiple units, facilities must determine which units are affected based upon the infectious period: 48 hours prior to the positive test and whether an exposure occurred (15 min. cumulative exposure in 24 hours [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to SARS-CoV-2 | CDC]).

- If a facility has had no new cases within the past 14 days, then serial testing of **unvaccinated** staff occurs, and the minimum testing frequency is based on county positivity rates (based on CMS data)[11] and CMS requirements (see CMS chart below).[17]

- **Fully vaccinated** staff do not have to be routinely tested.

Community COVID-19 Activity	County Positivity Rate in the Past Week	Minimum Testing Frequency
Low	**<5%**	**Once a month**
Medium	**5% -10%**	**Once a week***
High	**>10%**	**Twice a week***

***This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.**

[15] https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
[16] https://www.cdc.gov/coronavirus/2019-ncov/community/community-mitigation.html
[17] https://www.cms.gov/files/document/qso-20-38-nh.pdf

- Facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency.[16]
    - If the county positivity rate increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity are met.

    - If the county positivity rate decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency.

- If the local health department endorses a higher frequency of testing for staff at facilities within its jurisdiction, based on other factors for COVID-19 transmission,[18] then facilities in that jurisdiction must test staff at the higher frequency.

- Periodic retesting of staff can be done on a fractional basis (e.g., 50% of the staff on each testing occasion), provided that all staff are tested at the target frequency. A positive finding still must trigger immediate, facility-wide testing.

Mitigation Strategies for Staffing Shortages

IDPH does not support staff working while ill. Mitigation strategies listed below are intended to be used in the order that they appear. *Fully vaccinated health care personnel (staff) with higher-risk exposures who are asymptomatic do not need to be restricted from work following their exposure.*

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. These include:

- Attempt to hire additional staff; rotate staff; offer overtime, bonus, or hazard pay to support patient 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.

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[18] https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

- Determine if there are alternate care sites with adequate staffing to care for patients 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, request staff postpone elective time off from work.

- Allow *asymptomatic staff who are not fully vaccinated and have had a higher-risk exposure* but are not known to be infected to shorten their duration of work restriction.

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.

- Shift staff who work in other areas to support patient 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 human resources and occupational health services) may need to implement crisis capacity strategies to continue to provide patient care. When there are no longer enough staff to provide safe patient care:

- Implement regional plans to transfer patients with COVID-19 to designated health care facilities, or alternate care sites with adequate staffing.

- Allow *asymptomatic staff who are not fully vaccinated and have had a higher-risk exposure* to continue to work onsite throughout their 14-day post-exposure period. If permitted to work, these staff should be monitored for symptoms as described above.

- If shortages continue despite other mitigation strategies, as a last resort consider allowing staff with suspected or confirmed COVID-19 to perform job duties where they do not interact with others, such as in telemedicine services; or provide direct care only for patients with confirmed or suspected COVID-19, preferably in a cohort setting.

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

Vaccination (New)

- Facilities should continue to promote and provide vaccination for all staff and residents.
- Post-acute care facilities should continue to encourage vaccination among all new admissions.
- Facilities should maintain a record of the vaccination status of patients/residents and staff.
- Full vaccination for visitors is always preferred, when possible.

Vaccinated Health Care Personnel

IDPH recommends following CDC guidance for return to work and work restrictions specific for staff who have been vaccinated against COVID-19. https://www.cdc.gov/coronavirus/2019-ncov/Staff/infection-control-after-vaccination.html

Newly Admitted or Readmitted Residents

- Residents who are **not fully vaccinated** must quarantine for 14 days upon admission or readmission to the facility in transmission-based precautions.

- Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility if they are **fully vaccinated or within 90 days of confirmed COVID-19 infection** and have not had prolonged close contact with someone with COVID-19 infection in the prior 14 days.

Visitation

General Visitation Guidance - Required Visitation

This section aligns with the newly released revised CMS Nursing Home COVID-19 Visitation Guidance.[19]

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

[19] https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

would constitute a potential violation of 42 CFR § 483.10(f) (4), and the facility would be subject to citation and enforcement actions.

Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through closed windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. However, this restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described below.

CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection prevention, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated.

However, we acknowledge the toll that separation and isolation have taken. We also acknowledge there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. **Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitors (see new "visitor modifications based upon vaccination status" section below).** Regardless, visitors should physically distance from other residents and staff in the facility.

According to the new CMS guidance, visitation should be person-centered; consider the residents' physical, mental, and psychosocial well-being; and support their quality of life. Nursing homes should enable visits to be conducted with an adequate degree of privacy. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission.

Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance.

To conduct visitation, the facility must formulate a written visitation policy. This policy must balance clinical and safety considerations of infection control with the resident's right to receive visitors [42 CFR § 483.10(f)(4)]. The facility should develop a short, easy-to-read fact sheet on visitation policy for residents and visitors; distribute the visitation policy to residents; and post the visitation policy on the facility's website. Visitors are required to comply with the facility's visitation policy. If a visitor refuses to follow the facility's policy during the visit, then staff may end the visit.

Before allowing indoor visitation, the risks associated with visitation should be explained to patients/residents and their visitors so they can make an informed decision about participation. Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility if they are permitted to visit. Visitors should be counseled about recommended infection prevention and control practices that should be used during the visit (e.g., facility policies for source control or physical distancing).

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred even when the resident and visitor are fully vaccinated against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status) may hinder outdoor visits.

For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents (open on at least two sides), if available. When conducting outdoor visitation, all appropriate infection control and prevention practices should be adhered to.

Visits may occur:

- Outdoors;
- In dedicated indoor visitation spaces;
- In private rooms; or
- In shared rooms provided that only one resident can have visitors at a time in-room without the roommate present if possible, and core principles of infection control are maintained.

Visitation Considerations

- Full vaccination for visitors is always preferred when possible but it is not required to participate in visitation (outdoor or indoor).
- Visitors, regardless of their vaccination status, should wear source control and physically distance from staff and other patient/residents, or visitors that are not part of their group at all other times when in the facility.
- Hand hygiene should be performed by the patient/resident and the visitors before and after contact.
- High-touch surfaces in visitation areas should be frequently cleaned and disinfected.
- Facilities should have a plan to manage visitation and visitor flow.
- Facilities might need to limit the total number of visitors in the facility at one time in order to maintain recommended infection control precautions. Facilities might also need to limit the

number of visitors per patient/resident at one time to maintain any required physical distancing when applicable.

- The facility may limit the number of visitors per resident at one time.
- Create an appointment schedule with time slots for each visitation area.
- Schedule visits by appointment only; specify start, end time, and location for each visit.
- Limit sign-ups to the allowed number of visitors in each time slot and visitation area.
- If demand for appointment slots exceeds availability, set limits on the number of slots per week or per day for each resident.
- Pre-screening of visitors 24 hours in advance of the visit is no longer required.
- Screen all who enter the facility for signs and symptoms of COVID-19, including temperature checks, and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status).
- Maintain a record of all visitors with contact information for potential contact tracing.
- Record date and time of visit, name, address, telephone, and, if available, email address.
- Make records available to IDPH and local health department for inspection and, as needed, for contact tracing; retain at least 30 days.
- Notify all visitors upon arrival that if they develop symptoms within three days after visiting or test positive for COVID-19, they must immediately notify the facility.
- Ensure infection control practices are utilized, including that visitors keep at least a 6-foot separation between themselves and other visitors, staff, and residents.
- The long-term care facility must submit its visitation policy upon request to IDPH or the certified local health department.

Visitation Modifications Based upon Vaccination Status (New)
(applicable to outdoor and indoor visitation)

- **When the resident and all of their visitors are fully vaccinated**
  - While alone in the resident's room or in the designated visitation area, the resident and their visitor(s) can choose to have close contact (including touch) and NOT wear source control.

  - Visitors should wear source control and physically distance from staff and other residents and visitors that are not part of their group at all other times while in the facility.

- **When either the patient/resident or any of their visitors are NOT fully vaccinated:**
  - The safest approach is for everyone to maintain physical distancing and to wear source control.

  - However, if the patient/resident is fully vaccinated, they can choose to have close contact (including touch) with their unvaccinated visitor(s) while both continue to wear well-fitting source control.
- If unvaccinated residents or visitors are in the designated visitation area, all residents and visitors should use source control and continue to remain at least 6 feet from others.

Outdoor Visitation

- Vaccinated and unvaccinated residents with SARS-CoV-2 infection should not participate in outdoor visits until they have met criteria to discontinue transmission-based precautions.

- Vaccinated and unvaccinated residents in quarantine should not participate in outdoor visits until they have met criteria for release from quarantine.

- Facilities in outbreak status should follow guidance from state and local health authorities and CMS on when visitation should be paused.

- Additional information is available in the CMS memo addressing visitation at intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and psychiatric residential treatment facilities (PRTFs) -COVID19 (2/10/2021). (QSO-21-14-ICF/IID&PRTF)[20]

- Designate outdoor space for visitation.
  - Visits may take place under a canopy or tent with two open sides.

- Measure the designated outdoor space and determine the number of residents and visitors that can be accommodated at one time in that area with at least 6-foot separation between residents and their visitors.
  - Consider marking the ground to show how visitors can place themselves with at least 6-foot separation between their group and other groups.
  - Post maximum number of residents and visitors that can occupy the area.
  - Post signage to cue 6-foot separation, face covering, and hand hygiene.
  - Set up dispensers for alcohol-based hand rub.

- Designate outdoor visitation hours when staff for screening and supervision of visitors will be available.

- If feasible, the facility may construct an outdoor conversation booth for unvaccinated residents unable or unwilling to wear a cloth face mask or face covering.

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[20] https://www.cms.gov/files/document/qso-21-14-icf-iid-prtf.pdf

- The conversation booth is constructed as a three-sided box with transparent walls at least 3 feet higher than the seated height of the occupant and the visitor.
- The resident sits inside the box and the visitor sits opposite the front wall.

- Between visits clean and disinfect seating and frequently touched surfaces in the visitation area.

Indoor Visitation
Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (Note: compassionate care visits should be permitted at all times).

During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area.

Indoor visitation could be permitted for all residents except as noted below:

- Indoor visitation for unvaccinated residents should be limited solely to compassionate care situations if the COVID-19 county positivity rate is >10% and <70% of residents in the facility are fully vaccinated.
- Indoor visitation should be limited solely to compassionate care situations, for:
  - Vaccinated and unvaccinated residents with SARS-CoV-2 infection until they have met criteria to discontinue transmission-based precautions.
- Vaccinated and unvaccinated residents in quarantine until they have met criteria for release from quarantine.
- Facilities in outbreak status should follow guidance from state and local health authorities and CMS on when visitation should be paused.
- Additional information is available in the CMS memo addressing nursing home visitation – COVID-19 (Revised 3/102021 and 4/27/2021) and the CMS memo addressing visitation at intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and psychiatric residential treatment facilities (PRTFs) - COVID19 (2/10/2021). (QSO-21-14-ICF/IID&PRTF)

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.

Indoor Visitation During an Outbreak:

- While outbreaks increase the risk of COVID-19 transmission, a facility should **not** restrict visitations for **all** residents when there is evidence the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility.

- Facilities should continue to adhere to CMS regulations and guidance for COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing.

- When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed.

Visitation can resume based on the following criteria:

- If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation can resume for residents in areas/units with no COVID-19 cases.

- However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing. For example, if the first round of outbreak testing reveals two or more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.

- If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend visitations for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

While the above scenarios describe how visitation can continue after one round of outbreak testing, **facilities should continue all necessary rounds of outbreak testing**. In other words, this guidance provides information on how visitation can occur during an outbreak but **does not change any expectations for testing and adherence to infection prevention and control practices.** If subsequent rounds of outbreak testing identify one or more additional COVID-19 cases in other areas/units of the facility, then facilities should suspend visitations for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

NOTE: In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings. Lastly, facilities should continue to consult with their local health departments when an outbreak is identified to ensure adherence to infection control precautions, and for recommendations to reduce the risk of COVID-19 transmission.

The facility then notifies residents, their families or guardians, and the long-term care ombudsman of relevant operational changes. Facilities should meet this requirement by using multiple communication channels, such as email listservs, social media, website postings, recorded telephone messages, and/or paper notification. Facilities should post signage about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.

Compassionate Care Visits

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

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

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

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

Compassionate care visits, and visits required under federal disability rights law, should be allowed at all times, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak.

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 and follow all screening protocols established by the facility. 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.]

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

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

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

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

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

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

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

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).

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. We 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.

Essential Caregivers

Refer to the IDPH Essential Caregiver Guidance for Long-term Care Facilities Guidance https://www.dph.illinois.gov/covid19/community-guidance/essential-caregiver-guidance-long-term-care-facilities

Activities

Whenever visitation is suspended for residents in an affected area (e.g., a unit), or throughout the facility during an outbreak, suspension of social activities and communal dining should also be considered.

Communal Dining

While adhering to the core principles of infection prevention, communal dining may occur for all residents (vaccinated and unvaccinated).

- **Residents who CANNOT participate in communal dining (Updated)**
  - Vaccinated and unvaccinated patients/residents with SARS-CoV-2 infection, or in isolation because of suspected COVID-19, can NOT participate in communal dining until they have met criteria to discontinue transmission-based precautions.
  - Vaccinated and unvaccinated patients/residents in quarantine can NOT participate in communal dining until they have met criteria for release from quarantine.

- **Residents who CAN participate in communal dining (New)**
  - Fully vaccinated patients/residents can participate in communal dining without use of source control or physical distancing.

  - If unvaccinated patients/residents are dining in a communal area (e.g., dining room) all patients/residents should use source control when not eating and unvaccinated patients/residents should continue to remain at least 6 feet from others.

  - If vaccination status cannot be determined, the safest practice is for all participants to follow all recommended infection prevention and control practices, including maintaining physical distancing and wearing source control.

- Residents should wear a cloth face mask or face covering to and from the dining area.

- Staff must perform hand hygiene and change PPE as appropriate in between assisting residents.

- Clean and disinfect surfaces between shifts of diners.

Group Activities (Updated)
Small-group activities. Group activities may be considered for activities that improve the quality of life for residents. To conduct activities:

- Allow participation only by residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.

- Outdoor activities, such as a stroll on facility grounds, are encouraged. Provide hand sanitizer stations.

- Avoid crowding on ingress and egress.

- If all patients/residents participating in the activity are **fully vaccinated**, then they may choose to have close contact and to not wear source control during the activity. (New)

- If **unvaccinated** patients/residents are present, then all participants in the group activity should wear source control and unvaccinated patients/residents should physically distance from others. (New)

- Sanitize items used in activity between users (e.g., game pieces, craft tools, etc.)

- For live music, avoid vocal performances and sing-alongs. Limit performances to instruments that can be played while wearing a face mask or face covering.

- Worship services should avoid singing, chanting, and group recitation.

- 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.

- The beautician or barber is subject to the same infection control requirements as staff.

- Do not use hand-held blow dryers.

- Observe restrictions and precautions in Personal Care Services Guidelines for Restore Illinois https://dceocovid19resources.com/assets/Restore-Illinois/businessguidelines4/personalcare.pdf

- Where IDPH guidelines in this document are more stringent, the IDPH guidance applies.

Trips Outside of the Building

For trips away from the facility:

- Share the resident's COVID-19 status with transport staff, any attendant persons, and with the appointment destination.
- Screen the transport staff, patient, and any attendant persons for elevated temperature and COVID-19 symptoms before entry into vehicle.
- Limit occupancy in vehicle based upon the vaccination status of the residents being transported and the ability to maintain 6-foot separation between unvaccinated residents.
- Driver must wear a cloth face mask or face covering and use additional PPE as indicated by CDC guidelines; resident must wear a cloth face covering or face mask.
- Assist resident in performing hand hygiene on departure from facility and upon return to facility.
- Disinfect transport equipment and commonly touched surfaces, including vehicle handles and seatbelts, before and after transport.
- Maintain physical distancing, wear a cloth face mask or face covering, and hand hygiene throughout time spent at the destination.
- Residents taking social excursions outside the facility should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces.
- Residents should be encouraged and assisted with adherence to all recommended infection prevention and control measures, including source control, physical distancing, and hand hygiene.
- If they are visiting friends or family in their homes, they should follow the source control and physical distancing recommendations for visiting with others in private settings as described in the *Interim Public Health Recommendations for Fully Vaccinated People*.

Upon return of a resident from a trip outside the facility:

- **Unvaccinated residents** should be observed and monitored closely for development of symptoms during the following 14-day period following the outing. Decisions on whether to

place such residents into transmission-based precautions, should be made by assessing the potential for exposure while away using the IDPH Risk Assessment: http://dph.illinois.gov/sites/default/files/COVID-19_LTC_FacilityRiskAssessment.pdf

- **Unvaccinated residents** that spend overnight out of building should be placed in transmission-based precautions for 14 days.

- **Fully vaccinated** inpatients and residents are not required to quarantine.

- Residents **within 90 days of confirmed COVID-19 infection** do not need to quarantine.

IDPH Procedure for Applying Tiered Mitigation

Illinois Regional Metrics Leading to Tiered Mitigation.
If health metrics indicate resurgence of COVID-19 within one of the 11 defined Illinois COVID-19 regions, then IDPH will consider mitigation options within that region from a tiered menu. If sustained increases in health metrics continue unabated despite initial measures, further mitigations may be added from additional tiers. Actions for long-term care facilities by tier are shown in the following table:

Mitigation	Tier 1	Tier 2	Tier 3
Visitation	Suspend indoor visits. Continue outdoor visits.	Same as Tier 1	Suspend all visits except for EC or compassionate care.
Communal Dining	Continue	Continue	Suspend
Group Activities	Continue without outside leaders or off-site outings.	Same as Tier 1, plus limit to 10 participants.	Suspend
Barber and Beauty Shop	Suspend	Suspend	Suspend

If resurgence metrics exceed threshold within one of the 11 Illinois COVID-19 regions and mitigation measures are applied to long-term care facilities in that region, then LTC facilities must wait at least 14 days after metrics return to their target ranges before reversing tiered mitigation.

Mitigation options from a tiered menu may also be considered under other circumstances:

- A facility may voluntarily apply mitigation measures, if deemed necessary, in accordance with the facility's internal policies for infection control.
- IDPH or the local health department may direct a facility to apply temporary mitigation measures pending correction of deficiencies in its infection control program that are identified in a regulatory survey.

If tiered mitigation measures are applied, then the facility must notify residents, their families or guardians, the long-term care ombudsman, and the local health department of relevant operational changes.

In the event of a conflict between this guidance document and any previously issued interim guidance from IDPH, this guidance takes precedence.

Questions about reopening may be directed to DPH.LTCreopening@illinois.gov.