

Recommendations for Responding to Long Term Care Facility Cases of Coronavirus Disease 2019 (COVID-19) June 9, 2021

Background

The New Hampshire Department of Health and Human Services (DHHS), Division of Public Health Services (DPHS), COVID-19 Congregate Settings Investigation Unit will work closely with facilities if COVID-19 is identified. This guidance is intended to assist long term care facilities with responding to case(s) of COVID-19 within their organization. This guidance supplements but does not replace recommendations included in [CDC's Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes](#) and is intended for nursing homes and assisted living facilities, but may also be applicable to other long-term care and residential settings. Facilities should adhere to current CDC and [CMS guidance](#) (when applicable). Promptly notify the health department about any suspected/confirmed COVID-19 case or cluster of new-onset respiratory symptoms among staff or residents, within 24 hours as indicated in the [State of New Hampshire Reportable Infectious Diseases list](#), by calling **603-271-4496** (after-hours **603-271-5300**).

This guidance applies regardless of vaccination status and level of vaccination coverage in the facility. Some of these recommendations can be modified in response to COVID-19 vaccination. Those modifications, which will be regularly updated, are posted on CDC webpage, [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#).

Immediate Actions

Upon identification of suspect or confirmed COVID-19 in your facility, take the following immediate actions:

1. Isolate or exclude from work anyone with suspected or confirmed COVID-19 until they have met the [criteria to end isolation](#) or [return to work](#).
2. Quarantine [close contacts](#).
3. Suspend activities and limit resident and staff movement in the facility, until the extent of transmission can be assessed.
4. Observe relevant infection control and environmental disinfection protocols.
5. Notify staff, residents, and families [promptly about identification of COVID-19 in the facility](#) and maintain ongoing, frequent communication with residents, families, and staff with updates on the situation and facility actions.
6. Work with your investigator at DHHS to coordinate further testing and additional steps.

New Infection in Healthcare Personnel or Resident

- Because of the high risk of unrecognized infection among residents and staff the following should be evaluated as a potential outbreak:
 - A [nursing home-onset](#) COVID-19 case in a resident; or
 - A single new case of COVID-19 among a staff member who has been in the facility during their infectious period or does not have a known community source and may have acquired infection in the facility during their 14-day incubation period.
- Implement [facility-wide testing](#).
 - Continue [repeat viral testing](#) of all previously negative residents in addition to testing of staff, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or staff for a period of at least 14 days since the most recent positive result.
- Implement the following recommended infection prevention precautions:
 - All individuals entering the facility should wear at least a medical grade mask for [source control](#). This includes healthcare personnel, administrative staff, environmental service workers, visitors, and any other individual entering the facility.
 - Staff should care for residents on quarantine and isolation using 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.
 - Residents should generally be restricted to their rooms. It is recommended to restrict trips outside the facility to medically necessary appointments.
 - For residents going to medical appointments, regular communication between the medical facility and the nursing home (in both directions) is essential. Inform the medical facility of potential exposures due to the nursing homes outbreak status.
 - Close the affected unit(s) to new admissions. Current residents should be accepted back into the facility if they leave to receive care.
 - If disease transmission to other units/floors/wings occurs, DHHS will advise whether all admissions to the facility should be restricted.
 - Consideration should be given to halting social activities and communal dining; if these activities must continue for uninfected residents, they should be conducted using source control and physical distancing for all participants.
 - Suspend all visitation except compassionate care visitation, until at least one round of facility-wide testing is completed. When one round of facility wide testing is completed, visitation can resume based the [CMS Visitation Memo](#)
 - Guidance about visitation during facility outbreaks is available from [CMS](#). Residents could leave their rooms to permit visitation; visitors should be informed about the outbreak in order to make informed decisions about visitation.
 - For additional information about visitation, see [Visitation section below](#) and [CMS visitation memo](#).
 - [Restrict non-essential staff](#) for areas where [CMS limits indoor visitation](#).

- Consider implementing telehealth to offer remote access to healthcare.
- Consider increasing monitoring of all residents from daily to every shift to more rapidly detect those with new symptoms.
 - Maintain a line list of all residents and staff who are ill, illness onset dates, and symptoms. Refer to CDC [resources](#) for performing respiratory infection surveillance in long-term care facilities during an outbreak.
 - Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
 - Actively monitor all residents upon admission and at least daily for fever (temperature $\geq 100.0^{\circ}\text{F}$) and [symptoms consistent with COVID-19](#). Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions described in the section: [Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection](#).
 - Vital sign equipment should be cleaned and disinfected between each patient.
 - Information about the clinical presentation and course of patients with SARS-CoV-2 infection is described in the [Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 \(COVID-19\)](#). CDC has also developed [Testing Guidelines for Nursing Homes](#).
 - Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures $>99.0^{\circ}\text{F}$ might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection.
 - Educate staff about the potential for rapid clinical deterioration in residents with COVID-19
- Quarantine close contacts*:
 - Follow CDC's [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#) when determining if vaccinated residents or staff are exempt from close-contact quarantine.
 - Follow CDC guidance for when individuals [within 3 months of prior COVID-19 infection](#)[†] are exempt from close-contact quarantine
- Recommended precautions should be continued for residents until no new cases of SARS-CoV-2 infection have been identified for at least 14 days.
- Outbreaks are closed by the DHHS team after 14 days have passed without new cases and 14 days have passed since the last date of exposure at the facility, whichever is longer.

* **Close Contact:** Someone who was within 6 feet of an infected person for a cumulative total of 10 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.

[†] There might be clinical scenarios in which the uncertainty about a prior infection or the durability of the immune response exist, for which providers could consider testing for SARS-CoV-2 and quarantine following exposure that occurs less than 3 months after their initial infection ([CDC](#)).

- The incubation period for SARS-CoV-2 infection can be up to 14 days and the identification of a new case within that period after starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.

Evaluating and Managing Personnel and Residents

Evaluate and Manage Healthcare Personnel

- Implement [sick leave policies](#) that are non-punitive, flexible, and consistent with public health policies that support staff to stay home when ill.
- Determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission.
- Staff who report symptoms should be excluded from work and should notify occupational health services to arrange for further evaluation. In addition, asymptomatic staff who report close contact with others with SARS-CoV-2 infection might need to be excluded from work.
 - If staff develop fever (Temperature $\geq 100.0^{\circ}\text{F}$) or [symptoms consistent with COVID-19](#) while at work they should inform their supervisor and leave the workplace.
 - Information about risk assessment and work restrictions for staff exposed to SARS-CoV-2 is available in the [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to Coronavirus Disease 2019 \(COVID-19\)](#).
- Have a plan for how to respond to staff with SARS-COV-2 infection who worked while ill (e.g., identifying exposed residents and co-workers and [initiating an outbreak investigation](#) in the unit or area of the building where they worked).
 - If a staff member worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset, then the facility should:
 - Prioritize the ill staff member for COVID-19 testing. Exclude staff with COVID-19 from work until they have met all [return to work criteria](#).
 - Determine which residents received direct care from and which staff had unprotected exposure to the staff member who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset.
 - [Non-fully vaccinated residents who were cared for by these staff should be placed on quarantine using all recommended COVID-19 PPE](#) until results of staff COVID-19 testing are known. If the staff member is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.
 - Exposed staff should be [assessed for risk and need for work exclusion](#).
- Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including providing [resources](#) to assist staff with anxiety and stress. [Strategies to mitigate staffing shortages](#) are available.
- [During an outbreak, restrict entry of non-essential personnel](#). More information about when non-essential personnel should have limited entry into facilities can be found in the [CMS Re-opening Memo](#).

- Information about when staff with suspected or confirmed SARS-CoV-2 infection may return to work is available in the [Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19](#).
 - The symptom-based strategy is recommended.
- Information about risk assessment and work restrictions for staff exposed to SARS-CoV-2 is available in the [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to Coronavirus Disease 2019 \(COVID-19\)](#).

Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with Confirmed SARS-CoV-2 Infection

- Residents with confirmed or suspected COVID-19 should be roomed with others with COVID-19, taking into account any other relevant pre-existing conditions, such as multi-drug resistant organism colonization. Dedicate healthcare personnel to COVID-19 positive residents.
- Determine the location of the COVID-19 care unit and create a staffing plan.
 - Facilities that have already identified cases of SARS-CoV-2 infection among residents but have not developed a COVID-19 care unit should work to create one unless the proportion of residents with SARS-CoV-2 infection makes this impossible (i.e., the majority of residents in the facility are already infected).
- The location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with SARS-CoV-2 infection.
- Include visual reminders and signage for staff to wear appropriate PPE when caring for residents on isolation or quarantine.
- Assign dedicated resident care equipment (e.g., vitals machine) to the designated COVID-19 positive unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit.
- Identify staff who will be assigned to work only on the COVID-19 care unit when it is in use. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. If possible, staff should avoid working on both the COVID-19 care unit and other units during the same shift.
 - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
 - Ideally, environmental services (EVS) staff should be dedicated to this unit, but to the extent possible, EVS staff should avoid working on both the COVID-19 care unit and other units during the same shift.
 - To the extent possible, staff dedicated to the COVID-19 care unit (e.g., NAs and nurses) will also be performing cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. Staff should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from [List N](#) into the room and wipe down high-touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.

- staff working on the COVID-19 care unit should have access to a restroom, break room, and work area that are separate from staff working in other areas of the facility.
 - Ensure staff practice source control measures and physical distancing in the break room and other common areas (i.e., other than while eating, staff wear a respirator or source control and sit at least 6 feet apart while on break).
 - Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).

Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection

- Residents with suspected SARS-CoV-2 infection should be prioritized for testing.
- Residents with suspected or confirmed SARS-CoV-2 infection do not need to be placed into an airborne infection isolation room (AIIR) but should be cared for staff using 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.
 - [CDC PPE optimization strategies](#) include a hierarchy of strategies to implement when PPE are in short supply or unavailable (e.g., use of a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators or a [well-fitting facemask when](#) NIOSH-approved N95 or equivalent or higher-level respirators are not available).
 - Ideally a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending.
 - In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2. This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit. However, in some circumstances (e.g., memory care units), keeping the door closed may pose resident safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway.
 - If limited single rooms are available or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter-in-place at their current location pending return of test results.
 - Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection.
 - Roommates of residents with SARS-CoV-2 infection should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents while they are in quarantine (i.e., for the 14 days following the date their roommate was moved to the COVID-19 care unit).
- Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.

- For decisions on removing residents who have had SARS-CoV-2 infection from Transmission-Based Precautions refer to the [Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19](#).

If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation. **Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.**

Managing Residents with Close Contact

Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection

- Residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure.
- Risk assessment considerations for residents who are exposed in a healthcare setting is available in the [FAQs for Infection Control](#)
- Residents in quarantine should be placed in a single-person room. If limited single rooms are available or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter-in-place at their current location while being monitored for evidence of SARS-CoV-2 infection.
 - Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection. Placing a resident without confirmed SARS-CoV-2 infection (i.e., with symptoms concerning for COVID-19 pending testing or with known exposure) in a dedicated COVID-19 care unit could put them at higher risk of exposure to SARS-CoV-2.
- Staff 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 these residents.
 - [CDC PPE optimization strategies](#) include a hierarchy of strategies to implement when PPE are in short supply or unavailable (e.g., use of a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators or a [well-fitting facemask](#) when NIOSH-approved N95 or equivalent or higher-level respirators are not available).
- Residents can be transferred out of quarantine if they remain with no fever and without symptoms for 14 days.
 - Alternatives to the 14-day quarantine period are described in the [Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing](#). Healthcare facilities could consider these alternatives as a measure to mitigate staffing shortages, space limitations, or PPE supply shortages but, due to the special nature of healthcare settings (e.g., patients at risk for worsening outcomes, critical nature of staff, challenges with physical distancing), they are not the preferred option. Healthcare facilities should understand that shortening the duration of quarantine might pose additional transmission risk.

Guidance addressing quarantine and testing during an outbreak is described in section above: [Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident.](#)

Infection Prevention and Control Practices

Infection Prevention and Control Program

- During an outbreak, the infection control practitioner should reinforce infection control practices:
 - Reinforce social distancing and universal source control according to [CDC guidelines](#)
 - Review proper hand hygiene with residents and staff
 - Ensure all staff received training and competency validation on infection prevention measures, including hand hygiene, and the use of and steps to properly [put on and remove recommended personal protective equipment](#) (PPE)
 - Ensure staff are appropriately trained and have competency validation on environmental cleaning and disinfection
 - Consider monitoring hand hygiene, PPE use, and environmental cleaning in affected areas. Consider a product (e.g., [luminescent liquid to simulate germs](#)) to periodically assess proper cleaning technique, especially on high touch surfaces in resident rooms and common areas.

Hand Hygiene

- 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 dining hall, in 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 staff in accordance with Occupational Safety and Health Administration [\(OSHA\) PPE standards \(29 CFR 1910 Subpart I\)](#)
- Perform and maintain an inventory of PPE in the facility. (See CDC's "[Infection Control Program](#)" for more information.)
- Make necessary PPE available in areas where resident care is provided.
 - Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback, promoting appropriate use by staff.
- Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.

- Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.
- Bundle care activities to minimize the number of staff entries into a room.
- If PPE shortages are anticipated or exist, implement [CDC PPE optimization strategies](#). CDC Strategies for Optimizing the Supply of PPE during Shortages offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted, and are intended to be implemented sequentially (i.e., implementing contingency strategies prior to implementing crisis strategies).
- Additional information is available:
 - [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#)
 - [Personal Protective Equipment: Questions and Answers.](#)
 - [Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages | CDC](#)

Environmental Cleaning and Disinfection:

- Develop a schedule for and execute regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas.
- 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 might be contaminated with SARS-CoV-2. Ensure staff are appropriately trained on its use and follow the manufacturer’s instructions for all cleaning and disinfection products (e.g., concentration, application method, and contact time).
- Maximize facility ventilation by opening windows as appropriate.

Educate Residents, Healthcare Personnel, and Visitors about COVID-19

- Provide culturally and linguistically tailored information about [SARS-CoV-2 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 staff and residents are updated when this guidance changes.
- Educate and train staff 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 SARS-CoV-2.
 - Educate staff about any new policies or procedures.
 - Reinforce sick leave policies and **remind staff not to report to work when ill.**
 - Reinforce adherence to standard IPC measures including [hand hygiene](#) and [selection and correct use of PPE](#). Have staff demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities.

- CDC has created [training resources](#) for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
- Educate residents and families through educational sessions and written materials on topics including information about SARS-CoV-2, 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 staff, [including if cases of SARS-CoV-2 infection are identified among residents or staff](#).
- Contact the DHHS Healthcare-Associated Infections Program (HAInprogram@dhhs.nh.gov) or the Congregate Settings Investigation Unit (CongregateSettings@dhhs.nh.gov) for additional resources or assistance.

Notify staff, residents, and families about outbreaks, and report COVID-19, facility staffing, testing, and supply information to public health

- [Notify the health department promptly](#) about any of the following:
 - ≥ 1 residents or staff with suspected or confirmed SARS-CoV-2 infection,
 - Resident with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or staff with acute illness compatible with COVID-19 with onset within a 72 hour period
- Notify staff, residents, and families [promptly about identification of SARS-CoV-2 in the facility](#) and maintain ongoing, frequent communication with residents, families, and staff with updates on the situation and facility actions.
- Report SARS-CoV-2 infections, facility staffing and supply information, and [point of care testing](#) data to the [National Healthcare Safety Network \(NHSN\) Long-term Care Facility \(LTCF\) COVID-19 Module](#) weekly. CDC’s NHSN provides long-term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way.
 - Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services ([CMS](#)) [COVID-19 reporting requirements](#)
- Report adverse events such as death or hospitalization of individuals who have received any COVID-19 vaccine into the [Vaccine Adverse Event Reporting System \(VAERS\)](#)

Visitation

- Have a facility plan for managing visitation, including use of restrictions when necessary.
- During an outbreak, suspend all visitation except that required under federal disability rights law (i.e., compassionate care visitation), until at least one round of facility-wide testing is completed. Visitation can resume based on outbreak response testing results as outlined in the [CMS Visitation Memo](#)
 - While facilities are encouraged to facilitate in-person visits whenever possible, the [CMS visitation memo describes](#) situations requiring temporary restriction of indoor visitors, except for compassionate care reasons. Please refer to [CMS visitation](#)

[memo](#) and [CDC Updated Healthcare IPC Recommendations in Response to COVID-19 Vaccination](#).

- [Send letters or emails](#) to families reminding them not to visit when ill or if they have had close contact with someone with SARS-CoV-2 infection in the prior 14 days.
- When visitation is restricted:
 - [Send letters or emails](#) to families advising them of the restrictions
 - Facilitate and [encourage alternative methods for visitation](#) (e.g., video conferencing) and communication with the resident

Coordinate with the Congregate Settings Investigation Unit

For questions about responding to COVID-19, please contact the Healthcare Congregate Settings Investigation (CSI) Unit at 603-271-6996 (option 3 then option 1) or via email at CongregateSettings@dhhs.nh.gov.

Working in partnership with DHHS, **please prepare and send the following items** to the CSI Unit. Use the template provided via encrypted email to maintain confidentiality.

- Information on any staff and/or residents who have tested positive for COVID-19
- All staff and residents who have been identified as [exposed](#)* regardless of their vaccination status
 - Do not include individuals who are within 90 days of a prior COVID-19 infection

*within 6 feet for 10 minutes or more without proper PPE use

Additional Resources

Related Pages

- [Considerations for Memory Care Units in Long-Term Care Facilities](#)
- [Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19](#)
- [Long-Term Care Facility Toolkit: Preparing for COVID-19 Vaccination at Your Facility](#)
- [NHSN LTCF Weekly staff & Resident COVID-19 Vaccination Reporting](#)
- [Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination](#)