Public Health
Communicable Disease Programs
(925) 313-6740 (PHONE) | (925) 313-6465 (FAX)

CONTRA COSTA
HEALTH SERVICES

COVID-19 Long-Term Care and Congregate Living Facility Checklist

Managing COVID-19 in a long-term care or congregate living facility benefits from a prompt and coordinated team approach.

Steps to control and prevent COVID-19 transmission in your facility can be initiated and completed by facility administration, nursing or caregiving staff, and environmental services or cleaning staff. These steps should be initiated with a resident or staff at your facility with suspected or confirmed COVID-19. Symptoms concerning for COVID-19 include: Fever or symptoms of a respiratory illness such as cough and shortness of breath, but also include unusual symptoms such as fatigue, chills, myalgias, headache, sore throat, new loss of taste or smell, vomiting, nausea, or diarrhea. In addition to these symptoms, elderly patients may present with weakness, confusion, dizziness, or a subtle change from their baseline.

The recommended actions below are organized by priority and facility staff. Activities that benefit from two groups working together (e.g. Administration and Nursing/Caregiving) are included in each group's recommended activities.

Contra Costa Public Health will be monitoring and following your facility to aid in control and prevention of COVID-19 transmission, and is also available for technical assistance and testing.

Key

□**!** Start and complete this activity first

□ Complete this activity after all **!** actions are completed

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Facility Administration

Key

□**!** Start and complete this activity first

□ Complete this activity after all **!** actions are completed

Communication with Appropriate Entities

□**!** Immediately report confirmed cases in staff or residents to:

1) Your licensing body and other appropriate regulatory bodies;

2) Contra Costa Public Health Department at 925-313-6740.

3) Staff, the medical director, if applicable, and facility infection control lead or designee.

Restrict Visitation, New Admissions, and if appropriate follow up with exposed or symptomatic staff

□**! Do not admit new patients/resident to your facility until further notice.** Admission of new patients to the facility may be considered. These will need to be discussed with Contra Costa Public Health Department.

□**!** Post signage at the front entrance restricting visitors and non-essential staff. Ensure symptom checks and temperature checks of all staff entering the facility.

□Ensure noting other facilities staff have worked at in last 14 days. If staff are COVID positive and have worked in other facilities during this timeframe inform public health of the staff member and the other facility/facilities they have worked.

□**!** Send home any symptomatic Staff and refer them for testing. Staff may not come back to work until testing is done, results reviewed by public health, and further guidance has been reviewed with public health.

□For exposed staff, if there current staffing needs for the facility to continue operations, exposed staff may continue to work at the facility but should be instructed they may not work at any other facilities and should otherwise quarantine at home. Exposed staff should only work with yellow cohort (exposed residents who remain negative), red cohort (positive residents), or recently cleared residents, as much as possible. Staff should be monitored closely for symptoms and retested as instructed. If there is not current staffing needs, staff who are exposed to someone with COVID/a close contact to a COVID positive person, should quarantine at home for 14 days from last exposure and monitor for symptoms.

□ **!** Cohort residents who are COVID positive (red zone), exposed or unknown exposure and negative (yellow zone), or negative residents who clearly have no known exposure (green zone). Have a physical

barrier between cohorts, as much as possible. For facilities, such as assisted living, where residents have their own rooms where cohorting may not be possible residents may remain in their room but are still considered green, yellow, or red residents and appropriate PPE should be used based on resident status.

- As much as possible, staff should be assigned to care for only green, yellow, or red cohort and not move between these cohorts. If unable, staff should not move around to other cohorts during their shifts.

Ensure the facility has adequate supplies of Personal Protective Equipment (PPE)

□**!** Assess current facility inventory of PPE and continue to assess daily, and ensure more then one staff can do this.

- Facemasks
- Respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit-tested healthcare personnel).
  - Obtain FIT testing for staff, as possible, and have staff who are FIT tested work with COVID+ residents or exposed and negative residents.
  - If staff not FIT tested and using N95 should ensure doing seal check: https://www.cdc.gov/niosh/docs/2018-130/pdfs/2018-130.pdf with each use.
- Gowns
- Gloves
- Eye protection (i.e., face shield or goggles)

□ Make necessary PPE available in areas where patient/resident care is provided. Put a trash can near the exit inside the patient/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.

□ Develop plan for where staff will Don and Doff PPE. Have signs with directions on Don/Doffing posted outside of rooms, having a buddy whenever possible to ensure correct technique

□ Develop "buddy" system for staff when they need assistance while in room, or need supplies brought to them (may need to consider increasing staff to have extra hands/"runners")

Enforce and Revise Facility Policies for Staff

□**!** Reinforce sick leave policies. Remind all staff not to report to work when ill.

□**!** Restrict staff movement between areas of the facility with and without ill residents, and exposed residents.

□ Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of personal protective equipment (PPE). Have staff demonstrate competency with putting on and removing PPE.

□ Implement universal use of facemasks for all staff and any visitors while in the facility.

□ Designate separate breakrooms and bathrooms for staff working with different cohorts of patients/residents (green, yellow, red), when possible. If not possible, each cohort should have scheduled breaks in breakroom, and it must be cleaned between cohorts. Additionally, bathrooms and breakrooms, along with any high touch area must be cleaned regularly.

□ If an ambulance or other transport is called to the facility, notify them that the facility is currently experiencing an outbreak of COVID-19 prior to their arrival so they may don appropriate PPE prior to patient/resident contact. All patients/residents should be considered potentially exposed to COVID-19 during an outbreak and transport staff should wear appropriate PPE even if the resident has not tested positive yet. Make sure If going to medical facility or requiring ambulance complete: **Interfacility Transfer Communication Form - Comprehensive** **(PDF)** or **Interfacility Transfer Communication Form - Abbreviated** **(PDF)** ensure patient status is communicated appropriately.

□ Do not transfer patients/residents to other wards or facilities unless medically indicated. Any potential transfer should be discussed with public health. If transfer is medically indicated, inform the receiving facility verbally and in writing, if appropriate, that the resident is coming from a facility that is experiencing a COVID-19 outbreak and if negative will need to quarantine and monitored for any signs of infection. Residents/patients should be tested prior to transfer for planning and if negative will still need to be quarantined at the receiving facility with appropriate PPE. Also, discuss with facility that testing prior to release from quarantine should be done per the health officer order for transfers to facilities and due to potential exposure. If patient/resident being transferred is COVID positive they will need isolation and clearance based precautions per their COVID status.

□ Do not discharge residents/patients given potential exposure. It is recommended that all residents stay in place given potential exposure. If any planned or needed discharges residents maybe allowed to be discharge home to quarantine after discussion and with informed consent signed. Residents/patients may not be discharged to other congregate living facilities given potential exposure in facility.

Enforce and Revise Facility Policies for Patients/Residents

□**!** Restrict all patients/residents to their rooms with the door closed to the extent possible.

□**!** All group activities should be cancelled.

□**!** Communal dining should be cancelled unless assistance is required as part of the Resident care plan. Residents requiring assistance with feeding should maintain a 6 foot distance from other residents

during supervised meals and staff should perform hand hygiene when moving from one resident to another.

□ Use private rooms for isolation patients/residents who test positive for COVID-19 (red zone cohort) or have symptoms of COVID-19 whenever possible. If private rooms are not available, consider other placement options, such as grouping (cohorting) COVID positive patients/residents together ensuring at least 6 feet of separation and a physical barrier (e.g., curtain) between residents.

□ Use private rooms for isolation patients/residents who test negative for COVID-19 and are exposed and asymptomatic (Yellow Zone cohort). **Note:** Single occupancy rooms should be **prioritized** for the 14 day observation period of new admissions or re-admissions from the hospital, and exposed asymptomatic individuals who test negative and are still considered exposed (yellow zone). If private rooms are unavailable may consider other placement options, such as grouping (cohorting) COVID negative and exposed patients/residents with the same exposure together ensuring at least 6 feet of separation and a physical barrier (e.g., curtain) between residents. Note PPE must be changed between these residents as noted below.

□ If patients/residents must leave their room, patients/residents should wear a facemask or use tissues to cover coughs and sneezes, perform hand hygiene (wash hands with soap and water or use an alcohol-based hand rub), limit their movement within the facility, and perform social distancing (stay at least 6 feet from others). All Patients/Residents should also wear facemask during resident/patient care and when staff is within 6 feet of the resident for source control.

□ Residents/patients who had mild or moderate symptoms are considered cleared of COVID infection after 10 days have passed since symptom onset, and, at least 24 hours have passed since fever resolves without the use of fever-reducing medication and symptoms are improving, whichever period is longer. If residents never develop symptoms they are considered cleared after 10 days from the test date.

- Residents/patients who had severe disease requiring hospitalizations in the intensive care unit are considered cleared of COVID infection after 20 days have passed since symptom onset, and, at least 24 hours have passed since fever resolves without the use of fever-reducing medication and symptoms are improving, whichever period is longer.

Testing and Planning

□ Begin reviewing testing plan and Health officer order for requirement for testing residents and staff at residential facilities. Plan for weekly testing as noted in the Health officer order for all staff and residents, with public health support as needed. **Note:** You maybe asked to produce lab results to the public health department if using a contracted lab that is not currently reporting results to public health.

- Testing may be focused, in discussion with local public health, if thorough and accurate contact tracing of cases can take place. The infectious period of the case is considered to be 48 hours prior to symptom onset or 10 days prior to test date if no symptoms at test date. If the case is

asymptomatic and had testing within the 10 days, contact tracing may begin after the date of the last negative test.

- **Residents and staff who tested positive within 3 months, do not need to be re-tested, but if positive test result > 3 months ago will need to be included in testing plan**.
- Plan for testing until there are 2 serial testing with all negative results. If need further public health support, public health will request resident face sheets to aid in testing.

□ Ensure family and residents aware of testing plan and consent for testing obtained by facility from families, as appropriate, and/or residents.

□ Begin gathering information for a Staff Line & Resident Line List Template to aid in testing support from public health, and public health follow up. Public health will follow up with you with a shared line list to aid in this.

- **Note:** Public health and hospital partners maybe in touch to schedule an on-site visit to review map and infection control practices in light of possible exposure in facility/outbreak follow up.

□ Gather map of facility to share with public health for planning. Note on map current location of exposed residents, where positive staff worked, if applicable, and current location of positive and negative residents. If have plans for new wings given exposure, also note plans as appropriate/able.

Visitor Policies

□**!** Follow visitation guidance for facilities while in outbreak, and restrict all visitation to COVID positive residents (red zone residents) and COVID negative but exposed resident (yellow zone residents) except for certain compassionate care situations, such as end of life situations.

□**!** Restrict all volunteers and non-essential personnel, (e.g., barbers, podiatry, etc) from entering the facility until further notice.

□ All visitors that must enter the facility should sign-in, including: name of visitor, resident that was visited, date of visit and time. Visitors should be limited to 2 persons, and must wear appropriate PPE (e.g. gloves, gown and facemask unless times of PPE shortages, then prioritize a facemask).

Return to Work Criteria

□ Staff with confirmed or suspected COVID-19 may return to work after 10 days have passed since symptom onset, and, at least 24 hours have passed since fever resolves without the use of fever-reducing medication and symptoms are improving, whichever period is longer. For staff who did not have symptoms, they return to work 10 days after their test date. No repeat testing is needed and staff can return to work after they meet the criteria stated above. Staff should continue to wear a mask at all times while in the facility as noted above.

- Staff who had severe disease requiring hospitalizations in the intensive care unit are considered cleared of COVID infection after 20 days have passed since symptom onset, and, at least 24 hours have passed since fever resolves without the use of fever-reducing medication and symptoms are improving, whichever period is longer.

Note: Per current health officer order, all staff and visitors must wear a mask while in the facility.

Communicate with Residents, Family, and their Provider, as appropriate

□Inform patients/residents, family members, and visitors of confirmed or suspect case.

□ Ensure patients/residents results/COVID status have been discussed with residents and family, as appropriate.

□ Educate patients/residents and their families, including information about COVID-19 and actions the facility is taking to protect them and their loved ones, including visitor restrictions and how they can protect themselves.

□ Ensure medical director or residents/staff providers, as applicable, are involved in care and follow up of residents. Have providers and medical directors review and update POLST form with families and residents.

Facility Nursing/Care Giving

Key

□**!** Start and complete this activity first

□ Complete this activity after all **!** actions are completed

Isolation Precautions and Practice Social Distancing

□ **!**Cohort residents who are COVID positive (red zone), exposed or unknown exposure and negative (yellow zone), or negative residents who clearly have no known exposure (green zone). Have a physical barrier between cohorts, as much as possible. For facilities, such as assisted living, where residents have their own rooms where cohorting may not be possible residents may remain in their room but are still considered green, yellow, or red residents and appropriate PPE should be used based on resident status.

- As much as possible, staff should be assigned to care for only green, yellow, or red cohort and not move between these cohorts. If staff needs to move between cohorts for staffing needs it should be for different shifts and staff should not move between cohorts during their shift.

□**!** When there are cases of COVID-19 in your facility, staff should follow standard, contact and droplet precautions with the addition of eye protection (faceshield but if unable to obtain may use googles) for the care of all residents, regardless of symptoms or COVID status whenever possible. This means using a disposable or washable gown, gloves, a facemask and eye protection while caring for patients and per the resident/patient cohort/status.

Note: In times of shortages of Personal Protective Equipment (PPE), the following would be permitted for yellow and red zone cohorts:

- Extended use of gowns maybe implemented for COVID positive patients/residents only (red zone residents). For COVID negative residents/patients, gowns may not be used for more than one resident/patient, and must be changed between COVID negative patient/residents. If continued limited supply of gowns, gowns maybe preserved and used only during aerosol generating procedures; care activities where splashes and sprays are anticipated; and during high-contact resident care activities such as help with bathing or toileting. The same gown may not be used for more than one resident.

- Extend the use of respirators, facemasks, and eye protection. The same respirator, facemask, and eye protection may be used during the care of more than one resident with the same COVID status (ie) facemask and eye protection can only be used with positive patients or negative patients. The respirator or facemask should be discarded when: damp, damaged or hard to breathe through, if used during aerosol-generating procedure, if contaminated with blood or other body fluids.

- Eye protection must be replaced (can be reused after cleaning and disinfection) when damaged or hard to see through, if used during aerosol generating procedure, if contaminated with blood or other body fluid.

- Gloves must be removed and disposed of after each patient, and proper hand hygiene must be performed.

□**!** Implement universal use of facemasks for all healthcare personnel and staff while in the facility when an outbreak within the facility has been identified. All patients should also wear mask (if tolerated) as **source control** when not in room, for any patient care, and when staff are within 6 feet.

Note: Per current health officer order, all staff and visitors must wear a mask while in the facility.

□ Restrict staff movement between areas of the facility with and without ill patients/residents (ie) between resident cohorts.

□ If an ambulance or other transport is called to the facility, notify them that the facility is currently experiencing an outbreak of COVID-19 prior to their arrival so they may don appropriate PPE prior to patient/resident contact. All patients/residents should be considered potentially exposed to COVID-19 during an outbreak and transport staff should wear appropriate PPE even if the resident has not tested positive yet. Make sure If going to medical facility or requiring ambulance complete: **Interfacility Transfer Communication Form - Comprehensive** **(PDF)** or **Interfacility Transfer Communication Form - Abbreviated** **(PDF)** ensure patient status is communicated appropriately.

□ Restrict all patients/residents to their rooms with the door closed to the extent possible.

□ Use private rooms for isolation of patients/residents who test positive for COVID-19 (red zone cohort) or have symptoms of COVID-19 whenever possible. If private rooms are not available, consider other placement options, such as grouping (cohorting) COVID positive patients/residents together ensuring at least 6 feet of separation and a physical barrier (e.g., curtain) between residents. PPE for the red zone cohort should be implemented as noted above.

□ Use private rooms for isolation of patients/residents who test negative for COVID-19 (yellow zone cohort) and are exposed and asymptomatic. Isolate residents **Note:** Single occupancy rooms should be **prioritized** for the 14 day observation period of new admissions or re-admissions from the hospital, and exposed asymptomatic individuals who test negative and are still considered exposed. If private rooms are unavailable may consider other placement options, such as grouping (cohorting) COVID negative and exposed patients/residents who had same exposure together ensuring at least 6 feet of separation and a physical barrier (e.g., curtain) between residents. Note PPE must be changed between these residents as noted above. PPE for the red zone cohort should be implemented as noted above.

- Staff should be assigned to care for only positive patients/residents (red zone) OR only negative and exposed patients/residents (yellow zone) OR negative patients/residents with clearly no exposure (green zone), and not move between these groups as much as possible.

- For residents that are COVID negative with clearly no known exposures (green zone cohort):
    - Staff should wear a surgical mask when entering patient/residents room.
    - Faceshields should also be worn for any patient care or if staff are within 6 feet of the resident/patient.
        - Full PPE: gown, gloves, surgical mask, and face shield should be used when performing resident care with resident care activities with body fluids or chance of risk of splash and spray (high contact activity such as bathing, dressing, toileting, etc.). Staff should wear a N95, instead of a surgical mask, and use gown, gloves, and face shield when doing aerosol generating procedures such as breathing treatment, and if possible

switch breathing treatments to MDI. Doors should be closed when doing aerosol generating procedures. Other standard precautions for residents should continue in the green zone.

- Hand hygiene and gloves should be utilized when performing any activities requiring contact with the patient or equipment in a patient care area, such as attending to a bed alarm or administering IV medications.

- For Residents who have recently cleared infection:
  - Residents should be placed in the yellow cohort and cohorted together, if able. If unable to be placed in yellow cohort, maybe cohorted together in the green zone.
  - Recovered COVID patients should remain in a single room until discharge or transfer. If not possible, the patient can share a room with curtains drawn and 6 feet apart, ideally with another recovering COVID patient.
    - PPE should be based on zone placed (ie- yellow and red full PPE as noted above. If in the red zone may not extend use of PPE to recently cleared patients), but if green zone should follow enhanced standard precautions as other green zone patients.
      - Staff should wear a surgical mask when entering patient/residents room.
      - Face shields should also be worn for any patient care or if staff are within 6 feet of the resident/patient.
      - Full PPE: gown, gloves, surgical mask, and face shield should be used when performing resident care with resident care activities with body fluids or chance of risk of splash and spray (high contact activity such as bathing, dressing, toileting, etc.). Staff should wear a N95, instead of a surgical mask, and use gown, gloves, and face shield when doing aerosol generating procedures such as breathing treatment, and if possible switch breathing treatments to MDI. Doors should be closed when doing aerosol generating procedures.
      - Face shields should be worn for any patient care or if staff are within 6 feet of the resident/patient. Other standard precautions for residents should continue in the green zone.
  - Hand hygiene and gloves should be utilized when performing any activities requiring contact with the patient or equipment in a patient care area, such as attending to a bed alarm or administering IV medications.

□ All patients/ should also wear mask (if tolerated) as **source control** in room in their room for patient care when staff are within 6 feet of patient.

□ If patients/residents must leave their room, patients/residents should wear a facemask or use tissues to cover coughs and sneezes, perform hand hygiene (wash hands with soap and water or use an alcohol-based hand rub), limit their movement within the facility, and perform social distancing (stay at least 6 feet from others).

Monitor Staff and residents for symptoms of COVID-19

□ Active monitoring of all patients/residents should occur at least twice daily, and includes close clinical monitoring of residents who are positive for COVID-19 with more frequent clinical checks. Checks for COVID positive residents should be every 6-4 hours with full vitals given potential fast decline, and for all other patients consider clinical checks with vitals every 6-8 hours. Elderly patients and those with underlying medical conditions can have atypical, subtle, or unusual symptoms. The symptoms to watch out for are: fever, chills, cough, shortness of breath, sore throat, runny nose, weakness or fatigue, headache, muscle pain, dizziness, or a change in mental status (confusion).

□ Residents/patients who had mild or moderate symptoms are considered cleared of COVID infection after 10 days have passed since symptom onset, and, at least 24 hours have passed since fever resolves without the use of fever-reducing medication <u>and</u> symptoms are improving, whichever period is longer. If residents never develop symptoms they are considered cleared after 10 days from the test date.

- Residents/patients who had severe disease requiring hospitalizations in the intensive care unit are considered cleared of COVID infection after 20 days have passed since symptom onset, and, at least 24 hours have passed since fever resolves without the use of fever-reducing medication <u>and</u> symptoms are improving, whichever period is longer.

□ Ensure medical director or residents/staff providers, as applicable, are involved in care and follow up of residents. Have providers and medical directors review and update POLST form with families and residents.

□ Send updated line listings of residents and staff who have symptoms and/or have a positive test for COVID-19 to your Contra Costa Public Health Department contact no later than 10:00 a.m. daily. Also, discuss any symptomatic residents or staff, any new hospitalization, and any deaths at the facility during phone check-in with public health.

□ All staff and essential visitors should be screened for fever, respiratory illness (cough, shortness of breath, sore throat, fatigue or unusual weakness, body aches), headaches, nausea, vomiting, diarrhea and/or recent exposures to sick individuals prior to entering the facility.

- Public Health can provide a template daily employee temperature log for your use.
- Any staff member with a positive screen using criteria above, should immediately put on a facemask and sent home. They should be excluded from work until cleared by public health.

Staff with confirmed or suspected COVID-19 may return to work after 10 days have passed since symptom onset, and, at least 24 hours have passed since fever resolves without the use of fever-reducing medication <u>and</u> symptoms are improving, whichever period is longer. For staff who did not have symptoms, they return to work 10 days after their test date. No repeat testing is needed and staff can return to work after they meet the criteria stated above. Staff should continue to wear a mask at all times while in the facility as noted above.

- Staff who had severe disease requiring hospitalizations in the intensive care unit are considered cleared of COVID infection after 20 days have passed since symptom onset, and, at least 24 hours have passed since fever resolves without the use of fever-reducing medication and symptoms are improving, whichever period is longer.

Note: Per current health officer order, all staff and visitors must wear a mask while in the facility.

□ Reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of PPE. Have staff demonstrate competency with putting on and removing PPE. Use "buddy" system for staff whenever possible to ensure correct technique and for when they need assistance while in room, or need supplies brought to them.

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CONTRA COSTA
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Facility Environmental Services

Key

□! Start and complete this activity first

□ Complete this activity after all **!** actions are completed

Environmental Cleaning

□**!** Increase cleaning frequency of hard non-porous, high touch surfaces, including bathrooms, and breakrooms.

□ Use an EPA-registered, hospital-grade disinfectant for routine cleaning and to frequently clean high-touch surfaces and shared patient/resident care equipment. Refer to the EPA website for a complete list of approved disinfectants with an emerging viral pathogen claim: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2.

□ Make sure environmental services staff members are:

- Following label instructions on use of cleaners and disinfectants.
- Following cleaning and disinfection policies and procedures (e.g. clean dirty surfaces, then disinfect; change gloves and perform hand hygiene between rooms and between resident areas within the same room).

□ Ensure that all non-dedicated, non-disposable resident care equipment is cleaned and disinfected after each use (e.g. pulse ox, blood pressure cuffs, patient lifts) prior to use on additional residents.

Hand Hygiene & Personal Protective Equipment (PPE)

□**!** Ensure adequate hand hygiene supplies:

- Put alcohol-based hand sanitizer with 60–95% alcohol in every patient/resident room (ideally both inside and outside of the room) and other patient/resident care and common areas (nurses station, front entrance, etc)
- Make sure that sinks are well-stocked with soap and paper towels for handwashing.

□ Ensure adequate supplies for respiratory hygiene and cough etiquette

- Make tissues and facemasks available for all staff and patients/residents who must be outside of their rooms.
- Consider designating staff to steward those supplies and encourage appropriate use by patients/residents, visitors and staff.