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

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

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

DAILY PREVENTION MEASURES

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

- In general, congregate settings should continue to follow infection prevention and control recommendations for unvaccinated individuals (e.g., use of Transmission-Based Precautions for those that have had close contact to someone with SARS-CoV-2 infection) when caring for fully vaccinated individuals with moderate to severe immunocompromise due to a medical condition or receipt of immunosuppressive medications or treatments.

- Post visual alerts (e.g., signs, posters) in strategic places (e.g., entrances, bathrooms, break areas, kitchens, etc.) to provide instructions about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include wearing a cloth face covering or facemask for source control, and how and when to perform hand hygiene.
  - If tolerated, unvaccinated individuals should be encouraged to wear cloth face coverings indoors when there are others present or if staff are providing direct care. In areas of substantial or high transmission, fully vaccinated individuals are encouraged to wear a mask indoors in public.
  - Social/Physical Distancing

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• All individuals and staff should maintain a distance of at least 6 feet from each other in the individual setting and outside, unless providing essential personal care.
• Provide education to individuals, staff, and volunteers to monitor their distance from others.
• Rearranging furniture and creating visual cues (ex: tape on the floor) has proven to be helpful.
• All staff should wear face masks. Face masks are preferred over cloth face coverings for all staff because they offer both source control and protection for the wearer against exposure to splashes and sprays of infectious materials from others.
  • Staff should remove their facemasks and put on a cloth face covering when leaving the facility at the end of their shift (cloth face coverings are recommended for all people when outside the home).
  • If staff must touch or adjust their facemask or cloth face covering, hand hygiene should be performed immediately before and after touching.
• In the event that facemasks are not available or in ample supply, cloth facemasks may be used with additional precaution by staff.

• In general, source control is **recommended for EVERYONE while indoors to maximize protection from the Delta variant.**

• There are a few exceptions in counties with low to moderate community transmission where fully vaccinated individuals who do not have other indications for source control (e.g., close contact with someone with SARS-CoV-2 infection or symptomatic) could choose not to wear source control:
  • Fully Vaccinated staff when they are in well-defined areas that are restricted from resident access (e.g., staff meeting rooms, kitchen)
  • Fully vaccinated clients and their fully vaccinated visitors in single-person rooms; in multi-person rooms where roommates are not present; in designated visitation areas when others are not present.
  • Fully vaccinated individuals in group homes.

• Even in the exempted situations, source control remains recommended for individuals who have:
  • Not been fully vaccinated; or
  • Suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
  • Had close contact (clients and visitors) or a higher risk exposure (staff) with someone with SARS-CoV-2 infection for 14 days after their exposure, including those residing or working in areas of a healthcare facility experiencing SARS-CoV-2 transmission (i.e., outbreak); or
  • Otherwise had source control and physical distancing recommendations by public health authorities.

• Fully vaccinated people might also choose to continue using source control if they or someone in their household is immunocompromised or at increased risk for severe disease, or if someone in their household is unvaccinated.
o Mask donning and doffing training should be provided. Mask use with hand hygiene should be monitored.

o The supply and availability of facemasks have increased significantly over the last several months. Facilities should not be using crisis capacity strategies at this time and should promptly resume conventional practices.

o Facemasks are recommended for source control while staff are in the facility, to cover one’s mouth and nose to prevent spread of respiratory secretions when talking, sneezing, or coughing. When used for this purpose, facemasks may be used until they become soiled, damaged, or hard to breathe through. They should be immediately discarded after removal, e.g., lunch breaks.

  o If gloves and/or gowns are used with each client encounter, ensure they are being discarded between client cares and hand hygiene is performed after gloves are discarded.

  o Eye protection should be worn during unvaccinated client care encounters to ensure the eyes are also protected from exposure to respiratory secretions.

  o In general, fully vaccinated staff should continue to wear a well fitted face mask while at work. However, fully vaccinated staff could dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. If unvaccinated staff are present, everyone should wear source control and unvaccinated staff should physically distance from others.

  o Masks should not be hung from the ear, pushed up on forehead, worn under the chin or nose, or hung from a lanyard/neck strap.

  o Remove mask during eating and drinking and discard. Practice social distancing and hand hygiene when doffing and redonning mask. Disinfect surface area after break.

o Review training with staff for isolation protocols, donning and doffing of personal protective equipment (PPE), hand hygiene, and cough etiquette.

  o Staff should have been fit tested for the use of N95 masks (used during care of positives, close contacts, and with new/readmissions) and perform self-seal checks each time mask is donned.

o Screen staff at beginning of every shift for fever, symptoms, and risk of COVID-19.

  o Use the NDDoH COVID-19 Screening for Healthcare Employees for guidance.

  o Document symptoms and ask that staff also regularly monitor themselves for fever and other symptoms. Establish a process, regardless of their vaccination status, for those with any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for quarantine or exclusion from work.

  o Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.

  o If staff develop symptoms while at work, they should immediately put on a face mask (if not wearing one under universal masking), inform their supervisor, and leave the workplace.
All staff must be permitted to come into the facility as long as they are not subject to a work exclusion or showing signs or symptoms of COVID-19. In addition to staff, personnel educating and assisting in client transitions to the community should be permitted entry consistent with this guidance.

- All staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.
- Staff who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.
- Consider staffing models where staff only work at one home or as few as possible, instead of rotating among many homes.
- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill staff to stay home. Remind staff not to report to work when ill.
- Visitation is allowed for all individuals at all times, including compassionate care and end-of-life visitations.

  - If visitors do come in, screen visitors for fever, symptoms of COVID-19, exposure to a person infected with COVID-19 in the past 14 days or have a diagnosis of COVID-19 in the prior 10 days before they enter the facility. If fever, COVID-19 symptoms are present or exposure to someone with COVID-19, the visitor should not be allowed entry into the facility.

  - Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.
    - If visitors are for confirmed COVID-19 or presumptive cases, staff need to assist them with donning and doffing full COVID-19 PPE. Do NOT give N95 mask as they are not fit tested.
      - The individual should wear a well-fitting facemask (if tolerated). Visitors should be made aware of the risks of visitation, core principles of infection prevention. A facility is not required but may offer masks and other PPE as appropriate.
    - Educate not to touch eyes, adjust mask, etc. with gloved hands.
    - Have hand sanitizer available so staff can perform hand hygiene when assisted doffing is completed. Have visitor complete hand hygiene and don clean mask before exiting through facility.
    - Visitors should wear face coverings or masks when around other residents or staff, regardless of vaccination status.
      - The safest approach, particularly if either party has not been fully vaccinated, is for individuals and their visitors to maintain physical distancing (maintaining at least 6 feet between people).
      - If the individual is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing well-fitting source control.
• If both the client/individual and their visitor(s) are fully vaccinated, while alone in the client/individual’s room or the designated visitation room, client’s and their visitor(s) can choose to have close contact (including touch) and to not wear source control.

• Unvaccinated individuals may also choose to have physical touch based on their preferences and needs, such as with support persons for individuals with disabilities and visitors participating in certain religious practices, including in end-of-life situations. In these situations, unvaccinated clients (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit.

• Hand hygiene should be performed by the individual and the visitors before and after contact.

  o If county COVID-19 community level of transmission is **substantial to high**, all individuals and visitors, regardless of vaccination status, should wear face coverings or masks and physically distance, at all times.

  o In areas of **low to moderate** transmission, the safest practice is for individuals and visitors to wear face coverings or masks and physically distance, particularly if either of them is at increased risk for severe disease or are unvaccinated.

  o Visitors should be instructed that if they touch or adjust their cloth face covering, they should perform hand hygiene immediately.

  o Cloth face coverings should not be placed on anyone who cannot wear a mask safely, such as someone who has a disability or an underlying medical condition that precludes wearing a mask or who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance, or children under two.

  o Facilities should have a plan to manage visitation and visitor flow. Although there is no limit on visit length, frequency, or the number of visitors that an individual can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. Facilities should ensure that physical distancing can still be maintained during peak times of visitation (e.g., lunch time, after business hours, etc.). Also, facilities should avoid large gatherings (e.g., parties, events) where large numbers of visitors are in the same space at the same time and physical distancing cannot be maintained.

  o Visits for individuals who share a room should ideally not be conducted in the individual’s room. If in-room visitation must occur (e.g., individual is unable to leave the room), an unvaccinated roommate **should not** be present during the visit. If neither individual is able to leave the room, facilities should attempt to enable in-room visitation while maintaining recommended infection prevention and control practices, including physical distancing and source control.

  o Individuals may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., staff, visitors) enter the room.

  o A face shield may be considered if facemasks are not tolerated by the individual. Face shields are eye protection and are not to be used universally as a substitute for face masks.

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o Implement a laundering process for the individuals' cloth masks.

o Facilities must permit individuals to leave the facility as they choose. Should a individual choose to leave, the facility should remind the individual and any individual accompanying them to follow all recommended infection prevention practices including wearing a face covering or mask, physical distancing, and hand hygiene and to encourage those around them to do the same.

  o Individuals going outside of the facility or leaving with other individuals (e.g. family/friends):
    • Closely monitor individual for 14 days for fever and new onset of symptoms.
    • Educate individual and family/friends on the importance of infection control.
    • Consider testing 5-7 days after outing.
    • If the outing is greater than 24 hours, consider placing unvaccinated individuals on 14-day quarantine upon return from facility.
    • A facility may also opt to test unvaccinated individuals without signs or symptoms if they leave the facility frequently.
    • If an individual or family member reports possible close contact to a person with COVID-19 while outside of the facility, test the individual for COVID-19, regardless of vaccination status. Place the individual on quarantine if they have not been fully vaccinated.
    • If an individual develops signs or symptoms of COVID-19 after the outing, test the individual for COVID-19 and place the individual on Transmission-Based Precautions, regardless of vaccination status. If the resident tests negative with a PCR test, they can be removed from transmission-based precautions.

  o Facilities might consider quarantining unvaccinated individuals who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended infection prevention measures.

  o Limit and monitor entry points to the facility.

  o Screen individuals for symptoms and fever, at least daily.

    o Individuals with a temp ≥ 100.0 F (people 70 or immunocompromised may have fever at 99.6 F) or repeated low-grade temps (>99.0 F) or symptoms should be placed in a single room, if possible, and placed in isolation precautions using personal protective equipment (PPE) including gown, gloves, and N95 (facemask if N95 is not available) with face shield or goggles for eye protection pending further evaluation. These individuals should be prioritized for testing and staff should wear this PPE while waiting for results.

    o Dedicate equipment to these individuals and disinfect between use.

    o Ideally, include an assessment of oxygen saturation via pulse oximetry.

    o Individuals with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.

  o Document daily screening results.
Put alcohol-based hand sanitizer with 60-95% alcohol in every Individuals’ room (ideally both inside and outside of the room) and other individuals’ care and common areas and make sure sinks are well-stocked with soap and paper towels for handwashing.

Make tissues and face masks available for coughing people. Consider designating staff to steward those supplies and encourage appropriate use by individuals and staff.

When an individual or staff with suspected or confirmed COVID-19 is identified, facilities should be instructed to notify the NDDoH immediately at 1-888-391-3430 and made aware that they reside in a group home or other individual care setting.

Ensure all individuals are up to date for routine immunizations, including influenza and pneumococcal vaccines.

DAY-TO-DAY OPERATIONS

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

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• Individuals should not share personal items with others. This includes but is not limited to: Phones, computers, remote controls, toys, drinks, bed linen, washcloths, towels, toothbrushes, unwashed eating utensils, straws, etc.
• Personal items should be kept separately for each individual.
• If items must be shared, ensure proper cleaning between use (See cleaning below).
• Isolation, social distancing, and other stressful events of a disease outbreak may increase risk of adverse mental health outcomes, help support individuals in managing stress and anxiety during this time.
  o CDC Coping with Stress
  o ND DHS Behavioral Health Supports During the COVID-19 Pandemic
• Guidelines may be relaxed for individuals without COVID-19 while maintaining source control measures.

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

SYMPTOMATIC STAFF
• All staff who have symptoms that coincide with COVID-19 or have been exposed to someone with suspected or confirmed COVID-19 should self-isolate/quarantine and should not come to work. They should report their symptoms to their supervisor and contact their primary care provider for COVID-19 testing.
• If at all possible, unvaccinated close contacts should not return to work until they are cleared by the NDDoH to return to work and follow the facilities guidelines for returning to work after illness.
• Both vaccinated and unvaccinated close contacts must remain without symptoms if allowed to work as an essential worker.
• Continue to educate unvaccinated staff about the important role COVID-19 vaccine has in preventing client illness and death.
• Asymptomatic staff with a higher-risk exposure, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (no sooner than day 2) and if negative, again at 5–7 days after exposure.
• Positive cases of COVID-19 cannot return to work. See NDDoH Health Care Worker (HCW) Return to Work Guidance.
• Fully vaccinated staff with an exposure to someone with COVID-19 are not required to quarantine if they meet all the following criteria:
  • Are fully vaccinated (i.e., ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine)

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• Have remained asymptomatic since the current COVID-19 exposure.
• Work restrictions for the following fully vaccinated staff populations with higher-risk exposures should still be considered for:
  • Staff who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact level of protection provided by the COVID-19 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 staff should still monitor themselves for a fever and other symptoms consistent with COVID-19 and report these to the NDDoH if any were to develop.
• People with SARS-CoV-2 infection in the last 90 days do not need to be tested if they remain asymptomatic, including those with a known contact.
• If a staff does not meet above criteria of being fully vaccinated or having COVID-19 in the last 90 days, and the facility determines they are an essential worker, the facility may consider quarantining following CDC’s options to reduce quarantine. REMEMBER: if working because an essential worker or with reduced quarantine, the staff member must remain symptom-free, continue to monitor twice a day for symptoms, and wear an N95 mask (that they have been fit tested for) to decrease potential of transmission during the full 14-day monitoring period.
• Staff who feel unwell while at work should report to their manager immediately, separate themselves from others, go home and contact their primary care provider. They should inform their primary care provider they work in a group home or individual care setting.
• If a staff member tests positive for COVID-19 they should follow NDDoH guidelines for returning to work. In the event of a positive test the NDDoH will work with the facility, staff, and individuals to begin additional safety measures and will provide situation-specific guidance.

SYMPOMATIC INDIVIDUALS
• If individuals report or display any symptoms of COVID-19 or they have been exposed to a suspected or confirmed case, they should be isolated immediately. Their primary care provider should be contacted and made aware the patient resides in a group home or other individual care setting.
• The individual should immediately isolate in a room with a door that can be closed, as much as possible, to separate unwell individuals who have symptoms or are being tested for COVID-19 from those who are healthy for the recommended isolation/quarantine period. If not possible, other solutions or alternate locations may need to be explored to reduce exposure to others in the home.
• Have dedicated staff care for the individual(s).
• If possible, provide all meals, medications, and personal cares in the individual’s room.
• If a private room is not possible and will be shared by well and unwell individuals, make sure the room has adequate air flow (ex: open windows as security protocols and weather permits), and that the individual can be kept 6 feet away from others, and wears a surgical/procedure mask if they are able.

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• A private bathroom should be used. If that is not possible, consider developing a schedule for use with the unwell person going last, followed by a thorough cleaning of the bathroom.
• Provide recreation/leisure/entertainment activities in their room.
• Consider utilizing alternate care locations if needed.
• If an individual requires quarantine or isolation and has difficulties complying, the team should consider non-restrictive measures, while balancing health and welfare of that individual and everyone else in the home.
• If there is a known COVID-19 case in your facility it is recommended you have your direct care staff add face shields and N95 masks to their PPE, disinfecting face shields when visibly dirty or end of day. These should be dedicated to the staff. If face shields are not available, use eye goggles. Personal eyeglasses do not replace eye protection. Cloth face covering should NOT be worn in place of face masks or N95 masks.
• If N95 masks are not available for staff are not fit tested, a surgical mask and face shield can be worn.
• Monitor staff for proper use of PPE and hand hygiene.
• Follow all NDDoH guidelines for isolation/quarantine.
  o Consider additional testing of individuals and staff. If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated, until there are no new cases for 14 days.
  o If antigen testing (e.g., Binax) is used, more frequent testing (every 3 days), should be considered.

CLOSE CONTACT TO A POSITIVE COVID-19 CASE

Individuals
• Unvaccinated close contact to a case of COVID-19 should be placed in a private room and staff adhere to droplet precautions with a N95 respirator. This includes contacts to cases in another healthcare setting (hospital, clinic, etc.) or in the community.
• Consider utilizing alternate care locations if unable to quarantine individual in a private room such as moving the roommate in with other individuals who are non-suspect or known exposures.
  o Assess the individual twice a day for respiratory symptoms and fever.
  o Consider testing individual immediately but no sooner than 2 days and if negative again 5-7 days after last exposure or at any time if symptoms develop.
  o Increase monitoring of individuals for worsening of symptoms.
  o Keep the door to the individual room closed, as much as possible.
    • Attempts should be made to have these individuals cohorted with dedicated staff.
    • Close contacts may be removed from quarantine after 14 days from last contact with a case.
• Quarantine is no longer recommended following close contact with someone with SARS-CoV-2 infection for:
  o Fully vaccinated clients.
  o Clients who have had SARS-CoV-2 infection in the prior 90 days.
• Following close contact, potentially exposed clients should continue to wear source control and be immediately isolated if they develop symptoms or test positive for SARS-CoV-2 infection.
  o Individuals should be consistent in face mask use and maintaining social distancing.
  o Testing is recommended immediately but no sooner than 2 days, and if negative 5–7 days after exposure.
  o Continue to monitor daily for 14 days for symptoms consistent with COVID-19, including temperature, and oxygen saturation.

NEW ADMISSIONS & READMISSIONS RECOMMENDATIONS
• Quarantine is not recommended for individuals who are being admitted to a post-acute care facility if they are within 90 days of SARS-CoV-2 infection OR if fully vaccinated, asymptomatic, and have not had close contact with someone with SARS-CoV-2 infection in the prior 14 days.
• Facilities located in areas with minimal to no community transmission might elect to use a risk-based approach for determining which individuals require quarantine upon admission. Decisions should be based on whether the individual had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to infection prevention and control practices in healthcare settings, during transportation, or in the community prior to admission.
• A new admission that is not fully vaccinated and not confirmed or suspected of having COVID-19 should be placed in a private room, staff should adhere to droplet precautions including an N95 mask. If possible, the individual should wear a mask or cloth face covering for source control for 14 days. If the individual remains asymptomatic, then he/she can be moved to another room with a roommate.
  o Assess the individual twice a day for symptoms and fever for 14 days.
  o Keep the door to the individual room closed.
    • Attempts should be made to have these individual cohorted with dedicated staff.
  o If an individual becomes symptomatic, then he/she should be tested for COVID-19.
    • Increase monitoring of individuals for worsening of symptoms.
    • If transfer to an acute hospital is needed due to worsening condition, without testing or before test results are known, call ahead to make arrangements and notify the facility and transfer crew that the individual may have COVID-19.

OUR FACILITY HAS IDENTIFIED A CLIENT THAT IS POSITIVE FOR COVID-19
• Consider having pregnant or immunocompromised staff assigned to other areas in the facility.
• The individual can remain in the facility as long as their clinical care needs can be met.
• While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility.
Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If individuals or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the individual’s room.

Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.

- Place in private room or cohort COVID-19 positive individuals together, ideally placed 6 feet apart.
  - Consider multi-drug resistant organism (MDRO) infection/colonization status when making individual placement decisions. Staff must change their gown after working with individuals infected or colonized with a MDRO.
- If limited single rooms are available or if numerous individuals are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, individuals should shelter-in-place at their current location pending return of test results.
- Individuals should only be placed in a COVID-19 care area if they have confirmed SARS-CoV-2 infection.
- Roommates of individuals with SARS-CoV-2 infection should be considered exposed and potentially infected and, if at all possible, should not share rooms with other individuals while they are in quarantine (i.e., for the 14 days following the date their roommate was moved to the COVID-19 care area).
- Place individuals in droplet precautions, with the addition of an N95 mask for PPE.
  - Staff should have been fit tested for use of N95 masks and perform self-seal checks each time mask is donned.
  - The same mask and eye protection can be used for multiple individuals that are cohorted, but gown and gloves should be changed between individuals and hand hygiene performed. Mask should be discarded at the end of each shift or if visibly soiled, damaged, or difficult to breathe through.
  - Practices allowing extended use of N95 respirators as respiratory protection can also be considered for staff who are sequentially caring for a large volume of individuals with confirmed SARS-CoV-2 including those cared for in a COVID-unit or designated care area.
  - N95 respirators should be discarded immediately after being removed. If removed for a meal break, the respirator should be discarded and a new respirator put on after the break.
  - Cloth face coverings should NOT be worn in place of face masks or N95 respirators.
  - If N95 masks are not available or staff are not fit tested, a surgical mask and face shield can be worn.
    - Fit testing should be arranged as soon as possible for staff.
- Keep the door to the individual’s room closed, as much as possible.

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• This is especially important for individuals with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care area. However, in some circumstances (e.g., memory care), keeping the door closed may pose individual safety risks and the door might need to remain open. If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway.

- Dedicate equipment to these individuals and disinfect between use.
- A log should be kept of all staff going in and out of room.
- Increase monitoring for worsening of symptoms.
- Monitor staff for proper use of PPE and hand hygiene.
- Have dedicated staff care for the individual(s).
- Staff should organize their work and take on the duties of environmental cleaning to decrease number of staff entering the room, living space or apartment.
  - Environmental staff are usually not fit tested for N95 masks.
- If staff from the COVID-19 care area are working with individuals other than COVID-19 confirmed or suspected individuals, separate masks should be used for working with individuals who are not suspect or COVID-19 positive.
- N-95 masks used with positive individuals should be discarded after each treatment if individual is receiving nebulizer or other aerosolized therapy.
- Disinfect face shields after each use adhering to contact time.
- Provide notification to individual’s families/guardians when there is a case of COVID-19 identified in your facility.
- Testing of staff and individuals may be recommended once there has been a case identified or documented spread among staff or individuals.
- Individuals should generally be restricted to their rooms and serial SARS-CoV-2 testing performed.
- Consideration should be given to halting social activities and communal dining; if these activities must continue for uninfected individuals, they should be conducted using source control and physical distancing for all participants.
- Even though individuals are recovered and are not tested for 90 days unless they develop a new onset of symptoms, source control needs to be in place due to risk of reinfection. A person’s immunity time frame is uncertain and is not to be perceived as 90 days due to testing recommendations.

For facilities that need additional PPE, reach out to Tony Mutzenberger via email at tlmutzenberger@nd.gov.