RECOMMENDATIONS TO PREVENT AND RESPOND TO COVID-19 IN GROUP HOMES/INDIVIDUAL CARE SETTINGS

This guidance is to provide recommendations to programs that provide individual services in community settings. These facilities have clients living in a shared living space and may have health conditions that make them vulnerable to disease, therefore this guidance is modeled closely after the Centers for Disease Control and Prevention (CDC) guidance on Long Term Care. Strategies may be based on feasibility given the unique space and needs of the setting. Providers are encouraged to think creatively about all opportunities to increase the physical space between individuals and limit interactions in large group settings.

This document is to provide recommendations only. Each situation is unique and may require alternative considerations to provide for the health and safety of individuals within the setting.

DAILY PREVENTION MEASURES

Recommendations to prevent COVID-19 in Group Homes and other individual care settings include:

- In general, congregate settings should continue to follow infection prevention and control recommendations for not up to date individuals (e.g., use of Transmission-Based Precautions for those that have had close contact to someone with SARS-CoV-2 infection) when caring for up to date individuals with moderate to severe immunocompromise due to a medical condition or receipt of immunosuppressive medications or treatments.
- Post visual alerts (e.g., signs, posters) in strategic places (e.g., entrances, bathrooms, break areas, kitchens, etc.) to provide instructions about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include wearing a facemask (preferred) or cloth face covering for source control, and how and when to perform hand hygiene.
  - o If tolerated, not up to date individuals should be encouraged to wear cloth face coverings indoors when there are others present or if staff are providing direct care. In areas of substantial or high transmission, up to date individuals are encouraged to wear a mask indoors in public.
  - o Social/Physical Distancing
    - o All individuals and staff should maintain a distance of at least 6 feet from each other in the individual setting and outside, unless providing essential personal care.

- Provide education to individuals, staff, and volunteers to monitor their distance from others.
- Rearranging furniture and creating visual cues (ex: tape on the floor) has proven to be helpful.
- All staff should wear face masks. Face masks are preferred over cloth face coverings for all staff because they offer both source control and protection for the wearer against exposure to splashes and sprays of infectious materials from others.
    - Staff should remove their facemasks and put on a cloth face covering when leaving the facility at the end of their shift (cloth face coverings are recommended for all people when outside the home).
    - If staff must touch or adjust their facemask or cloth face covering, hand hygiene should be performed immediately before and after touching.
    - In the event that facemasks are not available or in ample supply, cloth facemasks may be used with additional precaution by staff.
- In general, source control is **recommended for EVERYONE while indoors to maximize protection from new variants.**
    - There are a few exceptions in counties with low to moderate community transmission where up to date individuals who do not have other indications for source control (e.g., close contact with someone with SARS-CoV-2 infection or symptomatic) could choose not to wear source control:
        - Up to date staff when they are in well-**defined areas that are restricted from resident access** (e.g., staff meeting rooms, kitchen)
        - Up to date clients and their up to date visitors in single-person rooms; in multi-person rooms where roommates are not present; in designated visitation areas when others are not present.
        - Up to date individuals in group homes.
    - Even in the exempted situations, source control remains recommended for individuals who have:
        - Not been up to date; or
        - Suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
        - Had close contact (clients and visitors) or a higher risk exposure (staff) with someone with SARS-CoV-2 infection for 14 days after their exposure, including those residing or working in areas of a healthcare facility experiencing SARS-CoV-2 transmission (i.e., outbreak); or
        - Otherwise had source control and physical distancing recommendations by public health authorities.
- Up to date people might also choose to continue using source control if they or someone in their household is immunocompromised or at increased risk for severe disease, or if someone in their household is not up to date.
- Mask donning and doffing training should be provided. Mask use with hand hygiene should be monitored.

- o The supply and availability of facemasks have increased significantly over the last several months. Facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices.
- o Facemasks are recommended for source control while staff are in the facility, to cover one's mouth and nose to prevent spread of respiratory secretions when talking, sneezing, or coughing. When used for this purpose, facemasks may be used until they become soiled, damaged, or hard to breathe through. They should be immediately discarded after removal, e.g., lunch breaks.
    - o If gloves and/or gowns are used with each client encounter, ensure they are being discarded between client cares and hand hygiene is performed after gloves are discarded.
    - o Eye protection should be worn during not up to date client care encounters to ensure the eyes are also protected from exposure to respiratory secretions.
    - o In general, up to date staff should continue to wear a well fitted face mask while at work. However, up to date staff could dine and socialize together in break rooms and conduct in- person meetings without source control or physical distancing. If not up to date staff are present, everyone should wear source control and not up to date staff should physically distance from others.
    - o Masks should not be hung from the ear, pushed up on forehead, worn under the chin or nose, or hung from a lanyard/neck strap.
    - o Remove mask during eating and drinking and discard. Practice social distancing and hand hygiene when doffing and redonning mask. Disinfect surface area after break.
- o Review training with staff for isolation protocols, donning and doffing of personal protective equipment (PPE), hand hygiene, and cough etiquette.
    - o Staff should have been fit tested for the use of N95 masks (used during care of positives, close contacts, and with new/readmissions) and perform self-seal checks each time mask is donned.
- o Screen staff at beginning of every shift for fever, symptoms, and risk of COVID-19.
    - o Use the NDDoH COVID-19 Screening for Healthcare Employees for guidance.
    - o Document symptoms and ask that staff also regularly monitor themselves for fever and other symptoms. Establish a process, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work.
    - o Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.
    - o If staff develop symptoms while at work, they should immediately put on a face mask (if not wearing one under universal masking), inform their supervisor, and leave the workplace.
- o All staff must be permitted to come into the facility as long as they are not subject to a work exclusion or showing signs or symptoms of COVID-19. In addition to staff, personnel educating and assisting in client transitions to the community should be permitted entry consistent with this guidance.

- Recommendations for evaluation and work restriction of these staff are in the [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.](#)
- All staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.
- Staff who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.
- Consider staffing models where staff only work at one home or as few as possible, instead of rotating among many homes.
- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill staff to stay home. Remind staff not to report to work when ill.
- Visitation is now allowed for all individuals at all times, including compassionate care and end-of-life visitations.
- If visitors do come in, screen visitors for fever, symptoms of COVID-19, exposure to a person infected with COIVD-19 in the past 14 days or have a diagnosis of COVID-19 in the prior 10 days before they enter the facility. If fever, COVID-19 symptoms are present or exposure to someone with COVID-19, the visitor should not be allowed entry into the facility.
  - Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.
    - If visitors are for confirmed COVID-19 or presumptive cases, staff need to assist them with donning and doffing full COVID-19 PPE. Do **NOT** give N95 mask as they are not fit tested.
      - The individual should wear a well-fitting facemask (if tolerated). Visitors should be made aware of the risks of visitation, core principles of infection prevention. A facility is not required but may offer masks and other PPE as appropriate.
    - Educate not to touch eyes, adjust mask, etc. with gloved hands.
    - Have hand sanitizer available so staff can perform hand hygiene when assisted doffing is completed. Have visitor complete hand hygiene and don clean mask before exiting through facility.
    - Visitors should wear face coverings or masks when around other residents or staff, regardless of vaccination status.
      - The safest approach, particularly if either party has not been up to date, is for individuals and their visitors to maintain physical distancing (maintaining at least 6 feet between people).
      - If the individual is up to date, they can choose to have close contact (including touch) with their visitor while wearing well-fitting source control.
      - If both the client/individual and their visitor(s) are up to date, while alone in the client/individual's room or the designated visitation room,

client's and their visitor(s) can choose to have close contact (including touch) and to not wear source control.

- Not up to date individuals may also choose to have physical touch based on their preferences and needs, such as with support persons for individuals with disabilities and visitors participating in certain religious practices, including in end-of-life situations. In these situations, not up to date clients (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit
- Hand hygiene should be performed by the individual and the visitors before and after contact.

- If county COVID-19 community level of transmission is **substantial to high**, all individuals and visitors, regardless of vaccination status, should wear face coverings or masks and physically distance, at all times.
- In areas of **low to moderate** transmission, the safest practice is for individuals and visitors to wear face coverings or masks and physically distance, particularly if either of them is at increased risk for severe disease or are not up to date.
- Visitors should be instructed that if they touch or adjust their cloth face covering, they should perform hand hygiene immediately.
- Cloth face coverings should not be placed on anyone who cannot wear a mask safely, such as someone who has a disability or an underlying medical condition that precludes wearing a mask or who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- Facilities should have a plan to manage visitation and visitor flow. Although there is no limit on visit length, frequency, or the number of visitors that an individual can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. Facilities should ensure that physical distancing can still be maintained during peak times of visitation (e.g., lunch time, after business hours, etc.). Also, facilities should avoid large gatherings (e.g., parties, events) where large numbers of visitors are in the same space at the same time and physical distancing cannot be maintained.
- Visits for individuals who share a room should ideally not be conducted in the individual's room. If in-room visitation must occur (e.g., individual is unable to leave the room), a not up to date roommate **should not** be present during the visit. If neither individual is able to leave the room, facilities should attempt to enable in-room visitation while maintaining recommended infection prevention and control practices, including physical distancing and source control.
- Individuals may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., staff, visitors) enter the room.
- A face shield may be considered if facemasks are not tolerated by the individual. Face shields are eye protection and are not to be used universally as a substitute for face masks.
- Implement a laundering process for the individuals' cloth masks.
- Facilities must permit individuals to leave the facility as they choose. Should an individual choose to leave, the facility should remind the individual and any individual accompanying them to follow all recommended infection prevention practices including wearing a face

covering or mask, physical distancing, and hand hygiene and to encourage those around them to do the same.

- o Individuals going outside of the facility or leaving with other individuals (e.g., family/friends):
    - Closely monitor individual for 14 days for fever and new onset of symptoms.
    - Educate individual and family/friends on the importance of infection control.
    - Consider testing 5-7 days after outing.
    - If the outing is greater than 24 hours, consider placing not up to date individuals on 10-day quarantine upon return from facility.
    - A facility may also opt to test not up to date individuals without signs or symptoms if they leave the facility frequently or for a prolonged length of time, such as over 24 hours.
    - If an individual or family member reports possible close contact to a person with COVID-19 while outside of the facility, test the individual for COVID-19, regardless of vaccination status. Place the individual on quarantine if they have not been up to date.
    - If an individual develops signs or symptoms of COVID-19 after the outing, test the individual for COVID19 and place the individual on Transmission-Based Precautions, regardless of vaccination status. If the resident tests negative with a **PCR** test, they can be removed from transmission-based precautions.
- o Facilities might consider quarantining not up to date individuals who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended infection prevention measures.
- o Limit and monitor entry points to the facility.
- o Screen individuals for symptoms and fever, at least daily.
    - o Individuals with a temp ≥100.0 F (people 70 or immunocompromised may have fever at 99.6 F) or repeated low-grade temps (>99.0 F) or symptoms should be placed in a single room, if possible, and placed in isolation precautions using personal protective equipment (PPE) including gown, gloves, and N95 (facemask if N95 is not available) with face shield or goggles for eye protection pending further evaluation. These individuals should be prioritized for testing and staff should wear this PPE while waiting for results.
    - o Dedicate equipment to these individuals and disinfect between use.
    - o Ideally, include an assessment of oxygen saturation via pulse oximetry.
    - o Individuals with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
    - o Document daily screening results.
- o Put alcohol-based hand sanitizer with 60-95% alcohol in every Individuals' room (ideally both inside and outside of the room) and other individuals' care and common areas and make sure sinks are well-stocked with soap and paper towels for handwashing.
- o Make tissues and face masks available for coughing people. Consider designating staff to steward those supplies and encourage appropriate use by individuals and staff.

- o When an individual or staff with suspected or confirmed COVID-19 is identified, facilities should be instructed to notify the NDDoH immediately at 1-888-391-3430 and made aware that they reside in a group home or other individual care setting.
- o Ensure all individuals are up to date for routine immunizations, including influenza and pneumococcal vaccines.

DAY-TO-DAY OPERATIONS

- A copy of the agency pandemic plan should be made available to all individuals, teams, and staff.
- Only allow one person and one staff person to use the kitchen at a time and clean and disinfect after each use.
- Do not utilize shared food containers in dining areas (ex: water pitchers, salt and pepper shakers, condiments, etc.).
  - o Dispense snacks directly to individuals or use pre-packaged food.
- If utilizing shared rooms, individuals should keep as far apart as possible from each other (ex: "head to foot" or "foot to foot" placement of beds, maintaining the 6 feet apart placement as much as possible).
- Arrange for delivery of medications.
- Create a schedule for individuals to use common spaces in shifts, to maintain physical distancing.
- Reconfigure common areas so seating ensures physical distancing.
- Group activities/Communal dining:
  - o While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. The safest approach is for everyone, regardless of vaccination status, to wear a face covering or mask while in communal areas of the facility.
  - o For more information, see the Implement Source Control section of the CDC guidance "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic."
- Individuals may utilize outside locations if physical distancing can be maintained. Explore alternative methods to meet individualized needs (e.g. telemedicine, phone calls with family, ordering groceries/supplies). Modify recreation/leisure activities and incorporate meaningful activities within the day for individuals to stay engaged while following the recommended guidelines.
- Individuals may be employed or wish to participate in community activities. All efforts should be made to prepare individuals to protect themselves and other when going out and returning to the facility.
- Individuals should not share personal items with others. This includes but is not limited to: Phones, computers, remote controls, toys, drinks, bed linen, washcloths, towels, toothbrushes, unwashed eating utensils, straws, etc.
- Personal items should be kept separately for each individual.
- If items must be shared, ensure proper cleaning between use (See cleaning below).

- Isolation, social distancing, and other stressful events of a disease outbreak may increase risk of adverse mental health outcomes, help support individuals in managing stress and anxiety during this time.
  - CDC Coping with Stress
  - ND DHS Behavioral Health Supports During the COVID-19 Pandemic
- Guidelines may be relaxed for individuals without COVID-19 while maintaining source control measures.

CLEANING

- Clean and disinfect high touch surfaces twice a day or more in common areas (ex: tables, doorknobs, light switches, phones, tablets, touch screens, remote controls, keyboards, handles, desks, toilets, sinks, etc.).
- Read and follow the product label for health and safety information about the products. List N Tool: COVID-19 Disinfectants | US EPA.
- Visit the Center for Disease Control and Prevention (CDC) for more information about cleaning and disinfecting.

WORK RESTRICTIONS FOR STAFF WITH SARS-CoV-2 INFECTION AND EXPOSURES

- All staff who have symptoms that coincide with COVID-19 should self-isolate, report their symptoms to their supervisor and contact their primary care provider for COVID-19 testing.
- Continue to educate not up to date staff about the important role COVID-19 vaccine has in preventing client illness and death.
- In general, asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days **do not** require work restriction following a higher-risk exposure.
- **CDC's mitigation strategies offer a continuum of options for addressing staffing shortages**. Contingency, followed by crisis capacity, strategies augment conventional strategies and are **meant to be considered and implemented sequentially** (i.e., implementing contingency strategies before crisis strategies).
- Staff with SARS-CoV-2 infection and exposures should be restricted from work under the following circumstances. Refer to CDC's updated recommendations below.

Work Restrictions for HCP with SARS-CoV-2 Infection and Exposure			
"Up to Date" with all recommended COVID-19 vaccine doses is defined in Stay Up to Date with Your Vaccines.			
Work Restrictions for HCP with SARS-CoV-2 Infection			
Vaccination Status	**Conventional**	**Contingency**	**Crisis**
Up to Date and Not Up to Date	10 days OR 7 days with negative test[1], if asymptomatic or mild to moderate illness	5 days with/without negative test, if asymptomatic or mild to moderate illness	No work restrictions, with prioritization considerations (e.g., types of patients they care for)

	(with improving symptoms)	(with improving symptoms)	
Work Restrictions for Asymptomatic HCP with Exposures			
Vaccination Status	**Conventional**	**Contingency**	**Crisis**
Up to Date	No work restrictions, with negative test on days 1± and 5-7	No work restrictions	No work restrictions
Not Up to Date	10 days OR 7 days with negative test	No work restrictions with negative test on days 1[2], 2, 3, & 5-7 (if shortage of tests prioritize Day 1 to 2 and 5-7)	No work restrictions (test if possible)

[1] Negative test within 48 hours before returning to work

[2] For calculating date of test: 1) for those with infection consider day of symptom onset (or first positive test if asymptomatic) as day 0; 2) for those with exposure consider day of exposure as day 0.

- For more details, including recommendations for staff who are immunocompromised, refer to [Healthcare Personnel with SARS-CoV-2 Infection or Exposures to SARS-CoV-2](#) (conventional standards) and [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#) (contingency and crisis standards).
- Contingency and Crisis standards should only be considered **after all alternative routes to obtain additional staff have been explored** (e.g., Department Operations Center, travel agencies) and **should be discussed with NDDoH HAI/COVID-19 Team.**
- Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and for safe patient care.
- Maximizing interventions to protect HCP, patients, and visitors are critical at all times, including when considering strategies to address staffing shortages.

SYMPTOMATIC INDIVIDUALS

- If individuals report or display any symptoms of COVID-19 or they have been exposed to a suspected or confirmed case, they should be isolated immediately. Their primary care provider should be contacted and made aware the patient resides in a group home or other individual care setting.
- If the symptomatic individual has a negative antigen test, it is recommended to collect another specimen for confirmatory RT-PCR (reverse-transcriptase polymerase chain reaction) testing. They should remain isolated while awaiting test results. Please see CDC's [Antigen Testing Algorithm Congregate Settings](#) for additional guidance specific to congregate settings.
- The individual should immediately isolate in a room with a door that can be closed, as much as possible, to separate unwell individuals who have symptoms or are being tested for COVID-19 from those who are healthy for the recommended isolation/quarantine period. If not possible, other solutions or alternate locations may need to be explored to reduce exposure to others in the home.
- Have dedicated staff care for the individual(s).

- If possible, provide all meals, medications, and personal cares in the individual's room.
- If a private room is not possible and will be shared by well and unwell individuals, make sure the room has adequate air flow (ex: open windows as security protocols and weather permits), and that the individual can be kept 6 feet away from others, and wears a surgical/procedure mask if they are able.
- A private bathroom should be used. If that is not possible, consider developing a schedule for use with the unwell person going last, followed by a thorough cleaning of the bathroom.
- Provide recreation/leisure/entertainment activities in their room.
- Consider utilizing alternate care locations if needed.
- If an individual requires quarantine or isolation and has difficulties complying, the team should consider non-restrictive measures, while balancing health and welfare of that individual and everyone else in the home.
- If there is a known COVID-19 case in your facility ***it is recommended you have your direct care staff add face shields and N95 masks to their PPE***, disinfecting face shields when visibly dirty or end of day. These should be dedicated to the staff. If face shields are not available, use eye googles. Personal eyeglasses do not replace eye protection. Cloth face covering should NOT be worn in place of face masks or N95 masks.
- If N95 masks are not available for staff are not fit tested, a surgical mask and face shield can be worn.
- Monitor staff for proper use of PPE and hand hygiene.
- Follow all NDDoH guidelines for isolation/quarantine.
    - Consider additional testing of individuals and staff. If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of not up to date, until there are no new cases for 14 days.
    - If antigen testing (e.g., Binax) is used, more frequent testing (every 3 days), should be considered.

CLOSE CONTACT TO A POSITIVE COVID-19 CASE

Individuals
- Individuals who are **not up to date** with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. This includes contacts to cases in another healthcare setting (hospital, clinic, etc.) or in the community.
- Consider utilizing alternate care locations if unable to quarantine individual in a private room such as moving the roommate in with other individuals who are non-suspect or known exposures.
    - Staff should adhere to droplet precautions with an N95 respirator.
    - Assess the individual twice a day for respiratory symptoms and fever.
    - Consider testing individual immediately but no sooner than 1 days and if negative again 5-7 days after last exposure or at any time if symptoms develop.
    - Increase monitoring of individuals for worsening of symptoms.

- Keep the door to the individual room closed, as much as possible.
  - Attempts should be made to have these individuals cohorted with dedicated staff.
- Individuals can be removed from Transmission-Based Precautions after day 7 following the exposure (day 0) if a viral test is negative for SARS-CoV-2 and they do not develop symptoms. The specimen should be collected and tested within 48 hours before the time of planned discontinuation of Transmission-Based Precautions.
- Following close contact, potentially exposed individuals should continue to wear source control and be immediately isolated if they develop symptoms or test positive for SARS-CoV-2 infection.
  - Individuals should be consistent in face mask use and maintaining social distancing.
  - Testing is recommended immediately but no sooner than 1 days, and if negative 5–7 days after exposure.
  - Continue to monitor daily for 14 days for symptoms consistent with COVID-19, including temperature, and oxygen saturation.
- Individuals who are **up to date** with all recommended COVID-19 vaccine doses who have had close contact with someone with SARS-CoV-2 infection should wear source control and be tested as described above.
- Individuals who are **up to date** and residents who have had SARS-CoV-2 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by staff using the full PPE recommended for the care of an individual with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the NDDoH.

NEW ADMISSIONS & READMISSIONS RECOMMENDATIONS

- Individuals who are **up to date** with all recommended COVID-19 vaccine doses and residents who have **recovered from SARS-CoV-2 infection in the prior 90 days** do not need to be placed in quarantine but should be tested immediately (but no sooner than 24 hours) and, if negative, again in 5-7 days.
- Facilities located in areas with minimal to no community transmission might elect to use a risk-based approach for determining which individuals require quarantine upon admission. Decisions should be based on whether the individual had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to infection prevention and control practices in healthcare settings, during transportation, or in the community prior to admission.
- A new admission that is **not up to date** and **not confirmed** or **suspected** of having COVID-19 should be placed in a private room, with droplet precautions including an N95 mask. If possible, the individual

- should continue to wear a mask or cloth face covering for source control for a total of 14 days. If the individual remains asymptomatic, then he/she can be moved to another room with a roommate after **10 days or 7 days with a negative viral test.**
  - Assess the individual twice a day for symptoms and fever for 14 days.
  - Keep the door to the individual room closed.
    - Attempts should be made to have these individual cohorted with dedicated staff.
  - If an individual becomes symptomatic, then he/she should be tested for COVID-19.
    - Increase monitoring of individuals for worsening of symptoms.
    - If transfer to an acute hospital is needed due to worsening condition, without testing or before test results are known, call ahead to make arrangements and notify the facility and transfer crew that the individual may have COVID-19.
- Newly admitted individuals and individuals who have left the facility for >24 hours, regardless of vaccination status, should have a series of two viral tests for SARS-COV-2 infection: immediately (but no sooner than 24 hours) and, if negative, again 5-7 days after their admission.

OUR FACILITY HAS IDENTIFIED A CLIENT THAT IS POSITIVE FOR COVID-19

- Consider having pregnant or immunocompromised staff assigned to other areas in the facility.
- The individual can remain in the facility as long as their clinical care needs can be met.
- While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility.
  - Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If individuals or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the individual's room.
  - Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.
- Place in private room or cohort COVID-19 positive individuals together, ideally placed 6 feet apart.
  - Consider multi-drug resistant organism (MDRO) infection/colonization status when making individual placement decisions. Staff must change their gown after working with individuals infected or colonized with a MDRO.
- If limited single rooms are available or if numerous individuals are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, individuals should shelter-in-place at their current location pending return of test results.
- Individuals should only be placed in a COVID-19 care area if they have confirmed SARS-CoV-2 infection.

- Roommates of individuals with SARS-CoV-2 infection should be considered exposed and potentially infected and, if at all possible, should not share rooms with other individuals while they are in quarantine (i.e., for the 10 days following the date their roommate was moved to the COVID-19 care area).
- Place individuals in droplet precautions, with the addition of an **N95** mask for PPE.
  - Best practice recommends staff should be fit tested for use of N95 masks and perform self-seal checks **each** time mask is donned.
  - The same mask and eye protection can be used for multiple individuals that are cohorted, but gown and gloves should be changed between individuals and hand hygiene performed. Mask should be discarded at the end of each shift or if visibly soiled, damaged, or difficult to breathe through.
  - Same gown may be considered if supply is low but individuals MDRO history has to be identified and staff trained on individual gown use for those individuals. See [Strategies of Optimizing Gown Shortages](#).
  - The CDC recommends that users store used N95 masks in a breathable container, that is well marked (to prevent accidental use), and according to the manufacturer's recommendations for temperature and moisture.
  - Cloth face coverings should NOT be worn in place of face masks or N95 respirators.
  - If N95 masks are not available or staff are not fit tested, a surgical mask and face shield can be worn.
    - Fit testing should be arranged as soon as possible for staff.
- Keep the door to the individual's room closed, as much as possible.
  - This is especially important for individuals with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care area. However, in some circumstances (e.g., memory care), keeping the door closed may pose individual safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway.
- Dedicate equipment to these individuals and disinfect between use.
- A log should be kept of all staff going in and out of room.
- Increase monitoring for worsening of symptoms.
- Monitor staff for proper use of PPE and hand hygiene.
- Have dedicated staff care for the individual(s).
- Staff should organize their work and take on the duties of environmental cleaning to decrease number of staff entering the room, living space or apartment.
  - Environmental staff are usually not fit tested for N95 masks.
- If staff from the COVID-19 care area are working with individuals other than COVID-19 confirmed or suspected individuals, separate masks should be used for working with individuals who are not suspect or COVID-19 positive.
- N-95 masks used with positive individuals should be discarded after each treatment if individual is receiving nebulizer or other aerosolized therapy.
- Disinfect face shields after each use adhering to contact time.
- Provide notification to individual's families/guardians when there is a case of COVID-19 identified in your facility.

- Testing of staff and individuals may be recommended once there has been a case identified or documented spread among staff or individuals.
- Individuals should generally be restricted to their rooms and serial SARS-CoV-2 testing performed.
- Consideration should be given to halting social activities and communal dining; if these activities must continue for uninfected individuals, they should be conducted using source control and physical distancing for all participants.
- Can consider allowing individuals to follow CDC's guidance on [Quarantine and Isolation](#) if not moderately to severely immunocompromised, able to wear source control outside of their home and reside in a private apartment OR receive services in their homes.
- Even though individuals are recovered and are not tested for 90 days unless they develop a new onset of symptoms, source control needs to be in place due to risk of reinfection. A person's immunity time frame is uncertain and is not to be perceived as 90 days due to testing recommendations.

For facilities that need additional PPE, reach out to Tony Mutzenberger via email at [tlmutzenberger@nd.gov.](mailto:tlmutzenberger@nd.gov)

Definitions

- **Up to date** means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.
- **Not up to date** means a person has NOT received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.
- **Source Control:** Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- **Severe Illness:** Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- **Critical Illness:** Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
- **Who Is Moderately or Severely Immunocompromised?**
  People are considered to be moderately or severely immunocompromised if they have:
  - Been receiving active cancer treatment for tumors or cancers of the blood
  - Received an organ transplant and are taking medicine to suppress the immune system
  - Received a stem cell transplant within the last 2 years or are taking medicine to suppress the immune system

- o Moderate or severe primary immunodeficiency (such as DiGeorge syndrome, Wiskott-Aldrich syndrome)
- o Advanced or untreated HIV infection
- o Active treatment with high-dose corticosteroids or other drugs that may suppress your immune response
- o Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.
- o Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.