COLORADO
Department of Public Health & Environment

COVID-19 GUIDANCE

Residential Care Facility (RCF) Comprehensive Mitigation Guidance

Table of Contents (Clickable)

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

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Summary of Recent Changes

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Updates as of 08/03/2021

- Added requirement for universal mask use for Health Care Personnel, visitors, and residents in Residential Care Facilities regardless of vaccination status. This change aligns CDPHE guidance with CMS and CDC guidance and includes exceptions for when only fully vaccinated residents or Health Care Personnel are present
- Added testing requirement for fully vaccinated Health Care Personnel and residents who have had close contact with an individual who has tested positive for SARS CoV-2 Testing includes both **lab-based** PCR immediately following the exposure and daily rapid testing during their incubation period
- Added clarifying language regarding quarantine requirements for Health Care Personnel with close contact with an individual who has tested positive for SARS CoV-2
- Added guidance that when discordant results are identified between POC testing and lab-based PCR, CDPHE should be consulted prior to discontinuing isolation for a resident or Health Care Personnel
  To align with CDC and CMS guidance, added clarification that residents who are not fully vaccinated should be excluded from group activities and communal dining anytime the facility has implemented outbreak testing

Updates as of 7/23/2021

The recent emergence of the SARS-CoV-2 virus Delta variant in certain parts of Colorado has highlighted there may be times when changing patterns of COVID-19 transmission or severity warrant enhanced infection control measures to ensure resident safety. Such measures are now being implemented for unvaccinated Health Care Personnel and/or residents.

- Added use of rapid (molecular or antigen) surveillance and outbreak testing in addition to **lab-based** PCR testing for unvaccinated Health Care Personnel and residents who have left the facility in the past 14 days
- Added clarification that facilities should use a CDPHE contracted lab for PCR testing or ensure that whole genome sequencing of specimens is possible (either performed at non-CDPHE contracted lab with results reported to CDPHE or lab sends positive specimen to CDPHE for sequencing)
- Updated Outbreak decision testing tree
- Added required eye protection for unvaccinated Health Care Personnel when outbreak testing is initiated
- Removed crisis standards of care for PPE (e.g., CDCs crisis capacity strategies) as an option for Colorado healthcare facilities
- Clarification added for testing and/or vaccination requirements for providers of Ancillary non-medical services
- To align with CMS, added the requirement to stop indoor visitation immediately when one or more positive cases are identified.

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- To align with CMS, added clarification that outbreak testing following identification of one or more positive cases must be initiated immediately
- Added information about monoclonal antibody therapy including the need for residents who are diagnosed with COVID-19 to be promptly evaluated by a healthcare provider to determine treatment eligibility

COVID-19 in Residential Care Facilities

Scope

The purpose of this document is to provide guidance to residential care facilities (RCF) when a resident or health care personnel (HCP) member is suspected or confirmed to have COVID-19 and to provide recommendations to prevent transmission of COVID-19 within the facility. These recommendations are specific for RCFs. Guidance provided in this document is based on currently available information at the time it was drafted and is subject to change. Updated case counts are available on the CDPHE website: Coronavirus Disease 2019 (COVID-19) in Colorado.

RCFs (skilled nursing facilities, assisted living residences, group homes, and intermediate care facilities) are licensed by the Colorado Department of Public Health and Environment (CDPHE). Some of these facilities are also federally certified by the Centers for Medicare and Medicaid Services (CMS). **In instances where state and federal guidance do not align, federally certified facilities are required to follow the more conservative guidance.**

Background

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), residential care facility populations are at high risk of being affected by respiratory pathogens like SARS-CoV-2 and other pathogens, including multidrug-resistant organisms (e.g., carbapenemase-producing organisms, *Candida auris*). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and health care personnel (HCP). Even as residential care facilities resume more normal practices and begin relaxing restrictions, **residential care facilities must sustain core IPC practices and remain vigilant for COVID-19 infection among residents and HCP in order to prevent spread and protect residents and HCP from severe infections, hospitalizations, and death.**

The information in this document applies regardless of vaccination status and level of vaccine coverage in the facility unless specifically stated.

Key Information about COVID-19

- **Agent**
  - SARS-CoV-2

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- **Incubation Period**
  - Range 2 to 14 days
- **Transmission/Communicability**
  - The virus is thought to spread mainly from person-to-person.
  - Between people who are in close contact with one another (within about 6 feet).
  - Through respiratory droplets produced when an infected person talks, coughs, or sneezes.
  - These droplets can land in the eyes, mouths, or noses of people who are nearby or possibly be inhaled into the lungs.
  - There is evidence that the virus can also be spread via airborne transmission, when smaller droplets and particles containing the virus remain suspended in the air for minutes to hours.
  - It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the main way the virus spreads.
- **Symptoms**
  - Symptoms associated with COVID-19 include: Fever (measured at >100.0°F or subjective), chills, cough, shortness or breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose. Consider also diarrhea, nausea or vomiting.

Definitions

For the purpose of this document, definitions are as follows:

Adult Day Services

- Adult Day Services Centers (ADSCs) are professional care settings where community-dwelling adults receive social or health services for some part of the day. ADSCs often serve adults age 65 years or older who may require supervised care and adults (of any age) living with dementia, cognitive decline, or disability. ADSCs are designed to provide a safe, community-based group setting where specific needs are addressed and individualized therapeutic, social, or health services are delivered.

Ancillary Non-Medical Services

- Ancillary non-medical services are such as those provided by hairstylists, barbers, cosmetologists, estheticians, nail technicians, and massage therapists not employed by the facility, but who enter the building to provide services to residents. Ancillary service providers must either participate in the facility's surveillance testing or provide proof of SARS CoV-2 **lab-based** PCR testing in accordance with these requirements.

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Close Contact

- Close contact refers to someone who has been within 6 feet of an infected person (laboratory-confirmed or a clinically compatible illness) for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5-minute exposures for a total of 15 minutes in one day).

Core Infection Prevention Principles

- Screening of all who enter the facility for signs and symptoms consistent with COVID-19, including a temperature check and questions about risk (e.g., close contact with someone with COVID-19 infection in the prior 14 days).
- Denying entry to those with signs or symptoms of COVID-19 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).
- Hand hygiene (use of alcohol-based hand rub is preferred).
- Face coverings or masks (covering mouth and nose) for unvaccinated individuals (HCP, residents, and visitors) and those caring for suspected or confirmed COVID-19 residents.
- Physical distancing of at least six feet between unvaccinated persons and others.
- Instructional signage throughout the facility and proper visitor education on COVID-19, including the signs and symptoms, infection control precautions, and other applicable facility practices (e.g., use of face covering or mask; specified entries, exits and routes to designated areas; hand hygiene).
- Increased cleaning and disinfecting of high-frequency touched surfaces throughout the facility, including designated visitation areas and shared medical equipment.
- Appropriate HCP use of Personal Protective Equipment (PPE) including when caring for a suspected or confirmed COVID-19 resident regardless of HCP vaccination status.
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care).
- Resident and HCPtesting as required per the Seventh Amended PHO 20-20.

Essential Health Care Service Providers

- Essential Health Care Service Providers (not staff) include but are not limited to physicians, hospice, and home health staff of all disciplines, along with other types of both medical and nonmedical health care and services. They must be screened and tested in accordance with the surveillance and outbreak testing prescribed in the Seventh Amended PHO 20-20.

Fully Vaccinated

- "Fully vaccinated" refers to a person who is ≥2 weeks following receipt of the second dose in a 2-dose vaccine series or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons, and has provided verification of vaccination status to the facility.

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Health Care Personnel (HCP)

- Includes staff and essential service providers and providers of healthcare.

Isolation

- Isolation is for someone who has developed illness (i.e., COVID-19 like symptoms) or who has tested positive for SARS CoV-2. Individuals with COVID-19 are infectious and can transmit COVID-19 to others. Individuals who have illness and/or who test positive for SARS CoV-2, the virus that causes COVID-19 should remain in isolation until at least 10 days have passed since their illness began or from the date of test if asymptomatic. For more information go to CDC: COVID-19: Quarantine vs. Isolation.

Medical Appointments

- Medical appointments (e.g., clinic visits, emergency department, outpatient surgical procedures, dialysis) are medical visits that are assumed to have occurred in a controlled environment in which proper infection control measures were maintained.

Outbreak Definition

- Outbreaks have been standardized across outbreak settings. An outbreak in a residential setting is defined as:
    - Two or more confirmed cases of COVID-19 among residents and/or HCP in a facility with onset in a 14-day period
      [OR]
    - One confirmed case and two or more probable cases of COVID-19 among residents and/or HCP in a facility with onset in a 14-day period.
- When determining if an outbreak has occurred in a facility, exclude residents with a diagnosis known at the time of admission to the facility. Exclude residents who test positive for SARS CoV-2, the virus that causes COVID-19 in the 14 days after admission **AND** are in observation for signs/symptoms of COVID-19 and following appropriate Transmission-Based Precautions.

Outbreak Testing

- Upon notification of a single positive COVID-19 case (HCP or resident), the facility must immediately implement facility-wide testing (outbreak testing) of **ALL** HCP and **ALL** residents (regardless of vaccination status) to identify additional asymptomatic, pre-symptomatic, or symptomatic infections. Outbreak testing specimens must be collected immediately from all individuals (who have not already tested PCR positive in the previous 90 days) and received by the testing lab within 48 hours of identifying the COVID-19 positive HCP or resident.

Physical Distancing

- Physical distancing refers to maintaining a physical distance of at least 6 feet whenever possible and is an important strategy to prevent COVID-19 transmission.

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Providers of Health Care Services

- Providers of health care services include those individuals providing medical services (such as podiatrists, dentists, physical or occupational therapists, or hospice nurses), not employed by the facility, but who enter the building to provide care or services to residents. Health care service providers must either participate in the facility's surveillance testing or provide proof of SARS CoV-2 PCR testing in accordance with these requirements.

Quarantine

- Quarantine is for someone who was possibly exposed to COVID-19 and needs to stay away from others for a certain period of time to determine whether they develop infection. This is to limit transmission in the event the exposed individual develops COVID-19. Because the incubation period for SARS CoV-2 is 2-14 days, individuals should remain in quarantine until 14 days have passed since their last possible exposure. Testing during this time will not rule out incubating disease and therefore cannot be used to shorten quarantine.
    - Of note: The options to shorten quarantine that CDC published do not apply to high-risk settings such as residential care facilities. The quarantine period for residential settings will remain 14 days after exposure.

Residential Care Facilities (RCF)

- Residential Care Facilities (RCF) are skilled nursing facilities, assisted living residences, intermediate care facilities, and group homes. This does not include non-residential settings such as Adult Day Services.

Service Repair Technicians, Delivery Persons, and Suppliers

- Service repair technicians, delivery persons, and suppliers (e.g., oxygen delivery suppliers) are not included in required facility testing but should follow core infection prevention practices to prevent COVID-19 including screening for illness prior to admission.

Source Control

- Source control refers to the use of well-fitting cloth masks, medical face masks, or respirators that cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.
    - In addition to providing source control, these devices also offer varying levels of protection against exposure to infectious droplets and particles produced by infected people. Fit-tested respirators (e.g. N95s) are most protective for the wearer. Ensuring a proper fit is important to optimize both the source control and protection offered.

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Staff

- Staff are defined as employees (e.g., nurses, licensed independent practitioners, students and trainees, therapists, environmental services) whether employed, contracted, consulting, or volunteer.

Unvaccinated and Partially Vaccinated Individuals

- These include persons who do not yet meet the definition of fully vaccinated, including persons who have never received a vaccine (unvaccinated) and persons who have received one or two doses but have not yet met the complete criteria for full vaccination (partially vaccinated). This includes individuals whose vaccination status is unknown for the purpose of this document. These populations are treated the same for disease control purposes.

Vaccine Breakthrough Case

- Vaccine breakthrough case refers to a person who tests positive for SARS-CoV-2 (regardless of symptoms) and ≥2 weeks has passed following receipt of the second dose in a 2-dose vaccine series, or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons. Vaccine breakthrough cases are treated the same as all individuals who test positive for SARS CoV-2.

Visitor

- A visitor does not meet the criteria of staff. Visitors may include musicians and other performers that provide group activities to more than one resident at a time or a family member or friend visiting one resident. Visitors do not typically participate in orientation or training programs. Visitors are not included in surveillance and outbreak testing nor are they offered vaccination. See visitation section for more information.

Volunteer

- Volunteers are unpaid staff members who provide routine services, generally have a recurrent role within the facility, and have received structured training and orientation on resident rights and infection prevention practices. Volunteers generally are 18 and older and have an ongoing relationship with a contract, role, and/or schedule. Volunteers are not infrequent visitors (e.g., Girl Scout troops, musicians, individuals seeking community service hours). Volunteers should be treated as staff and should be included in surveillance and outbreak testing and offered vaccination (e.g., influenza, COVID-19).

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Infection Prevention and Control (IPC) Program

Infection Control Training

- Facilities should assign at least one individual with training in IPC to provide on-site management of their COVID-19 prevention and response activities. This should be a full-time role for at least one person in facilities that have more than 100 residents. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the facility risk assessment. Staff members who are managing the IPC program should complete the CDC's online training modules or complete/have documentation of other comparable infection prevention training education.

Provide Necessary Supplies

Provide supplies necessary to adhere to recommended infection prevention and control practices:

- **Hand Hygiene Supplies**
  - Put FDA-approved alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside the dining hall, in the therapy gym).
  - Unless hands are visibly soiled, performing hand hygiene using an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations (e.g., before and after touching a resident) due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands.
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- **Personal Protective Equipment (PPE)**
  - Employers should select appropriate PPE and provide it to HCP in accordance with Occupational Safety and Health Administration (OSHA) PPE standards (29 CFR 1910 Subpart I).
  - Facilities should have supplies of face masks, N95 or higher-level respirators, gowns, gloves, and eye protection (i.e., face shield or goggles that cover the front and sides of the face).
    - Make necessary PPE available in areas where resident care is provided.
  - Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard (29 CFR 1910.134) for employees if not already in place. The program should include medical evaluations, training, and fit testing.
  - Perform and maintain an inventory of PPE in the facility including: face masks, respirators (if available and the facility has a respiratory protection program with trained medically cleared, and fit-tested providers) gowns, gloves, and

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eye protection (i.e., face shield or goggles that covers the front and sides of the face).
        - Consider designating HCP responsible for stewarding those supplies,monitoring and providing timely feedback, and promoting appropriate use by HCP.
        - Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools.
        - For PPE resource requests, facilities should notify their local public health agency or refer to the Concept of Operations (CONOPS) for Coronavirus Disease (COVID-19) Personal Protection Equipment Shortage (CDPHE).
    - In addition to masks, unvaccinated HCP working in facilities located in counties with >10% two-week average test positivity rate ("Colorado Covid Dial") and those facilities conducting outbreak testing should wear eye protection (i.e., face shields or goggles that cover the front and the sides of the face) during all resident care activities to protect against viral spread from asymptomatic individuals.
    - N95 respirators should be prioritized for use as PPE versus source control.
    - For more on PPE, to include CDCs Optimization Strategies and how to implement them safely, go to CDPHE PPE FAQ.
- **Environmental Cleaning and Disinfection**
    - Develop a schedule for regular cleaning and disinfection of frequently touched surfaces in resident rooms and common areas.
    - Shared equipment (e.g., thermometers, pulse ox, blood pressure cuffs, resident lifts) should be cleaned and disinfected according to manufacturer instructions in between residents.
    - Equipment utilized to care for individuals on transmission-based precautions should be disposable or dedicated to an individual resident whenever possible. If disposable or dedicated equipment is not possible, all equipment must be cleaned and disinfected prior to use on additional residents.
    - Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
    - Use an EPA-registered disinfectant from List N:disinfectants for coronavirus (COVID-19) on the EPA website to disinfect surfaces that are frequently touched and those that might be contaminated with SARS-CoV-2.
    - Ensure HCP are appropriately trained on use and follow the manufacturer's instructions for all cleaning and disinfection products (e.g., concentration, application method, and contact time).

Education

Educate residents, health care personnel, and visitors about COVID-19 , current precautions being taken in the facility, and actions they should take to protect themselves.

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- Provide culturally and linguistically tailored information about COVID-19 infection, including the signs and symptoms that could signal infection.
- Provide information about strategies for managing stress and anxiety.
- Regularly review CDC's Interim Infection Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic for current information and ensure HCP and residents are updated when this guidance changes.
- Educate and train HCP, including facility-based and consultant personnel (e.g., rehabilitation therapy, wound care, podiatry, barber), ombudsman, and volunteers who provide care or services in the facility. Including consultants is important since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of COVID-19. Training should occur prior to providing any care or contact with residents.
- Educate HCP about any new policies or procedures.
- Reinforce sick leave policies and remind HCP not to report to work when ill.
- Reinforce adherence to standard IPC measures including hand hygiene and selection and correct use of PPE. Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities. Keep a written record of these observations and provide feedback to HCP on their performance.
- CDC has created training resources for front-line HCP that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
    - At minimum observe and record HCP adherence to the following practices:
        - Hand hygiene (HH)
        - PPE use, to include proper glove use
        - Shared medical equipment cleaning and disinfection
        - Isolation precautions and cohorting
        - Environmental decontamination, to include isolation rooms
        - Surveillance
- Educate residents and families through educational sessions and written materials on topics including information about COVID-19, actions the facility is taking to protect them and their loved ones, any visitor restrictions that are in place, and actions they should take to protect themselves in the facility, emphasizing the importance of source control, physical distancing and hand hygiene.
- Have a plan and mechanism to regularly communicate with residents, families and HCP, including if cases of COVID-19 infection are identified among residents or HCP.

Vaccinate Residents and Health Care Personnel against SARS-CoV-2

- Receiving a COVID-19 (SARS CoV-2) vaccination is an important step to prevent getting sick with COVID-19 disease.

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- Encourage residents and HCP to receive and complete a COVID-19 (SARS CoV-2) vaccination series. Provide accurate information to persons with questions, and support practices that allow residents and HCP to receive vaccination (e.g., time off to receive a vaccine, no penalties for time off if there are side effects after vaccination).
- Facilities should maintain a record of vaccination status for all residents and staff and any visitors who wish to follow guidance for fully vaccinated individuals.
- Language in this document has been updated to address vaccinated vs. unvaccinated status given the increased protection experienced by fully vaccinated individuals.
- The Long-Term Care Facility Toolkit: Preparing for COVID-19 Vaccination at Your Facility provides resources including information on preparing for vaccination, vaccination safety monitoring and reporting, frequently asked questions, and printable tools.
- How do I get more vaccines? Visit the strike team website for ongoing COVID-19 (SARS CoV-2) vaccination.

Ongoing Vaccination Plans

Each facility must establish and maintain a COVID-19 mitigation plan that promotes vaccine confidence and acceptance and must continue to offer vaccinations to all consenting staff and residents. Each facility shall submit to CDPHE a plan which details how the facility ensures vaccinations are offered and provided to all consenting staff and residents. A template for this plan is available on the CDPHE webpage. Minimally, this information must include:

1. How the facility assesses and addresses the vaccination status of new staff and residents;
2. The identification of designated staff who coordinate vaccination information, administration and tracking of the vaccination status of staff and residents on an ongoing basis,
3. Ongoing measures to promote vaccine confidence and acceptance, and;
4. The vaccination status of all current staff and residents.

Submission of this information may be completed utilizing this form and must be submitted via email to residentialcarestriketeam@state.co.us on or before Monday, June 14, 2021. This plan must be kept current by the facility and be presented for review during health facility inspections.

Implement Source Control Measures

- **All Who Enter the Facility**

  EVERYONE who enters the facility is required to wear a face covering that covers both their nose and mouth at all times.

  - Individuals who cannot wear appropriate source control must be excluded from the facility. These individuals may visit with fully vaccinated staff and/or

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residents outdoors as an alternative. Information specific to indoor and outdoor visitation can be found here.

- **Unvaccinated Health Care Personnel**
  - HCP who are not fully vaccinated should arrive at the facility wearing their community source control (i.e. face covering or cloth mask). HCP who do not provide resident care (e.g. clerical personnel) may continue to wear their community source control throughout their shift.
  - HCP who are not fully vaccinated and providing resident care should remove their community source control upon arriving at work and don a well-fitting medical grade face mask or respirator. This should remain in place for the duration of the time in the facility except for the examples listed below.
  - To reduce the number of times HCP must touch their face, and the potential risk for self-contamination, HCP should consider extended use of masks and respirators as outlined in the PPE FAQ.
  - When leaving the facility at the end of their shift, HCP who are not fully vaccinated should remove and dispose of their medical grade face mask or respirator (do not store for later use), perform hand hygiene, and put on their community source control. For additional guidance on recommended source control or PPE use, refer to CDPHEs PPE FAQ or CDCs Interim for Infection Prevention and Control Recommendations.
  - HCP who are not fully vaccinated should wear a mask and socially distance themselves from others whenever possible while in the facility, including but not limited to breakrooms, meeting rooms, and offices.
- **Fully Vaccinated Health Care Personnel**
  - Fully vaccinated HCP are required to wear a well-fitting medical grade face mask or respirator. This should remain in place for the duration of the time in the facility except for the examples listed below. .
  - Fully vaccinated HCP can dine and socialize together in employee break rooms with their mask removed when only fully vaccinated individuals are present.
  - Fully vaccinated HCP can participate in in-person meetings with their mask removed when only fully vaccinated individuals are present.
  - If unvaccinated individuals are present when in break rooms or meetings, masks must be worn by all individuals.
  - Fully vaccinated HCP must provide verification of vaccination status.
- **Unvaccinated Residents**
  - Residents should wear a well-fitting form of source control whenever they leave their room, including in common areas or outside of the facility.
  - Source control 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.
  - Ensure residents who are not fully vaccinated are educated on how to safely remove their masks (should they need to do so) while out of the facility.
  - Residents who are not fully vaccinated should continue to wear a mask and practice social distancing during activities and facility outings.

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    - Residents who are not fully vaccinated should wear a mask until seated in the dining room for a communal meal and should be socially distanced from other residents. The mask should be replaced once the meal has ended.
- **Fully Vaccinated Residents**
    - Fully vaccinated residents are required to wear a mask while in the facility and outside of their room.
    - Fully vaccinated residents may share a table with other fully vaccinated residents.
    - Fully vaccinated residents do not need to wear masks while participating in group activities and facility outings when only fully vaccinated individuals are present.
    - Fully vaccinated residents must provide verification of vaccination status.

Implement Physical Distancing Measures

- Although most care activities require close physical contact between residents and HCP, when possible, maintaining physical distance between unvaccinated people (at least 6 feet) is an important strategy to prevent COVID-19 transmission.
- Remind unvaccinated HCP to practice physical distancing when in break rooms or common areas (as outlined above). Wearing a mask does not negate the need for social distancing but serves as another infection control measure to prevent disease transmission. The more infection control measures consistently implemented and maintained, the more successful we will be at preventing disease transmission.

Surveillance for Respiratory Illness in Residents during COVID-19

- Assess resident vital signs including temperature and pulse oximetry daily.
- Routinely monitor residents for possible COVID-19 symptoms, including:
    - Cough
    - Shortness of breath, difficulty breathing, or signs of new hypoxemia
    - Fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)
    - Other symptoms in the setting of a suspected or confirmed COVID-19 outbreak (e.g., rhinorrhea, diarrhea, nausea or vomiting)
    - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include changes in cognition, new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, or loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population.
- Identification of any one symptom should prompt facilities to follow the guidance below for when a Respiratory Illness or a Positive Test is Identified.
- Ensure residents have been educated on the signs and symptoms of COVID-19 and how to report if they develop illness.

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Respiratory Illness or a Positive Test is Identified (Isolation)

Residents with Illness or a Positive Test

Residents who test positive (regardless of symptoms) and those with signs or symptoms of COVID-19 should be cared for in the following manner (regardless of vaccination status):

- Residents with newly identified signs or symptoms of COVID-19 should be tested immediately using point of care rapid testing if not already completed.
- Residents should be cared for following transmission-based precautions in a single person room with a private bathroom (i.e. isolated).
    - HCP caring for these individuals should follow transmission-based precautions.
    - If single person rooms are not available, or numerous residents are simultaneously identified as having signs or symptoms of COVID-19, residents should shelter in place while awaiting testing results.
    - Residents with suspected or confirmed COVID-19 do not need to be cared for in a negative airborne isolation room (AIIR) but should be cared for using an N95 or higher level respirator, eye protection, gloves, and a gown.
    - The door to the room should be closed whenever possible. If the door being closed creates a safety concern (e.g. memory care unit), work with facility engineers to minimize airflow into the hallway (e.g. running the bathroom exhaust fan).
    - A COVID-19 care area can be used if available, but should only house individuals who have a positive **lab-based** PCR test confirming COVID-19.
- Avoid moving ill residents both inside and outside of the facility. If an ill resident requires care outside of the facility, notify EMS and/or the receiving facility of known or suspected COVID-19 prior to arrival.
- Only essential personnel should enter the room of residents being cared for following transmission-based precautions. Consider having designated HCP care for ill residents and/or bundle care activities to limit the number of interactions and PPE utilized.
- Increase monitoring of all residents (regardless of vaccination status) for signs and symptoms of COVID-19 to at least 3 times per day.
- Consult the Discontinuation of Isolation for Residents and Health Care Personnel section in this document to determine when isolation is no longer necessary.

Monoclonal Antibody Therapy for Residents with a Positive Test

Monoclonal antibodies are approved for treatment of patients who are diagnosed with COVID-19 and have a high risk of progression of disease, but are not yet ill enough to require hospital admission. Treatment with monoclonal antibodies has the potential to alleviate symptoms and limit progression to severe disease in patients with mild to moderate COVID-19.

- All residents who are diagnosed with COVID-19 by a PCR or antigen test for SARS CoV-2 and are not hospitalized should be evaluated by a health care provider to determine if they are eligible for monoclonal antibody therapy.
- A health care provider should be consulted immediately after the positive test result is received, as there is only a 10-day window to initiate monoclonal antibody therapy after the onset of symptoms (or documentation of a positive test in patients without symptoms).

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- IV administration is the preferred route for monoclonal antibody therapy. However, one monoclonal antibody product is approved for subcutaneous (SQ) administration, and inability to obtain IV access or provide IV infusions should not disqualify a patient from receiving monoclonal antibody therapy.
- Vaccinated patients who test positive for SARS CoV-2 are eligible for monoclonal antibody therapy.
- For more information about monoclonal antibody therapy, please consult the NIH Treatment Guidelines.
- For more information on specific monoclonal antibody medications, please consult the FDA fact sheets for REGEN-COV and sotrovimab.
- For Colorado specific information on monoclonal antibody medications, consult the CDPHE COVID-19 Treatments webpage.

Health Care Personnel with Illness or a Positive Test

- Facilities should have a process in place to ensure all HCP (including consultant and ancillary personnel) are screened at the beginning of their shift for fever or respiratory symptoms, regardless of vaccination status. A sample form can be found here.
    - Screening should ask about close contact with a person infected with COVID-19 and any ill household member.
    - Facilities can choose to actively screen their HCP or allow HCP to self-screen but must ensure screening occurs and responses are monitored to promptly respond to HCP who report illness or close contact exposures.
    - As part of routine practice, ask HCP to regularly monitor themselves for fever and symptoms of respiratory infection. Remind HCP to report illness promptly.
    - Remind HCP to stay home when they are ill. HCP should not report to the facility if they are feeling ill.
    - Prioritize testing if it has not already been done.
        - POC testing can be used (in addition to the required PCR testing but not as a replacement) to assist with prompt identification of SARS CoV-2, the virus that causes COVID-19. See point of care rapid testing section for additional information.
- Discourage HCP from working in multiple facilities, as this can increase the risk of transmission and an outbreak among multiple facilities. If such limitations cannot be maintained, keep a record of other healthcare facilities where your HCP are working and ask about exposure to facilities with recognized COVID-19 cases.
- Consult the Discontinuation of Isolation for Health Care Personnel section in this document to determine when isolation is no longer necessary.

Alternate Diagnosis

- If HCP or residents have COVID-19 ruled out and have an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work/discontinuation of transmission-based precautions should be based on that diagnosis. However, if concurrent COVID-19 infection is suspected based on association with a suspected or confirmed outbreak, return to work criteria should follow the strategies above.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Management of those who had Close Contact with COVID-19

Asymptomatic Residents and Health Care Personnel who had Close Contact with Someone with COVID-19 Infection (Quarantine)

The following recommendations are based on what is known about currently available COVID-19 (SARS CoV-2) vaccines. These recommendations will be updated as additional information becomes available, including information regarding vaccine effectiveness to prevent infection with novel variants. This could result in additional circumstances when work restrictions for fully vaccinated HCP are recommended.

Fully Vaccinated Health Care Personnel

- Fully vaccinated asymptomatic HCP, **do not** need to be restricted from work for 14 days following close contact with someone with COVID-19 but should report a close contact to someone with COVID-19 for testing purposes, as described below. Work restrictions for higher-risk exposures should still be considered:
    - HCP who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact the level of protection provided by the COVID-19 (SARS CoV-2) vaccine. However, data on which immunocompromising conditions might affect response to the COVID-19 vaccine and the magnitude of risk are not available.
- Fully vaccinated HCP should participate in daily POC testing until 14 days have passed since the last exposure to the positive individual. If the HCP cannot separate from the sick individual (e.g. parent/child), rapid testing should continue until 14 days after the sick individual is released from isolation.
- Fully vaccinated HCP should have a lab-based PCR test conducted immediately after recognizing the exposure.

Unvaccinated Health Care Personnel

- HCP who are unvaccinated or partially vaccinated should report a close contact to someone with COVID-19, should be excluded from work and follow a home quarantine for 14 days from the last known exposure. If the HCP cannot separate from the sick individual (e.g. parent/child), the HCP should continue to quarantine at home until 14 days after the sick individual is released from isolation.

All Residents in Health Care Settings

- Following close contact (roommates and those within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period) with someone with COVID-19 infection, all

residents (regardless of vaccination status) who reside in a health care setting should quarantine, have a lab-based PCR test immediately, and participate in daily rapid POC testing.
    - Residents in quarantine should be placed in a single-person room with a private bathroom whenever possible. If single rooms are not available or if multiple residents are simultaneously identified to have known COVID-19 exposures or symptoms concerning for COVID-19, residents should shelter-in-place at their current location while being monitored for evidence of COVID-19 infection.
        - If at any time during the quarantine period a resident tests positive for or has symptoms concerning for COVID-19, the resident starts isolation and remains in isolation until Discontinuation of Isolation Criteria are met. For more information on isolation, refer to Respiratory Illness or a Positive Test is Identified (Isolation).
        - Residents should only be placed in a COVID-19 care unit if they have confirmed COVID-19 infection (i.e. positive PCR test for SARS-CoV-2). Placing a resident without confirmed COVID-19 infection (e.g. with symptoms concerning for COVID-19 pending testing or with a close contact in a dedicated COVID-19 care unit could put them at higher risk of exposure to COVID-19.
- Asymptomatic residents, regardless of vaccination, who have had close contact with someone with COVID-19 infection, should have a **lab-based** PCR test immediately upon identifying the exposure and participate in daily rapid POC testing until 14 days have passed since the last known close contact.

Newly Admitted Residents

Unvaccinated Residents & Residents Who Leave The Facility Overnight

In general, all new admissions and readmissions that are not fully vaccinated, should be placed in a 14-day quarantine, even if they have a negative test upon admission. Exceptions are listed below. Residents who leave the facility overnight (generally 24 hours or longer) should be managed as a new admission.

- Unvaccinated new admissions should be included in surveillance and outbreak testing.
- HCP should wear an N95 or higher-level respirator, eye protection (i.e. goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for residents on transmission-based precautions (e.g. isolation and quarantine).

Fully Vaccinated Residents

- Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility **if they are fully vaccinated and have not had prolonged close contact with someone with COVID-19 infection in the prior 14 days**. Facilities should have a process in place to assess for such risk upon admission.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Considerations for Residents Who are Within 3 Months of Prior Infection

- CDC recommendations indicate that asymptomatic residents who have recovered from COVID-19 and are within 3 months of their positive PCR test may not need to quarantine or test following re-exposure to someone with COVID-19 infection. However, there might be clinical scenarios for which providers could consider testing for SARS-CoV-2 and quarantine. Examples could include:
    - Residents with underlying immunocompromising conditions (e.g., patient after organ transplantation) or who become immune compromised (e.g., receive chemotherapy) in the 3 months following COVID-19 infection and who might have an increased risk for reinfection. However, data on which specific conditions may lead to higher risk and the magnitude of risk are not available.
    - Residents for whom their initial diagnosis of COVID-19 infection might have been based on a rapid antigen or molecular test, and a confirmatory nucleic acid amplification test (NAAT) was not performed.
    - Residents for whom there is evidence that they were exposed to a novel SARS-CoV-2 variant (e.g. exposed to a person known to be infected with a novel variant) for which the risk of reinfection might be higher.

Discontinuation of Isolation (Residents and Health Care Personnel)

Residents or HCP requiring isolation due to suspected or confirmed COVID-19 infection may be released from isolation and/or return to work when the following are true:

Individuals with Mild to Moderate Illness Who are Not Severely Immunocompromised

- At least 10 days have passed since symptoms first appeared.
  [AND]
- At least 24 hours have passed since the last fever without the use of fever-reducing medications.
  [AND]
- Symptoms (e.g., cough, shortness of breath) have improved.
- Patients who were asymptomatic throughout their infection and are not severely immunocompromised should wait until at least 10 days have passed since the date of their first positive viral test.

Individuals with Severe to Critical Illness or Who are Severely Immunocompromised

- At least 10 days and up to 20 days have passed since symptoms first appeared.
  [AND]
- At least 24 hours have passed since the last fever without the use of fever-reducing medications.
  [AND]

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Symptoms (e.g., cough, shortness of breath) have improved.
- For severely immunocompromised residents who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test.
- Patients who are severely immunocompromised may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. Consultation with infectious diseases specialists is recommended. Use of a test-based strategy for determining when Transmission-Based Precautions may be discontinued could be considered.

When SARS-CoV-2 and Influenza Viruses are Co-circulating

- When SARS-CoV-2 and influenza viruses are found to be co-circulating based upon local public health surveillance data and/or testing at local health care facilities, facilities should implement the following:
    - Place symptomatic residents in Transmission-Based Precautions using all recommended PPE for SARS CoV-2, the virus that causes COVID-19 and test for both viruses (SARS CoV-2 and influenza).
    - Because some of the symptoms of influenza and COVID-19 are similar, it may be difficult to tell the difference between these two infections based on symptoms alone. Residents in the facility who develop symptoms of acute illness consistent with influenza or COVID-19 should be moved to a single room, if available, or remain in the current room, pending results of viral testing. **They should not be placed in the COVID-19 care unit unless influenza is ruled out and they are confirmed to have COVID-19 by SARS-CoV-2 (PCR) testing.**
    - Facilities should promptly contact public health for consultation and further investigation if co-circulating viruses are suspected.
    - Additional CDC guidance for influenza can be found here. The CDPHE guidelines for influenza outbreaks in long-term care facilities can be found here.
- CDPHE provides a basic tracking tool: Line List Template to Monitor Residents and Health Care Personnel. Collection of additional variables may be recommended in the setting of a suspected or confirmed COVID-19 outbreak.

Return to Work After Travel

Travel may increase an individual's risk of catching and potentially spreading COVID-19. Those living in a residential care facility are at an increased risk of poor outcomes if they become infected. Facilities should consider the following when assessing risk of those who have recently traveled and will be coming into contact with residents.

Fully Vaccinated Travelers

- Domestic travelers who are fully vaccinated do not need to get a SARS-CoV-2 viral test or self-quarantine after travel.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- International travelers who are fully vaccinated should get tested with a viral test 3-5 days after travel and isolate if positive.
    - Travelers do not need to self-quarantine after international travel.
- In either scenario, the traveler should continue to self monitor for signs and symptoms for a full 14 days.

Unvaccinated or Partially Vaccinated Travelers

- In general, CDC recommends people delay travel (domestically or internationally) until they are fully vaccinated.
    - Unvaccinated or partially vaccinated travelers should notify the facility of their travel plans prior to departure whenever possible. Facilities should have processes in place to assess traveler risk prior to travelers being allowed to return to work.
- Domestic travelers are recommended to get tested with a viral test 3-5 days after travel and isolate if positive. Like all unvaccinated or partially vaccinated domestic travelers, HCP should self-quarantine for a full 7 days if testing negative. If testing does not occur, the traveler should be quarantined for 10 days after travel.
- International travelers should get tested with a viral test 3-5 days after travel AND stay home and self-quarantine for a full 7 days after travel. Even if they test negative, travelers should stay home and self-quarantine for the full 7 days. If they test positive, travelers should isolate themselves to protect others from getting infected.
    - If they don't get tested, travelers should stay home and self-quarantine for 10 days after travel.
    - International travelers should avoid being around people who are at increased risk for severe illness for 14 days after return, whether they get tested or not.
    - International travelers should self-monitor for COVID-19 symptoms for 14 days, and isolate and get tested if they develop symptoms.

Considerations for completing a risk assessment should include at minimum: location of travel, method of travel (e.g. air, bus, car), and activities during travel (e.g. camping vs amusement park or large indoor gathering). The goal of a risk assessment is to determine if the risk of being exposed to COVID-19 is greater during travel than the risk within the community. If risk is greater, travelers should quarantine for 14 days in addition to the other CDC travel recommendations.

Public Health Order 20-20 requires facilities to participate in surveillance and outbreak testing as described in this guidance document.

Residents and HCP with asymptomatic and presymptomatic COVID-19 infection, who likely play a significant role in transmission of COVID-19, cannot be identified without testing. Cohorting residents within a facility is difficult without expanded testing. Residents without illness and those with an unknown SARS CoV-2 status should not be cohorted with COVID-19-positive residents. Without routine surveillance testing of unvaccinated HCP and residents, residential care settings might implement cohorting strategies that could contribute to increased transmission within the facility because of others who may be infected and are either at the early stage of infection or are infected with SARS CoV-2 but are asymptomatic.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

CDPHE will provide testing supplies for all facilities to implement surveillance and outbreak testing, or facilities may choose to procure their own resources for laboratory based PCR testing that meets or exceeds the testing services provided by CDPHE, as outlined in this document and required by the PHO. All facilities should use a CDPHE contracted lab (e.g. CDPHE, CSU, Mako) for lab-based PCR testing. If using a lab other than these labs, contact the Residential Care Strike Team to ensure that your contracted lab will meet the requirements necessary to perform or facilitate whole genome sequencing on all positive specimens to identify current and emerging variants.

Surveillance Testing

- All facilities must implement surveillance testing for SARS CoV-2, the virus that causes COVID-19 utilizing laboratory based PCR testing (weekly or twice weekly as outlined below) AND rapid molecular or antigen testing for unvaccinated or partially vaccinated individuals (daily or per shift as outlined below).
- Surveillance testing should be based on the prevalence of the virus in the community (as outlined in this section) and the vaccination status of the individual being tested.
- HCP and residents (regardless of vaccination status) with close contact to an individual who has tested positive for SARS-CoV-2 should have a lab-based PCR test immediately upon recognizing the exposure and participate in daily rapid POC testing until 14 days have passed since the last exposure to the sick individual (HCP do not need to participate in POC testing on the days they are not in the facility).Fully Vaccinated

Health Care Personnel and Residents

Fully vaccinated HCP and residents DO NOT need to participate in routine surveillance testing as long as they remain asymptomatic and have not had a known close contact.

Health Care Personnel and Residents Who Recovered from COVID-19 in the Previous 90 Days and Remain Asymptomatic.

- Residents and HCP who have tested positive for SARS-CoV-2 (by lab-based PCR) in the previous 90 days and remain asymptomatic **SHOULD NOT** be included in routine surveillance testing.

Health Care Personnel Who Are Not Fully Vaccinated

- HCP who are not fully vaccinated (employees, consultants, agency staff, contractors, volunteers, students, caregivers, and others who provide care and services to residents) should be included in routine surveillance testing.

Residents Who Are Not Fully Vaccinated

- Residents who are not fully vaccinated **DO NOT** need to participate in routine surveillance (POC and PCR) testing **UNLESS** they have left the facility overnight in the past 14 days.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Testing Frequency

Facilities should monitor their county's two-week test positivity rate every other week (e.g., first and third Monday of each month) using the Colorado COVID-19 dashboard and adjust the frequency of testing as outlined below. The facility should test all HCP and residents at the frequency indicated in the routine testing interval table below.

Routine Surveillance Testing Interval Table

Individuals who should participate in routine surveillance testing	County Positivity Rate using CO COVID-19 dashboard	Test Type and Frequency
HCP who are not fully vaccinated: *Exclude those who tested positive in the past 90 days.	< 10% two-week test positivity.	• Test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test, at the beginning of every shift. **AND** • Complete **once weekly lab-based PCR testing.**
HCP who are not fully vaccinated: *Exclude those who tested positive in the past 90 days.	>10% two-week test positivity.	• Test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test, at the beginning of every shift. **AND** • Complete **twice weekly lab-based PCR testing.**
Residents who are not fully vaccinated AND have left the facility (overnight - generally 24 hours or longer) in the past 14 days: *Exclude those that tested positive in the past 90 days.	< 10% two-week test positivity.	• **Approximately the same time each day,** test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test. • Daily rapid testing should continue for 14 days *(The date the resident returns to the facility is counted as day 1).* **AND** • Complete **weekly lab-based PCR testing for two weeks.** The second round of testing should be collected on or after

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		day 14 *(e.g. collect day 7 and day 14)*.
Residents who are not fully vaccinated AND have left the facility (overnight - generally 24 hours or longer) in the past 14 days: *Exclude those that tested positive in the past 90 days.	>10% two-week test positivity.	• **Approximately the same time each day,** test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test. • Daily rapid testing should continue for 14 days *(The date the resident returns to the facility is counted as day 1)*. **AND** • Complete **twice weekly lab-based PCR testing for two weeks.** The final round of testing should be collected on or after day 14 *(e.g. collect day 3, 7, 10 and day 14)*.
HCP who are fully vaccinated:	n/a	• Exempt from routine surveillance testing, unless a known close contact exists.
Residents who are fully vaccinated regardless if they have left the facility:	n/a	• Exempt from routine surveillance testing, unless a known close contact exists.
Residents and HCP (regardless of vaccination status) who have had close contact to someone who tested positive for SARS-CoV-2		• Asymptomatic individuals should have a **lab-based** PCR viral test for SARS-CoV-2 infection immediately after recognizing the exposure. **AND** • Participate in daily rapid poc testing approximately the same time each day (HCP should test prior to each shift) (until 14 days following the last exposure to the positive individual. If the resident or HCP cannot separate from the sick

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		individual, then rapid testing should continue until 14 days after the sick individual is released from isolation).

- Providers of health care or ancillary non-medical services for residents of the facility must do one of the following:
    - Provide proof that they are fully vaccinated to the facility.
    - Participate in the facility outbreak and/or surveillance testing.
    - Provide a copy of a negative PCR lab report for SARS CoV-2, the virus that causes COVID-19 from a specimen collected within the past 7 days
      AND
      completes a rapid molecular or antigen test, which is negative prior to entering the facility.
- Facilities should have a process in place that ensures and maintains the required documentation (i.e., a copy of the individual's vaccination record or a copy of negative **lab-based** PCR test results) prior to exemption.
- Facilities may choose to expand testing beyond these minimum requirements, such as testing all unvaccinated residents on a more frequent basis.
- POC testing may be offered to visitors; visitors may be excluded from visiting if they test positive, but cannot be denied entry if testing is refused.
- Facilities may not restrict Ombudsman, Adult Protective Services workers, or Emergency Medical Services workers from entering their building for any reason, including the absence of proof of testing and/or vaccination.

Individuals Who Refuse Testing When Indicated

Facilities must have procedures in place to address residents, HCP, and others who refuse testing. Procedures should ensure that HCP who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return-to-work criteria are met.

- HCP and residents (or resident guardians/representatives) may exercise their right to decline SARS CoV-2 (COVID-19) testing. Facilities must have written infection control policies and procedures in place to address HCP and residents who refuse SARS CoV-2 (COVID-19) testing.
- If outbreak testing has been triggered (identification of a positive resident or HCP member) and an asymptomatic HCP refuses testing (**lab-based** PCR, rapid molecular or antigen test), the HCP should be restricted from the facility for 14 days following each round of refused testing or until the procedures for outbreak testing have been completed (e.g., outbreak resolved).
- Symptomatic residents, regardless of vaccination status, who refuse testing should be placed on transmission-based precautions in a private room until symptom-based criteria for the discontinuation of isolation precautions have been met.
- Asymptomatic residents who refuse testing (**lab-based** PCR, rapid molecular or antigen test) should be quarantined for 14 days following each round of refused testing or until

the the procedures for outbreak testing have been completed (e.g. outbreak resolved) and HCP shall use PPE effective against COVID-19 until the outbreak resolves.

Implement Outbreak Testing

When one or more positive tests are identified in a resident or a HCP (regardless of vaccination status), the facility moves to outbreak testing and follows additional response measures.

Outbreak Testing Interval Table

Individuals who should participate in outbreak testing **Exclude those who tested PCR positive in the past 90 days and remain asymptomatic.*	Test Type and Frequency
HCP who are not fully vaccinated:	• Test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test, at the beginning of every shift. **AND** • Complete twice weekly **lab-based** PCR testing.
Residents who are not fully vaccinated regardless if they have left the facility.	• Approximately the same time each day, test for SARS CoV-2, the virus that causes COVID-19 using a rapid molecular or antigen test. **AND** • Complete twice weekly **lab-based** PCR testing.
HCP who are fully vaccinated:	• Complete twice weekly **lab-based** PCR testing.
Residents who are fully vaccinated:	• Complete twice weekly **lab-based** PCR testing.
Continue to follow this testing frequency until no new positives are identified. When no additional positives are identified, move to "Outbreak Exit Testing". Refer to "Decision Tree" for testing frequency.	
• All individuals who test positive with a rapid test should have a second sample collected **immediately** and sent for lab-based PCR testing. • HCP who test positive, regardless of vaccination status, should be excluded from	

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work and instructed to be isolated at home. HCP should self-report positive results to any additional employer(s) so that disease control measures can be implemented if necessary.
- Residents who test positive should be isolated in a private room and cared for using PPE effective against SARS CoV-2, the virus that causes COVID-19. Residents should not be cohorted with other positive residents until lab-based PCR confirmation is received.
- Notify public health immediately of positive results.

After the positive test(s), take the following steps:

- Initiate outbreak testing and stop indoor visitation immediately. Perform round 1 of outbreak testing (See decision tree), including all HCP and residents regardless of vaccination status, except those who have tested positive in the previous 90 days and remain asymptomatic. Testing must be initiated immediately. Specimens must be sent to the testing laboratory as soon as possible but not greater than 48 hours after identifying the positive test result. This is to promptly identify other asymptomatic, presymptomatic, and symptomatic infections.
    - The results for each round of testing will determine the next step in responding to the outbreak, as outlined in the Outbreak Testing Results and Response section.
    - Conduct contact tracing to identify individuals (HCP and residents) with prolonged exposure and quarantine accordingly.
    - Facilities must immediately report an outbreak of COVID-19 (suspected or confirmed) to public health. Review Reporting Test Results to Public Health within this document for additional information.

Outbreak (OB) Testing Results and Response (See decision tree)

- **Facilities that Identify No Positives in Residents or Health Care Personnel**
    - Move to OB Exit Testing.
        - Facilities must ensure testing of ALL HCP and residents except those who have tested positive in the previous 90 days in order to move to OB Exit Testing.
    - **Lab-based** PCR testing frequency decreases to every 7 days until the outbreak is closed.
        - Daily rapid testing continues for HCP and residents who are not fully vaccinated.
    - Facilities may resume or continue admissions, communal dining and group activities, and indoor visitation for all residents regardless of vaccination status.
- **Facilities that Identify a positive resident or Health Care Personnel**
    - Continue to follow OB testing protocol.
    - Lab-based PCR testing frequency is every 3-4 days.
    - Facilities should stop admissions, communal dining, group activities, and indoor visitation for unvaccinated persons.

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    - The facility may continue **outdoor** visitation for all residents (regardless of vaccination status) as long as the resident otherwise meets the criteria for visitation.
    - When discordant results are identified between POC testing and lab-based PCR, CDPHE should be consulted prior to discontinuing isolation for a resident or HCP.
- **Outbreak Exit Testing**
    - Outbreak exit testing begins when a round of lab-based PCR testing identifies no positive residents or HCP. Facilities must ensure testing of ALL eligible HCP and residents (i.e., individuals who have not tested PCR positive in the previous 90 days) in order to move to OB Exit Testing.
    - A minimum of 7 days have passed since the previous round of testing, until two additional rounds of **lab-based** PCR testing (three consecutive rounds at least 7 days apart) identify no positive residents or HCP.
    - If at any point a round of testing (rapid molecular, antigen test, or lab-based PCR) identifies a new positive, the facility returns to OB testing.
    - Facilities may resume or continue admissions (regardless of resident COVID-19 status), communal dining and group activities, and indoor visitation.
- Additional information for CMS regulated facilities, to include next steps in responding and visitation during an outbreak, can be found in the Visitation During an Outbreak section.

Testing Previous Positives

- CDPHE does not recommend repeat testing of persons who previously tested positive for SARS CoV-2, the virus that causes COVID-19 utilizing a laboratory-based PCR test in the past 90 days. For positives identified using a rapid test, confirmation testing using **lab-based** PCR should be collected immediately. This includes those who are asymptomatic and identified during outbreak testing. **Repeated testing of any positive individual cannot be used to release someone from isolation or resolve an outbreak.** For adults who have recovered from COVID-19 infection, a positive SARS-CoV-2 RT-PCR result without new symptoms during the 90 days after illness onset more likely represents persistent shedding of viral RNA than reinfection.
- If such a person becomes symptomatic during this 90-day period and an evaluation fails to identify a diagnosis other than COVID-19 infection (e.g., influenza), then the person may warrant evaluation for COVID-19 reinfection in consultation with an infectious disease or infection control expert.
    - Quarantine may be warranted during this evaluation, particularly if symptoms developed after close contact with an infected person.
    - Serologic testing should not be used to establish the presence or absence of COVID-19 infection or reinfection. See Duration of Isolation and Precautions for Adults with COVID-19.

Point of Care (POC) Rapid Testing

Rapid tests are available as point-of-care (POC) diagnostics for SARS-CoV-2, offering a rapid turnaround time. Tests are available as antigen or molecular tests; they often have a lower

sensitivity but similar specificity to **lab-based** PCR testing. Rapid tests can play an important role in disease mitigation including: testing symptomatic individuals, testing asymptomatic individuals who have had a close contact with a COVID-19 case or someone who has tested positive for SARS CoV-2, and testing asymptomatic health care workers as part of an outbreak response.

Considerations for use:

- POC tests supplement but cannot replace the required **lab-based** PCR testing. The facility must have a CLIA Certificate of Waiver. Information on obtaining a CLIA Certificate of Waiver can be found here.
- The facility should be familiar with the instructions for use of the specific test being utilized, including the FDA EUA for tests.
- Considerations for interpreting rapid antigen or molecular test results in residential care facilities can be found here.
- POC testing results need to be reported (positive, negative, and inconclusive) to CDPHE as the performing laboratory (as outlined below in Reporting Test Results to Public Health).
- If the facility encounters a negative result among symptomatic residents or HCP , the facility must immediately conduct a **lab-based** PCR test to confirm the results. Ensure the individual remains isolated until results are confirmed.
- Residents who test positive using a POC rapid test should be isolated in a private room. Facilities should not make cohorting decisions until **lab-based** PCR confirmation results are received.
- When discordant results are identified between POC testing and lab-based PCR, CDPHE should be consulted prior to discontinuing isolation for a resident or HCP.

Specimen Collection

- The type of specimen collected when testing for current or past infection with SARS-CoV-2 is based on the test being performed and its manufacturer's instructions. Some of the specimen types will not be appropriate for all tests.
- For initial diagnostic testing for current SARS-CoV-2 infections, CDC recommends collecting and testing an upper respiratory specimen.
- CDC interim guidelines for collecting and handling of clinical specimens for COVID-19 testing should be followed.

Reporting Requirements

Reporting Test Results to Public Health

- COVID-19 (SARS-CoV-2 positive lab testing) is a reportable communicable disease in Colorado requiring both the ordering provider and laboratory to report SARS-CoV-2 test results. Your facility is responsible for reporting all results (positive, negative, and inconclusive) for specimens that are collected and tested by your facility (e.g., rapid point-of-care tests) as described below. Additionally, your facility is responsible for reporting positive results from laboratory-based testing directly to CDPHE. **Your facility is exempt from reporting lab-based PCR results only if you are currently**

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participating in state-funded surveillance and outbreak testing via your assigned laboratory. The facility is responsible for reporting POC results to CDPHE.
- **For additional questions about reporting SARS-CoV-2 results, please email the team in PHIRR:** cdphe_covidreporting@state.co.us.
- Facilities performing POC testing must report all SARS-CoV-2 results (positive, negative, and inconclusive) to CDPHE directly.
- All tests, whether submitted to a laboratory or conducted as a point of care test, MUST include all of the required information necessary for the provider and testing lab to process the tests and should include:
    - Full name of the individual being tested.
    - Date of birth.
    - Sex.
    - Ethnicity and race.
    - Complete street address (only residents may utilize the facility address—the address should be where the individual resides).
    - Phone number (only residents may use the facility phone number).
    - Collection date
    - Specimen type
- Any suspected or confirmed case **or** outbreak (e.g., one or more cases) of COVID-19 among residents or HCP shall immediately be reported to the local or state public health agency using the COVID-19 Outbreak report form.
    - Facilities can send this form to their local public health agency OR to CDPHE by securely emailing the completed form to cdphe_covid_outbreak@state.co.us. Facilities may also contact CDPHE at 303-692-2700 (8:30 - 5:00, Monday - Friday) or 303-370-9395 (after hours, holidays, and weekends).
    - Additionally, facilities should promptly notify public health for any of the following: Suspected or confirmed case of influenza in a resident or HCP (may indicate co-circulation); a resident with severe respiratory infection resulting in hospitalization or death; or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of one another.

EMResource

- ALL residential care facilities should report COVID-19 information weekly, using the CDPHE EMResource.

NHSN

- CMS nursing homes must report COVID-19 data to NSHN at least once weekly. CDPHE does not currently have NHSN reporting requirements for Nursing Homes. You may view the required reporting information for CMS here.
    - POC testing results reported to NHSN do not require duplicate reporting to CDPHE.
- Reporting information to NHSN does not fulfill state COVID-19 reporting requirements.

Communal Dining/Group Activities/Facility Outings

Facilities may participate in communal dining, group activities and facility outings as outlined

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

below:

- Documented proof of vaccination status is required and must be maintained by the facility for all staff, residents and any visitors participating in group activities.
- Residents with symptoms of illness, including signs and symptoms of COVID-19, or those that require isolation or quarantine (regardless of the reason) should be excluded from participating in communal dining, group activities, and facility outings.
- Facilities that are conducting outbreak testing related to the identification of one or more positive COVID-19 cases should follow the OB testing guidance and decision tree to determine when communal dining and group activities should be stopped, or resumed.
- Pets other than ADA service animals should not be included in communal dining or group activities. See visitation for individual pet visits.
- Hand hygiene should occur before and after all communal dining, group activities, and outings.

Communal Meals

- **Fully Vaccinated Residents**
  - Can participate in communal dining and share a table with other fully vaccinated residents without source control or physical distancing.
- **Residents Not Fully Vaccinated**
  - Should be excluded from group activities and communal dining anytime the facility's county two-week positivity rate is >10% and <70% of residents in the facility are vaccinated.
  - Should be excluded from group activities and communal dining anytime the facility has implemented outbreak testing. Refer to the decision tree.
  - Should wear masks at all times when outside of their room and until seated at a table to consume a meal.
  - Meals should be consumed while socially distanced from other residents or in the resident's room.

Group Activities

- **Fully Vaccinated Residents**
  - May choose to participate in group activities without using a mask or social distancing when only fully vaccinated individuals are present.
  - The consumption of food and drink can occur during group activities.
- **Residents Not Fully Vaccinated**
  - Should be excluded from group activities and communal dining anytime the facility's county two-week positivity rate is >10% and <70% of residents in the facility are vaccinated.
  - Should wear masks at all times when outside of their room, including while participating in group activities and facility outings.
  - While participating in group activities, residents should socially distance themselves from other residents and HCP.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

    - Food and drink should not be consumed during group activities and facility outings unless food and drink are consumed outdoors and residents are socially distanced from other residents and HCP.
- **Fully Vaccinated Visitors**
    - Fully vaccinated visitors (e.g., family members, musicians, entertainers) may participate in group activities, facility outings, and communal meals. Visitors must provide proof of vaccination.
    - Visitors who are unable to provide proof of vaccination are restricted from participating in group activities, facility outings, and communal dining and should follow visitation guidance.
    - Visitors are required to wear a well-fitting mask that covers both their nose and mouth if participating in activities, facility outings and communal meals.

Facility Outings

It may not be possible to social distance from others while riding in shared transportation required for facility outings. This should be considered prior to allowing unvaccinated residents to participate in such activity. If residents who are not fully vaccinated are sharing transportation to/from an activity, all unvaccinated individuals in the vehicle should wear masks and vehicle ventilation should be increased.

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. They should be encouraged and assisted with adherence to all recommended infection prevention and control measures, including source control, physical distancing, and hand hygiene.

Documented proof of vaccination status is required and must be maintained by the facility for all visitors participating in dining, group activities, and visitation intended for vaccinated individuals.

- **Fully Vaccinated Residents**
    - May choose to participate in facility outings without using a mask or social distancing when only fully vaccinated individuals are present.
    - If unvaccinated individuals are present, all individuals are required to wear a well fitting mask.
- **Residents Not Fully Vaccinated**
    - Unvaccinated residents should be excluded from group activities and communal dining anytime the facility's county two-week positivity rate is >10% and <70% of residents in the facility are vaccinated.
    - Unvaccinated residents should wear masks and physically distance themselves from others.
    - Food and drink should not be consumed during facility outings unless food and drink are consumed outdoors and socially distanced from other residents and HCP.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Visitation

While COVID-19 continues to present a substantially increased risk of mortality among older adults and individuals with underlying medical conditions in the state of Colorado, social isolation of individuals in nursing homes, group homes, assisted living communities, intermediate care facilities, and other congregate settings imposes substantial physical and mental health consequences. Visitation should be person-centered; consider the residents' physical, mental, and psychosocial well-being; and support their quality of life.

The facility must be in compliance with all public health orders as part of the implementation for this guidance. Residential care providers must routinely evaluate and update their visitation policies and procedures as guidance, facility resources, and the degree of community spread changes. Individual facilities may be required to enact stricter requirements based on their local COVID-19 community transmission levels, but may not waive any of these requirements.

General Visitation Guidance

The following guidance outlines requirements for all indoor and outdoor visitation, as well as circumstances when visitation should be limited. Visitation can be conducted through different means based on a facility's structure and residents' needs such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. Visitation is offered as a means for families and friends to have an opportunity to have personal interactions with one or two residents in the case of an established relationship (e.g., siblings, married couple, life partners); in general, visits should be limited to a single resident unless all participants are fully vaccinated.

For all visitation, the facility shall:

- Have adequate staffing and personal protective equipment (PPE), as reported in EMResource. The facility may cease visitation if it does not have necessary staff or PPE to perform infection control practices. **The facility must contact CDPHE (residentialcarestriketeam@state.co.us) if it wishes to cease visitation due to a lack of staffing or PPE.**
- Unvaccinated residents should wear a well-fitting mask which covers their nose and mouth unless it is medically contraindicated.
- Require unvaccinated visitors to schedule an appointment for the visit to ensure the facility can safely accommodate the number of people and have enough staff to monitor compliance with required infection prevention activities.
- Appropriately schedule visits for unvaccinated visitors, so staff have sufficient time to ensure rooms and/or surfaces can be properly cleaned and disinfected according to manufacturer's instructions between each visit.
- Require unvaccinated visitors to remain in their cars or outside the building until their scheduled visit time.
- Require unvaccinated visitors to wear a well-fitting mask which covers their nose and mouth during the entirety of the visit.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Deny entry to visitors, regardless of vaccination status, who do not pass screening or who refuse to comply with any of the indoor visitation requirements set forth in this guidance.
- Cease visitation for visitors and residents, regardless of vaccination status, who do not adhere to the core principles of COVID-19 infection prevention during the visit.
- If a visitor is participating in activities reserved for only those that are fully vaccinated, the visitor must share a copy of their vaccination record with the facility prior to the visit. The facility is required to maintain a copy of such records.

Who May Visit

All residential care facilities, including those that do not meet the criteria for indoor visitation, must allow entry and may not deny entrance for the following services. The following service providers must wear a mask when entering the facility unless they are able to provide a copy of their vaccination record to the facility prior to the visit.

- **Essential Health Care Service Providers**
  - These include but are not limited to physicians, hospice, and home health staff of all disciplines, along with other types of both medical and nonmedical health care and services.
  - Essential health care services providers must be screened and tested in accordance with the surveillance and outbreak testing prescribed in the Seventh Amended PHO 20-20.
  - Essential health care service providers must either produce a negative SARS CoV-2 (COVID-19) test within the prescribed testing frequency the facility is following or submit to facility testing.
- **Religious Exercise**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Adult Protective Services**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Long Term Care Ombudsman**
  - Screening is required. Testing is strongly encouraged, but must not be required.
- **Designated Support Persons**
  - Support service providers must be screened and may be offered testing in accordance with the surveillance and outbreak testing prescribed in the Seventh Amended PHO 20-20.
- **Compassionate Care Visits Should be Permitted at All Times**
  - Screening is required.
- **Emergency Medical Service Personnel**
  - Neither screening nor testing is required.
  - Emergency medical and service personnel shall not be delayed from response or access in relation to responding and carrying out their duties.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- **Ancillary Non-Medical Services**
    - Includes hairstylists, barbers, cosmetologists, estheticians, nail technicians, and massage therapists.
    - Ancillary services must be provided in the resident's room or in a separate room that is appropriately disinfected between uses.
    - Must wear appropriate PPE and follow appropriate infection control measures prior to, during, and after each resident encounter.
    - Comply with the policy and procedures regarding infection control, and abide by all other precautions and restrictions imposed on their profession that would be required in any setting.

Visitation Restrictions

Facilities may NOT offer or allow general visitation (as opposed to other types of required visitation) on the premises if:

- The resident participating in the visit has symptoms of COVID-19 or has had a positive test for SARS CoV-2 and requires transmission-based precautions.
- The resident participating in the visit is on transmission-based precautions (e.g., COVID-19 isolation, droplet or contact precautions). This includes residents required to be quarantined following admission.
- Statewide restrictions are implemented due to increased cases of COVID-19.
- Facilities should allow for 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 high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times).
- Indoor visitation for unvaccinated residents should be limited to compassionate care visits only IF any of the following are true:
    - The facility has a two-week SARS CoV-2 (COVID-19) test positivity rate of more than 10%, and fewer than 70% of residents in the facility are fully vaccinated. The facility shall utilize the COVID-19 Colorado Dial Dashboard to determine their county's average two-week positivity rate.
    - The facility has an outbreak of COVID-19 among the residential population.
    - Refer to the outbreak testing and response (or decision tree) to determine when indoor visitation for unvaccinated residents may resume.
    - Visitation during an outbreak may occur under certain circumstances as outlined here.

Prior to Implementing Visitation

- Notify residents' families and friends that general visitation is occurring in the facility. The notification should include:
    - Requirements, expectations, and limitations of visitation.
    - Instructions for self-screening along with information about when the results of the screening would require a cancellation of the visit.
    - Information on minimizing the spread of COVID-19.
    - Instructions for physical distancing and requirements for wearing a mask.
    - Instructions for scheduling visits, arriving, checking in for the visit, and screening prior to entry.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Outdoor Visitation

Outdoor visitation is preferred even when the resident and visitor are fully vaccinated against SARS CoV-2, the virus that causes COVID-19, as these visits generally pose a lower risk of transmission due to increased space and airflow. Visits should be held outdoors whenever possible. However, poor weather conditions or an individual resident's health status may preclude the possibility of an outdoor visit. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, all appropriate core infection control and prevention practices should be adhered to, and the following practices should be followed:

- The designated meeting area should be isolated. The facility should ensure that residents not participating in visits continue to have access to separate outdoor space.
    - The meeting area should be monitored by facility staff to ensure it remains separated from the facility population and from HCP .
- The allowable number of persons (resident,HCP, and visitors) will depend on the size of the space and should allow for social distance of at least 6 feet for residents and visitors who are unvaccinated.
    - Any codes, regulations, or ordinances requiring a smaller number of people must be followed.
    - The number of maximum visitors allowed must be documented in the visitation plan.
- Furniture used for external visits should be appropriately disinfected between visits.

Indoor Visitation

Facilities should allow indoor visitation at all times and for all residents, as outlined in this document. Ensuring the following:

- Visitation can still occur when there is an outbreak but under certain circumstances, as outlined in Outbreak Testing Results and Response (or decision tree below) and Visitation During an Outbreak section.
- The facility should restrict the total number of unvaccinated visitors (according to the size of the facility in order to maintain core principles of infection prevention) as well as the number of unvaccinated visitors allowed per resident at one time. CDPHE generally recommends allowing no more than two visitors per resident per room.
- Visitors are not required to be vaccinated or show proof of SARS CoV-2 (COVID-19) vaccination unless they are participating in activities requiring vaccination. To participate in these activities, the facility must:
    - Ensure visitors are aware of this requirement when scheduling their visit.
    - The facility must maintain documentation of the visitor vaccination status as outlined in the group activities section.
- Facilities may choose to offer rapid testing of visitors; however, it cannot be a contingency for visitation. Facilities should deny entry to visitors who test positive.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

    - Facilities should have a process in place to respond to positive results. Should a potential visitor test positive, the visitor's positive test will not impact the facility's outbreak status even if the visitor has been in the facility during the prior 14 days. The visitor could be counted towards the facility's outbreak status if an epidemiological link is identified.
    - If the facility arranges, suggests, or performs SARS CoV-2 testing for visitors, the test results must be obtained in a reasonable amount of time and visitation cannot be denied as a result of prolonged turnaround time.
- All visitors must be screened for COVID-19 symptoms, regardless of vaccination status, and facilities should limit visitor movement in the facility by following these procedures:
    - Greet visitors at a designated area at the entrance of the facility where a staff member must:
        - Perform temperature check and symptom screening.
        - Document the visitor's contact information and the results of the screening. This example form may be used to document the information.
        - Deny entry to visitors who have a positive test or display symptoms during the screening.
        - Ensure the unvaccinated visitor has a face mask and ensure the mask covers the visitor's nose and mouth.
        - Have the visitor clean their hands with alcohol-based hand sanitizer.
        - Escort the unvaccinated visitor to the designated visitation area.
    - Indoor visitation for unvaccinated residents and visitors should occur in dedicated visitation spaces that allow for appropriate physical distancing if required and increased ventilation (open windows, etc.), and cleaning and disinfection between visitors.
- Residents who are fully vaccinated and those who are within 3 months of a prior COVID-19 infection may have private in-room visits with unvaccinated visitors. Both the resident and their visitor should wear a well-fitting face mask and perform hand hygiene before and after limited physical contact (e.g., hugging and/or hand-holding).
    - Visitors should still physically distance themselves from other residents and HCP in the facility.
    - If the room is shared, the resident's roommate must be fully vaccinated and the facility shall obtain the consent of the roommate and/or the roommate's POA that visitation may occur in the room.
    - Visitors must not access the roommate's living area or have contact with the roommate's environment.
    - If the room is shared, ensure visits do not overlap. This is to limit the number of visitors in a resident's room at any given time.
    - In-room visits with unvaccinated visitors do not require staff supervision but do require staff to escort the unvaccinated visitor to and from the room.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Visitation During an Outbreak

CDPHE guidance related to visitation during an outbreak. For full guidance and requirements please consult: CMS guidance and CDC recommendations. CDPHE and CMS guidance are now aligned for visitation during an outbreak.

Visitation can still occur when there is an outbreak but under certain circumstances as outlined in Outbreak Testing Results and Response (or decision tree below):

- If outbreak testing reveals no additional COVID-19 cases in residents, then indoor visitation can continue regardless of resident vaccination status. Follow testing recommendations in the testing decision tree to determine next steps.
- If outbreak testing reveals one or more additional COVID-19 cases in residents, then facilities should stop indoor visitation, communal dining, and group activities for unvaccinated residents.
- The facility may continue with **outdoor** visitation for all residents (regardless of vaccination status) as long as the resident meets the criteria for visitation (as outlined below).
- In all cases:
    - Residents in isolation or quarantine are not eligible for visitation until transmission-based precautions are discontinued.
    - Visitors should be notified about the potential for COVID-19 exposure in the facility.
    - Refer to Visitation Restrictions if the facility's SARS CoV-2 (COVID-19) county test positivity rate is more than 10% and fewer than 70% of residents in the facility are fully vaccinated.

Note: Compassionate care visits and visits required under federal disability rights law should be allowed at all times, for any resident, and regardless of vaccination status.

Visitation: Miscellaneous Considerations

- With pre-notice and facility permission, pets may accompany a visitor for a visit with a single resident. Pets can aid in the transmission of COVID-19 and therefore the pet must be kept away from other HCP and residents during the visit (inside or outside). The facility should have policies and procedures regarding the safety and parameters for pet visitation, including criteria for vaccinations and infection control.
- Remind visitors that they should refrain from visiting for at least 14 days if they have been in close contact with anyone who has tested positive for or has symptoms consistent with COVID-19. Visitors should alert the facility if they develop fever or other symptoms consistent with COVID-19, or if they are diagnosed with COVID-19 in the 14 days following visitation. Promptly notify public health if such notification occurs.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Supplemental Resources

Required Isolation Plans

Facilities must have and maintain an isolation plan that allows for prompt isolation of residents with COVID-19 (suspected or confirmed) to limit transmission.

- Residents who test positive for SARS CoV-2, the virus that causes COVID-19 should be isolated in a private room with a private bathroom away from others (as outlined here) or in a COVID-19 care area.

When Creating a COVID-19 Care Area Within the Facility

- Identify a location within the facility that can be separate from healthy residents. This could potentially be a hall, wing, group of rooms, etc., that can house COVID-19-positive residents and allow for staffing and other resources to be separated from other residents and HCP . Identifying a location and developing a staff plan to allow for dedicated HCP ahead of time allows facilities to rapidly move residents if identified as positive for COVID-19.
    - Facilities that have already identified cases of COVID-19 among residents but have not developed a COVID-19 care area should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are already infected).
- If residents are being moved to another area of the facility in order to create space for COVID-19-positive residents, ensure testing results are available for ALL residents before moves occur (results preferably have been collected 24-48 hours prior to the move or utilizing a point of care rapid test if significant lab delays are being experienced).
    - Residents who test positive for a COVID-19 infection should only be placed in a single room with a private bathroom or a room with another COVID-19-confirmed individual, assuming neither resident has other transmissible diseases (e.g., multi-drug resistant organisms, Clostridioides difficile, etc.).
- Ideally the space should be physically separated from other rooms or units housing residents without confirmed COVID-19.
    - Whenever possible, the area within the facility dedicated to care for COVID-19 residents should be located on a separate floor, wing, or cluster of rooms.
- Assign dedicated health care providers (HCP) to work only in the COVID-19 care area. This should occur consistently and across multiple shifts to limit the number of HCP exposed. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents.
- HCP working in the COVID-19 care area should ideally have a restroom, breakroom, and work area that are separate from HCP working in other areas of the facility. Consider only allowing one person at a time to utilize breakroom areas to allow appropriate physical distancing until the outbreak is resolved.
- Consider excluding health care personnel who are at higher risk for severe illness from caring for residents with confirmed or suspected COVID-19 infection.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- To the extent possible, restrict access of non-essential ancillary personnel (e.g., dietary, housekeeping) from working in an area designated for care of the COVID-19 residents.
    - Bundle care activities whenever possible; this allows less resident/HCP contact and reduced use of personal protective equipment.
    - Dietary, housekeeping, and other HCP not directly involved in nursing care of residents should not be allowed in the COVID-19 designated area. Consider having HCP deliver supplies, meals etc., to the entrance of the area without entering the area and risking exposure or further spread to other areas of the facility.
    - HCP should utilize dedicated or disposable supplies and equipment whenever possible.
    - Environmental Protection Agency (EPA)-registered disinfectants (e.g., wipes) from List N should be utilized to perform environmental surface disinfection.
    - Ensure that high-touch surfaces (e.g., light switch, doorknob, bedside table) in staff break rooms and work areas are frequently cleaned and disinfected utilizing an Environmental Protection Agency (EPA)-registered disinfectant from List N. Place signage at the entrance to the dedicated COVID-19 area that instructs health care providers that they must wear eye protection and an N95 or higher level respirator (or face mask if a respirator is not available) at all times while in the area. Gowns and gloves should be worn prior to entering resident rooms. Gloves should be removed and disposed of and HCP should immediately perform hand hygiene upon exit and prior to assisting additional residents.
- If PPE shortages exist, notify public health for assistance and implement CDC's strategies to optimize PPE. Once PPE supplies are restored, facilities should return to standard PPE usage.
- Bundle care activities to minimize the number of health care providers' entries into a room whenever possible.
    - CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. Contingency and crisis capacity strategies augment conventional capacity measures and are meant to be considered and implemented sequentially. When using PPE optimization strategies, training on PPE use, including proper donning and doffing procedures, must be provided to health care providers before they carry out patient care activities. As PPE availability returns to normal, health care facilities should promptly resume standard practices. **Crisis capacity strategies should no longer be used in Colorado. Facilities requiring crisis capacity strategies must notify their local or state public health for assistance.**

Strategies for Memory Care or Facilities Serving People with Developmental Disabilities

- ### COVID-19 Care Area in Memory Care
    - Because isolation amongst memory care residents or individuals with developmental disabilities can be challenging, facilities should consider

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additional measures to prevent COVID-19 from entering the facility and rapidly responding once illness is identified.

- **Limit Health Care Personnel Movement as Much as Possible**
  - Assign dedicated health care providers (HCP) to work only with individuals who have tested positive for SARS CoV-2, the virus that causes COVID-19. This should occur consistently and across multiple shifts to limit the number of HCP exposed. At a minimum, this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents.
  - To prevent dietary staff from entering the unit and/or resident rooms, consider having dietary staff deliver meals or meal carts to the unit and allow the designated HCP to deliver the meal trays to the residents.
  - To prevent housekeeping staff from entering the unit and/or resident rooms, consider having the designated HCP place bagged laundry in a hamper outside the unit or resident room to allow housekeeping staff to collect these items. A similar practice can be used when returning clean linens back to the unit.
  - Consider having the designated HCP clean and disinfect common areas and high touch surfaces more frequently to limit the frequency of environmental staff in the unit or resident room.
  - Discourage HCP from visiting other units and from interacting with other HCP outside of their designated unit.
- **Miscellaneous Considerations for Memory Care Residents**
  - To the extent possible, consider cohorting residents to the smallest area/unit possible, depending on the facility layout.
  - Consider closing fire doors or placing temporary barriers at the end of hallways or neighborhoods while allowing for Life Safety Requirements. This consideration is an attempt to limit the movement of residents interacting with each other by limiting movement throughout the facility.
  - Consider re-arranging furniture to provide places for residents to sit that are spaced at least six feet apart.
  - Activities should be provided in a cohorted neighborhood or POD while maintaining physical distance.
  - If activities or dining occur in common spaces shared by multiple neighborhoods, consider staggering the times when residents in cohorted neighborhoods will access the common space so that two neighborhoods are not in the shared space at the same time.
  - Consider alternate activities that residents can participate in while in their rooms (hallway Bingo, television, music, arts, making their own masks, etc.).
  - If space allows, consider designating a location to care for residents with confirmed COVID-19, separating them from other residents promptly to mitigate spread.

Strategies for Small Residential Settings (13 or Fewer Residents)

These strategies have been developed to meet the needs of small assisted living residences, intermediate care facilities (ICFs), and group homes typically operating in single-family homes which typically have 13 or fewer residents. These settings operate similarly to a single family residence due to the smaller spaces and congregate setting between residents and HCP and

therefore may need to consider additional strategies when trying to implement IPC recommendations.

- **Dining**
  - If it is not always possible to stop communal dining (e.g., during outbreak testing when new positive residents are being identified) due to space constraints or if the resident requires assistance (as outlined in their care plan), dining should be limited to 2 residents at a time in order to maintain social distances.
  - Unvaccinated residents should remain at least 6 feet away from each other during meal times. Four (4) foot tables can only seat one resident in this case. The facility may consider adding an additional four foot table to accommodate additional residents during meals, but should adhere to residents remaining at least 6 feet away from each other. Consider scheduling times and locations for meals to allow for social distancing for unvaccinated residents.
  - Maintain physical distances of at least 6 feet for unvaccinated residents and HCP at all times and while residents are entering and leaving the dining room.
  - Keep hand sanitizer on each table for use before and after mealtime.
  - Disinfect all surfaces in between each resident.
  - Consider using disposable plates, napkins, and silverware.
  - All HCP should wear a medical grade face mask when in the presence of other HCP or residents.
  - Unvaccinated residents should wear masks that cover their nose and mouth when entering and leaving the dining room and anytime they are out of their room.
- **Feeding Sick Residents**
  - Stay separated: The person who is sick should eat (or be fed) in their room, if possible.
  - Sick residents should not participate in communal meals or group activities.
  - It is strongly recommended to stop all communal dining and group activities within the home while an ill resident resides there. If you have no other option to care for residents, limit meals and activities to no more than two people in a shared room at the same time and provide as much space between individuals as possible.
  - Handle any dishes, cups/glasses, or silverware used by the person who is sick with gloves. Wash them with soap and hot water or in a dishwasher.
  - Clean hands after taking off gloves or handling used items.
  - Do not share dishes, cups/glasses, silverware, towels, bedding, or electronics (like a cell phone) with the person who is sick.
- **Self-Isolation**
  - The sick person, their roommates, and close contacts within the house need to self-isolate and limit their use of shared spaces as much as possible until public health determines your outbreak is over.

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    - A mask helps prevent a person who is sick from spreading the virus to others. It keeps respiratory droplets contained and prevents them from reaching other people.
- **Bedrooms and Bathrooms**
    - If possible, have the person who is sick use a separate bedroom and bathroom and keep the door closed as much as possible. If possible, have the person who is sick stay in their own "sick room" or area and away from others. Try to keep yourself and others at least 6 feet away from the sick person.
    - If a sick person must share a bedroom, make sure the room has good airflow. Open the window to increase air circulation if possible. Caution should be utilized if considering the use of an individual room fan; consult CDPHE's COVID-19 Ventilation Guidance for more information. Improving ventilation within a room or home helps remove respiratory droplets from the air and works to dilute the amount of virus present. Space beds in a shared room at least 6 feet from one another; consider placing heads of beds at opposite ends of the room.
    - Disinfect shared bathrooms after each use and leave the exhaust fan running. Wear a mask and wait as long as possible after the sick person has used the bathroom before coming in to clean and use the bathroom.
    - If a sick person is using a separate bedroom and bathroom: Only clean the area around the person who is sick when needed, such as when the area is soiled. This will help limit your contact with the sick person.
- **Avoid Sharing Personal Items**
    - Everyone should avoid placing toothbrushes directly on counter surfaces. Totes can be used for personal items so they do not touch the bathroom countertop.
- **Washing and Drying Laundry Items**
    - Do not shake dirty laundry or hold it close to you.
    - Wear disposable gloves while handling dirty laundry.
    - Dirty laundry from a person who is sick can be washed with other people's items.
    - Wash items according to the label instructions. Use the warmest water setting you can.
    - Remove gloves and wash hands right away.
    - Dry laundry completely on hot or high if possible.
    - Wash hands after putting clothes in the dryer.
    - Clean and disinfect clothes hampers. Wash hands afterwards.

Personal Protective Equipment: FAQ

Eye protection | Face masks | General guidance | Gloves | Gowns | N95 respirators

The information below is to assist healthcare settings with proper use of personal protective equipment (PPE) during COVID-19 and when implementing CDC's Strategies to Optimize the Supply of PPE and Equipment. This may not answer all questions pertaining to PPE usage, and facilities are encouraged to contact their local or state health departments or consult CDC guidance (Information for Healthcare Professionals about Coronavirus (COVID-19)) if they have

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

questions that are not answered in this FAQ. This FAQ does not replace guidance but serves as a tool to answer frequently asked questions and/or clarify misinterpreted guidance.

PPE general guidance

What is the recommended PPE when caring for COVID-19 patients?

- When caring for a patient with suspected or confirmed COVID-19, health care personnel (HCP) should wear an N95 respirator (to obtain a higher level of protection), gowns, gloves, and eye protection (i.e., face shield or goggles). Of note: prescription glasses and trauma glasses do not provide adequate protection as they do not cover the sides of the face and therefore do not qualify as PPE.

Are hair coverings or shoe covers needed as PPE for the care of patients with suspected or confirmed COVID-19?

- No, neither of these are required for the care of patients with suspected or confirmed COVID-19.

What manufacturer of PPE should we use?

- CDC does not recommend a specific manufacturer of PPE. You should select PPE from any manufacturer that meets the specifications outlined in the PPE guidance document.

What are CDC's optimization strategies for PPE?

- CDC's optimization strategies for PPE offer options for use when PPE supplies are stressed, running low, or absent. Contingency and crisis strategies are intended to be temporary with facilities promptly resuming conventional capacity strategies when PPE availability returns to normal. There are three capacity strategies:
    - Conventional capacity: Measures consisting of engineering, administrative, and PPE controls should already be implemented in general infection prevention and control plans in health care settings.
    - Contingency capacity: Measures that may be used temporarily during periods of expected shortages. Contingency capacity strategies should only be implemented after considering and implementing conventional capacity strategies. While current supply may meet the facility's current or anticipated utilization rate, there may be uncertainty if future supply will be adequate and therefore, contingency capacity strategies may be needed.
    - Crisis capacity: Strategies that are not commensurate with U.S. standards of care but may need to be considered during periods of known shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. **Crisis capacity**

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

strategies should no longer be used in Colorado. Facilities must notify state or local public health prior to implementing crisis strategies.

When would it be appropriate to implement CDC's optimization strategies?

- Conventional capacity strategies should already be implemented and maintained. Contingency capacity strategies can help stretch PPE supplies when shortages are anticipated, for example if facilities have sufficient supplies now but are likely to run out soon or there may be uncertainty in future supply. Crisis strategies can be considered during **severe PPE shortages** and should be used with the contingency options to help stretch available supplies for the most critical needs. Contingency and then crisis capacity measures augment conventional capacity measures and are meant to be considered and implemented sequentially. **As PPE availability returns to normal, healthcare facilities should promptly resume conventional practices.**

- When using PPE optimization strategies, training on PPE use, including proper donning and doffing procedures, must be provided to HCP before they carry out patient care activities.

Can we use crisis capacity strategies to help limit the financial impact on our facility?

- No, PPE expense should **not** be a determining factor and should not interfere with use of conventional capacity. CDC's strategies are available to assist facilities when supply availability is uncertain or during severe PPE shortages. Facilities should implement administrative controls and prioritization of PPE to further limit PPE use.

Do we need to seek public health approval prior to implementing CDC's optimization strategies?

- It depends on the capacity strategy being implemented. Conventional and contingency strategies do not require public health approval. Facilities should, however, ensure the following:
    - The employer has made a good faith effort to obtain other alternative filtering facepiece respirators, reusable elastomeric respirators, or PAPRs appropriate to protect workers;

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

    - The employer has monitored their PPE supply/burn rate and is making every attempt to maintain adequate supply and prioritize their use according to CDC guidance.
    - Facilities should maintain documentation which supports their efforts and the optimization strategy being used.
    - Surgical masks and eye protection (e.g., face shields, goggles) were provided as an interim measure to protect against splashes and large droplets (note: surgical masks are ***not*** respirators and do not provide protection against aerosol-generating procedures); and
    - Other feasible measures, such as using partitions, restricting access, cohorting patients (healthcare), or using other engineering controls, work practices, or administrative controls that reduce the need for respiratory protection, were implemented to protect employees.
    - When using PPE optimization strategies, training on PPE use, including proper donning and doffing procedures, must be provided to HCP before they carry out patient care activities.
- **Crisis capacity strategies should no longer be used in Colorado.** Crisis capacity strategies can only be considered during severe PPE shortages and must be approved by public health prior to implementation.

https://www.osha.gov/memos/2020-04-03/enforcement-guidance-respiratory-protection-and-n95-shortage-due-coronavirus

What does extended use of PPE mean?

- Extended use refers to the practice of wearing the same PPE for repeated close contact encounters with several patients, without removing the PPE between patient encounters. The capacity strategy depends on the PPE being used.
    - Extended use of respirators is a contingency capacity strategy whereas extended use of a gown is a crisis capacity strategy. **Crisis capacity strategies should no longer be used in Colorado.**

What does reuse of PPE mean?

- Reuse is a crisis capacity strategy and refers to the practice of using the same PPE (e.g., facemasks, eye protection, and reusable gowns) for multiple patient encounters but involves the HCP doffing (taking off) the PPE after use, storing it, and redonning it (putting on) to use again. **Crisis capacity strategies should no longer be used in Colorado.** Crisis strategies can only be considered during **severe PPE shortages and must be approved by public health.**

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

N95 respirators

My N95 has a valve on it. Is that ok?

- Although previous guidance discouraged the use of N95 filtering facepiece respirators with exhalation valves, CDC recently updated its guidance to allow for their use.
    - A NIOSH-approved N95 filtering facepiece respirator with an exhalation valve offers the same protection to the wearer as one that does not have a valve. As source control, findings from NIOSH research suggest that, even without covering the valve, N95 respirators with exhalation valves provide the same or better source control than surgical masks, procedure masks, cloth masks, or fabric coverings.
- In general, individuals wearing NIOSH-approved N95s with an exhalation valve should not be asked to use one without an exhalation valve or to cover it with a face covering or mask. However, NIOSH-approved N95 respirators with an exhalation valve are not fluid resistant. Therefore, in situations where a fluid-resistant respirator is indicated (e.g., in surgical settings), individuals should wear a surgical N95 or, if a surgical N95 is not available, cover their respirator with a surgical mask or a face shield. Be careful not to compromise the fit of the respirator when placing a facemask over the respirator.

Can I use an N95 respirator if I have not been fit tested?

- During times of extreme supply constraints when there may be limited availability of respirators or fit test kits, employers may face challenges in fit testing workers.
- While this is not ideal, you should work with your employer to choose the respirator that fits you best as, even without fit testing, a respirator would provide better protection than a facemask when a higher level of protection is needed.
- Users should always perform a seal check when donning a respirator to ensure a tight fit. Without an adequate seal, air and small particles leak around the edges of the respirator and into the wearer's breathing zone. For additional information, consult the following CDC resource.
- With PPE supply availability returning to normal, including fit testing supplies and kits, facilities should make every effort to ensure that HCP who need to use tight-fitting respirators are fit tested to identify the right respirator for each HCP member. It is important to note that OSHA requires an initial respirator fit test to identify the right model, style, and size respirator for each person and annually thereafter.

https://www.cdc.gov/niosh/docs/2018-129/pdfs/2018-129.pdf?id=10.26616/NIOSHPUB2018129

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Can I use an N95 respirator if I have facial hair?

- It depends. The OSHA Respiratory Protection standard specifically requires employers not to permit respirators with tight-fitting facepieces to be worn by employees who have facial hair that comes between the sealing surface of the facepiece and the face. See 29 CFR 1910.134(g)(1)(i). Therefore, healthcare workers must be fit tested to ensure that facial hair will not interfere with the safe use of an N95 or other tight-fitting respirators. CDC has created a visual aid to help health care providers determine if their facial hair is compatible with respirator use.

I have prescription glasses; can I wear those with an N95 respirator?

- Yes, however, HCP should be fit tested while wearing their prescription glasses to ensure that the glasses will not interfere with the safe use of an N95 or other tight-fitting respirators. Of note: prescription glasses do not provide adequate eye protection as they do not cover the sides of the face and therefore do not qualify as eye protection for PPE. Prescription glasses will need to be covered with approved PPE for eye protection (i.e., goggles or face shields).

What is a fit test?

- A "fit test" tests the seal between the respirator's facepiece and your face. It takes about fifteen to twenty minutes to complete and is performed at least annually by trained personnel using a qualitative fit test method accepted by OSHA. A fit test should not be confused with a user seal check.

Where can I get fit tested?

- Some facilities that do not already have a respiratory program that includes fit testing have been able to make arrangements with local hospitals or health departments for fit testing. The Hospital Respiratory Protection Program Toolkit contains more information about fit testing.
- Information about respiratory fit in crisis situations may be found at *Fit Under Fire: Situational Strategies to Achieve the Best Respirator Fit During Crisis*: Proper N95 Respirator Use for Respiratory Protection Preparedness.

Can I wear any respirator once I am fit tested?

- No, after passing a fit test with a respirator, personnel must use the exact same make, model, style, and size respirator on the job.

I was fit tested by my previous employer. Do I need to be fit tested again?

- That depends on when you were last fitted for the N95 respirator. Fit testing is recommended annually or more frequently if there have been changes that may

interfere with respirator seal (e.g., weight gain, weight loss, facial hair, etc.). If the new employer does not stock the same make, model, style, and size respirator for which you were fit tested, you should be fit tested again using the respirators your new employer uses.

What is a user seal check?

- A user seal check is a quick check performed by the wearer each time the respirator is put on. It determines if the respirator is properly seated to the face or needs to be readjusted. A seal check should not be confused with a fit test. More information is available here.

Can I implement extended use of my N95 respirator?

- Yes, this is a contingency capacity strategy that allows respirator use to be prolonged, using one respirator per HCP per day/eight-hour shift or until removed (see below). This strategy allows HCP to wear the same respirator for multiple patient encounters. **However, extended use of respirators should only be implemented after conventional capacity strategies have been considered and implemented.**
- Generally, extended use of N95 respirators is best implemented when multiple patients are infected with the same pathogen (e.g., a COVID-19-positive unit); however, during the current COVID-19 pandemic response, implementation of extended use of N95 respirators across multiple patients with positive, negative, and unknown COVID-19 status may be considered when there may be uncertainty if future supply will be adequate. If extended use of N95 respirators is permitted, HCP should dispose of respirators immediately if:
    - Respirators are removed (doffed) at any time, to include at the end of their shift, when doffing for breaks, and/or to eat/drink.
    - Performing aerosol generating procedures (as outlined above).
    - Contaminated with blood, respiratory, or nasal secretions, or other bodily fluids.
    - Caring for patients co-infected with an infectious disease requiring contact precautions (e.g., methicillin-resistant Staphylococcus aureus, vancomycin-resistant enterococci, *Clostridium difficil*e, norovirus, etc.).
    - A respirator is obviously damaged or becomes hard to breathe through.
- Consider use of a cleanable face shield over an N95 respirator and/or other steps (e.g., masking patients for source control, use of engineering controls) to reduce surface contamination of the N95 respirator.
- HCP must take care not to touch their respirator. They should perform hand hygiene before and after touching or adjusting their respirator. Avoid touching the inside of the respirator. If inadvertent contact is made with the inside of the respirator, discard the respirator and perform hand hygiene.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Can I wear a face shield or surgical mask over my N95 respirator to prevent contamination during aerosol-generating procedures?

- During contingency or crisis capacity strategies (respirator shortages), the IDSA guideline panel suggests that health care personnel involved with aerosol-generating procedures on suspected or known COVID-19 patients add a face shield or surgical mask as a cover for the N95 respirator to allow for REUSE as part of appropriate PPE. Note that this is not considered to be a conventional capacity strategy.
- Following the aerosol-generating procedure, the face shield should be discarded or reprocessed according to the manufacturer's guidance and the surgical mask discarded. Of note: a cloth mask or homemade mask (handkerchief) should not be used as personal protective equipment.

  Infectious Diseases Society of America Guidelines on Infection Prevention in Patients with Suspected or Known COVID-19 (IDSA)

Does my N95 respirator still provide adequate protection if extended use is implemented?

- Extended use alone is unlikely to degrade respiratory protection. However, healthcare facilities should develop clearly written procedures to advise HCP to discard any respirator that is removed, obviously damaged, or becomes hard to breathe through.

Can I reuse my N95 respirator for multiple shifts?

- Limited reuse is listed as a crisis capacity strategy and should no longer be utilized in Colorado.

Can I disinfect my N95 respirator for reuse?

- No, previous options for decontamination are no longer recommended. According to CDC, there are no manufacturer-authorized methods for N95 respirator decontamination.

Should N95 respirators be used for ALL aerosol-generating procedures or just when caring for patients with COVID-19 (suspected or confirmed)?

- The use of a NIOSH approved respirator is recommended (regardless of vaccination status) when:
  - Patient-care activities are likely to generate splashes or sprays of blood, body fluids, or secretions (e.g., suctioning, endotracheal intubation, etc.), regardless of COVID-19 infection.
  - During aerosol-generating procedures (AGPs) performed on patients with suspected or proven infections transmitted by respiratory aerosols, including patients with COVID-19 (suspected or confirmed).

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- The use of a N95 or higher-level respirator is also recommended for all AGPs performed (regardless of patient COVID-19 infection status) in facilities located in areas of moderate to substantial community transmission as these HCP would be more likely to encounter asymptomatic or pre-symptomatic patients with COVID-19 infection.
- HCP working in areas with minimal to no community transmission should continue to adhere to Standard and Transmission-Based Precautions based on anticipated exposures and suspected or confirmed diagnoses.

Refer to Appendix A and the interim IPC guidance for HCP (sections on "HCP working in facilities located in areas with moderate to substantial community transmission" and "Recommended infection prevention and control practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection") for more information.

Discard N95 respirators following use during aerosol-generating procedures. Extended use should not be employed for an N95 respirator following an aerosol-generating procedure, and N95 respirators should not be re-used following an aerosol-generating procedure.

What procedures are considered to be aerosol-generating?

- Development of a comprehensive list of AGPs for healthcare settings has not been possible, due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining if reported transmissions during AGPs are due to aerosols or other exposures.
- There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of AGPs for health care settings.
- Commonly performed medical procedures that are often considered aerosol-generating procedures, or that create uncontrolled respiratory secretions, include:
    - Open suctioning of airways.
    - Sputum induction.
    - Cardiopulmonary resuscitation.
    - Endotracheal intubation and extubation.
    - Non-invasive ventilation (e.g., BiPAP, CPAP).
    - Bronchoscopy.
    - Manual ventilation.
- Based on limited available data, it is uncertain whether aerosols generated from some procedures may be infectious, such as:
    - Nebulizer administration.*
    - High flow O2 delivery.**

*Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure and increased risk of infection might be due to aerosols generated by the procedure or due to

increased contact between those administering the nebulized medication and infected patients.

**Based on limited data, high-flow oxygen use is not considered an aerosol-generating procedure for respirator prioritization during shortages over procedures more likely to generate higher concentrations of infectious respiratory aerosols (such as bronchoscopy, intubation, and open suctioning). For more information please see: Healthcare Infection Prevention and Control FAQs

Can we use KN95s?

- The use of KN95s as respirators are considered a crisis capacity strategy and should no longer be utilized in Colorado as respiratory protection.

Face Masks

Can we implement extended use of face masks?

- This is a contingency capacity strategy that allows face mask use to be prolonged, using one mask per HCP per day/eight-hour shift or until doffed (removed). This strategy should only be employed under contingency capacity conditions. This strategy allows HCP to wear the same face mask for multiple patient encounters. If extended use of face masks is permitted, HCP should dispose of masks immediately if:
    - Face masks that are removed (doffed) at any time, to include at the end of their shift, when doffing for breaks, and/or to eat/drink.
    - Contaminated with blood, respiratory or nasal secretions, or other bodily fluids.
    - Caring for patients co-infected with an infectious disease requiring contact precautions (e.g., methicillin-resistant Staphylococcus aureus, vancomycin-resistant enterococci, *Clostridium difficil*e, norovirus, etc.).
    - Any face mask is obviously damaged or becomes hard to breathe through.
- The most significant risk of extended use is contact transmission from touching the surface of the contaminated face mask. Respiratory pathogens on the face mask surface can potentially be transferred by touch, contaminating the hands of the wearer, and in turn be transmitted via self-inoculation or to others via direct or indirect contact transmission. HCP must take care not to touch or adjust their face mask. If they do, they must immediately perform hand hygiene. HCP should remove and discard the face mask if soiled, damaged, or hard to breathe through. Ensure HCP leave patient care areas before removing their mask.

Can Health Care Personnel reuse their face masks?

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Limited reuse is a crisis capacity strategy and should no longer be utilized in Colorado.

Can we use face masks that tie?

- Yes, however, ensure both ties are secured and that the mask is tight fitting. This is to ensure adequate protection for both the wearer and others. Ensure tie masks are doffed and disposed of appropriately, following each use, as these masks are not appropriate for reuse, even when implementing CDCs crisis capacity strategy (as outlined above).

How do I safely store my face mask for later use?

Storing a face mask for later use, otherwise known as re-use, is a crisis capacity strategy and should no longer be utilized in Colorado. **Can Health Care Personnel wear cloth face coverings or homemade masks (e.g., bandana, scarf)?**

- Cloth face coverings and/or homemade masks are not considered PPE, since their capability to protect HCP is unknown. Cloth face coverings are intended for community source control and are not approved PPE and therefore should not be worn by HCP interacting with patients. However, if HCP do not have any interactions with patients nor work in parts of the building where patients are located, cloth face coverings could be considered.

If I am wearing a face shield, do I still need to wear a face mask?

- Face shields function as eye protection and are not an adequate substitute for a face mask. COVID-19 spreads primarily from person to person via close contact through respiratory droplets that are produced when we talk, sing, shout, or even breathe. By design, a face shield is not able to stop these respiratory droplets from escaping or entering when worn alone.

Can I wear a face mask while caring for a suspected or confirmed SARS CoV-2 resident if no respirators are available to me?

- A face mask should only be used to care for a patient with suspected or confirmed COVID-19 infection if respirators are severely limited or unavailable (i.e., in crisis). Crisis capacity strategies should no longer be utilized in Colorado. **Facilities must notify state or local public health for assistance and prior to implementing crisis strategies**.
- If your facility is experiencing a shortage of N95 respirators (or higher), prioritize them for HCP caring for patients who are symptomatic, are positive for COVID-19, or when COVID-19 is suspected.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Eye protection

Why do we need to follow universal use of eye protection when our facility is in an area with >10% two-week average positivity rate?

- As we learn more about COVID-19, we are able to develop better strategies and interventions for preventing transmission. Universal eye protection during direct patient care is one such intervention. Continuously protecting our eyes from respiratory droplets in a patient-care setting is an added step to keep our unvaccinated HCP safe from infection. When infection rates might be high, adding eye protection to routine care adds additional protection for HCP.

Who needs to follow universal use of eye protection?

- In addition to masks, unvaccinated HCP working in facilities located in counties with >10% two-week average positivity rate and those facilities conducting outbreak testing should wear eye protection (i.e., face shields or goggles) during **all patient care activities** to protect against viral spread from asymptomatic and presymptomatic individuals.
- HCP who do not encounter residents during their time at the facility may not need to wear eye protection.
- However, HCP should always follow standard, contact, and droplet precautions (gown, gloves, N95, and eye protection) for any resident with fever, respiratory symptoms, or when COVID-19 is suspected.

Do we need to follow universal use of eye protection at all times while in the facility?

- If your facility is in a county with >10% two-week average positivity rate, unvaccinated HCP should wear eye protection (in addition to a facemask) during any direct patient care activity. It is not required for unvaccinated HCP to wear eye protection outside of patient rooms/in areas without patients in them. Consider following CDC's PPE optimization guidance for eye protection by keeping the eye protection in place during multiple patient encounters (extended use), and/or reprocessing the eye protection after use to use again later (reuse).
- If your facility is experiencing a shortage of eye protection, prioritize wearing eyewear when caring for patients who are symptomatic, are positive for COVID-19, or when COVID-19 is suspected.

What is considered acceptable eye protection?

- Goggles or a face shield are recommended to ensure appropriate protection. Eye protection should cover the front and sides of the eyes (i.e., goggles or a face shield). There should not be gaps in between the eye protection and the face, unless you are using a face shield. Protective eyewear (safety glasses, trauma glasses) or corrective

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

glasses with gaps between glasses and the face likely do not protect eyes from all splashes and sprays.
- Protective eyewear (e.g., safety glasses and trauma glasses) that have extensions to cover the side of the eyes can be considered under CDC's Crisis Capacity Strategies for Optimization of Protective Eyewear.

Can I implement extended use of my eye protection?

- This is a contingency capacity strategy that allows for extended use of eye protection and can be applied to disposable and reusable devices. Eye protection should be removed and replaced if it becomes visibly soiled, damaged, or difficult to see through. Eye protection worn during aerosol-generating procedures should be considered soiled. HCP must take care to not touch their eye protection. If they touch or adjust their eye protection, they must immediately perform hand hygiene.

Can I reprocess a disposable face shield or goggles for reuse?

- Follow manufacturer instructions for cleaning and disinfection. When manufacturer instructions for cleaning and disinfection are unavailable, such as for single use disposable face shields or goggles, consider:
    - While wearing a clean pair of gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with a neutral detergent solution or cleaner wipe.
    - Carefully wipe the **outside** of the face shield or goggles using a wipe or clean cloth saturated with an EPA-registered **hospital disinfectant solution**.
    - Wipe the outside of the face shield or goggles with clean water or alcohol to remove residue.
    - Fully dry (air dry or use clean absorbent towels).
    - Remove gloves and perform hand hygiene.
    - Cleaned and disinfected eye protection can be stored onsite, in a designated clean area within the facility.

Strategies for Optimizing the Supply of Eye Protection

Do I need to change or wipe down my eye protection in between patients?

- When using conventional capacity strategies, disposable eye protection should be removed and discarded. Reusable eye protection should be cleaned and disinfected after each patient encounter according to manufacturer instructions.
- When it is necessary to use contingency capacity strategies (i.e., implementing extended use of eye protection), it is acceptable to wear the same eye protection for multiple patients without cleaning and disinfecting your eyewear in between patients unless it is being removed, or if it is visibly soiled or comes in direct contact with respiratory secretions (e.g., worn during aerosol-generating procedures).

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

- Eye protection should be removed and discarded if damaged or difficult to see through. HCP must take care not to touch their eye protection. If they touch or adjust their eye protection, they must immediately perform hand hygiene.

Gowns

Can I store and reuse my disposable gown?

- Reuse and extended use of isolation gowns is considered a crisis standard and should no longer be utilized in Colorado.

Can I reuse my disposable gown if I disinfect it?

- Disposable gowns are intended for single use.

Can I use disposable gowns that are expired?

- Only as a contingency capacity strategy. The majority of isolation gowns do not have a manufacturer-designated shelf life. However, if a shelf life is designated, considerations can be made to use gowns beyond the designated shelf life when PPE shortages exist.

Can I use coveralls?

- Only as a contingency capacity strategy, which can be used if your facility falls into the contingency category for gowns. Coveralls are less convenient to use in most healthcare settings. Their one-piece design covers the back and lower legs, in addition to arms and the front of the body, making them useful for situations in which vigorous physical mobility is anticipated (e.g., emergency medical services).
- If coveralls are used, the material and seams should be appropriate to serve the intended barrier function effectively. Facilities should anticipate challenges and potential hazards to HCP related to doffing coveralls and should provide training and practice in their safe use and designated places for donning and doffing, before providing them for patient care.

Can I implement extended use of gowns in a COVID-19 positive care area?

- Extended use of gowns is considered a crisis capacity strategy and should no longer be utilized in Colorado.

Can I implement extended use of gowns for non-COVID-19 cohorts or units with mixed COVID-19 status (e.g., negatives, unknowns, positives)?

- Extended use of isolation gowns should not be implemented under any strategy if caring for multiple patients with positive, negative, and unknown COVID-19 status.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Extended use of gowns is a crisis capacity strategy and should no longer be utilized in Colorado.

Can I prioritize gowns to be used only during high-risk activities?

- This is considered a crisis capacity strategy and should no longer be utilized in Colorado.

Gloves

Can I implement extended use of gloves for COVID-19-positive cohorts?

- Do not use the same pair of gloves for the care of more than one patient. Gloves become contaminated and a source of transmission. Proper glove use and hand hygiene should always be maintained and in accordance with CDC guidelines.
- Ensure HCP understands that wearing gloves is not a substitute for hand hygiene. Gloves should always be doffed (removed) following patient care and before leaving the patient room. Contact public health immediately should your facility have concerns about their glove supply.

Is it okay to extend the use of gloves if they are cleaned between uses?

- CDC does not recommend that gloves be cleaned and reused, even if caring for the same patient. Gloves do not negate the need for hand hygiene. Ensure that all HCP are following appropriate glove use, including:
    - Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur,
    - Performing hand hygiene immediately prior to donning gloves and immediately after doffing gloves,
    - Ensuring HCP understands that wearing gloves is not a substitute for hand hygiene,
    - Removing gloves upon completing a task or when soiled during the process of care, even if caring for the same resident,
    - Gloves should be changed and hand hygiene performed when moving from dirty to clean activities (e.g., after patient care activities, before handling clean supplies)
    - Always remove gloves and perform hand hygiene before leaving the resident's room or care areas,
    - Do not use the same pair of gloves for the care of more than one resident.

Hand Hygiene in Healthcare Settings: http://www.cdc.gov/handhygiene OR https://www.cdc.gov/handhygiene/providers/guideline.html

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Is it OK to double-glove (i.e., wear more than one pair of gloves)?

- CDC guidance does not recommend double gloves when providing care to suspected or confirmed 2019-COVID patients.

Other guidance may apply, specifically for federally certified facilities. The facility is responsible for following the more comprehensive guidance in those cases.

Decision Tree