OKLAHOMA State Department of Health

COVID-19
Phased Reopening Guidance for Long Term Care Facilities

Revised August 28, 2020

Summary of Changes:

- Corresponding updates are made related to COVID-19 case rates in the community within each Phase discussed in this document.
- Visitation and communal activities guidance are revised to clarify variations in phases 2 and 3 and provides a link to *CMS' Frequently Asked Questions (FAQs) on Nursing Home Visitation*, which offers and promotes creative and flexible options for providers when balancing resident health and safety needs versus social isolation.
- Revises reporting requirements on facility Phase status to require reporting only when a facility's Phase does not align with the County alert status for the facility.

As Oklahoma progresses in the battle against COVID-19, different sectors have begun to reopen. The Governor's Solution Task Force has continued to closely monitor the incidence and prevalence of the virus. Based on guidance being issued by the Centers for Disease Control and Prevention (CDC) and the Centers for Medicare and Medicaid Services (CMS), the State has identified guidance for Long-Term care facilities to assist with transition of allowing for visitation, outings and third-party vendors to enter the facility.

This guidance offers recommendations in a phased approach for select facilities in the development of their reopening plan, with incorporation of CDC guidance, and CMS regulations (as applicable).

Background

While public health mitigation efforts remain critically important in long-term care settings where residents may be more vulnerable to severe illness from COVID-19; quality of life and dignity of residents must be considered. The Oklahoma State Department of Health (OSDH) has collaborated with our trade associations on how to responsibly ease restrictions in long-term care facilities while COVID-19 remains in communities across the state.

The phases below are specifically targeted at nursing homes. Other facilities or congregate care settings, such as adult day care centers, assisted living or residential care facilities, and homes for the individuals with intellectual disabilities may choose to have their infection preventionist follow an independently developed framework for easing restrictions using this plan as a guide and the Centers for Disease Control (CDC) COVID-19 mitigation strategies shown below:

- Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities: https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
- COVID-19 Guidance for Shared or Congregate Housing: https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html
- Guidance for Group Homes for Individuals with Disabilities: https://www.cdc.gov/coronavirus/2019-ncov/community/group-homes.html
- Preparing for COVID-19 in Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

Infection Preventionist

The Centers for Disease Control (CDC) recommends for **nursing homes** that "Facilities should assign at least one individual with training in IPC [infection prevention and control] to provide on-site management of their COVID-19 prevention and response activities because of the breadth of activities for which an infection prevention and control program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of Health Care Personnel and auditing adherence to recommended IPC practices." The CDC refers all health care providers and shared or congregate housing providers to their **Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings**, which describes the IPC standards to be addressed by the infection preventionist. The Infection Preventionist role includes monitoring case trends.
For more background, see appendix A.

Within four weeks of the issuance of this re-opening plan(now extended to July 22, 2020), all operating adult day care, residential care, assisted living, nursing and skill nursing facilities, and intermediate care facilities for individuals with developmental or intellectual disabilities will:

1) Identify to the Oklahoma State Department of Health (OSDH) by name, phone and email, a **licensed health care professional** as their infection preventionist (IP), the IP may serve more than one facility and their full time employment is not required;
2) Provide the Department evidence the IP completed the CDC's **Nursing Home Infection Preventionist Training Course**, the American Health Care Association/National Center for Assisted Living's Infection Prevention Control Officer Course, or other equivalent and Department approved training;[1]

3) Have their IP provide the OSDH documentation of an **Infection Prevention and Control Risk Assessment** using this **template**, provided through the course, and a monitoring plan for the facility's:

- infection surveillance,
- competency-based training of Health Care Personnel (HCP)[2],
- adherence to recommended Infection Prevention and Control (IPC) practices, and
- adherence to recommended personal protective equipment (PPE) practices;
- this assessment is not the CDC's *Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19* but is a comprehensive infection control assessment that will be expanded for COVID-19 and adapted to the facility type. The assessment will have been performed or updated on or after the issuance of this plan, to account for the guidance and requirements in this plan, including the facility's visitation and outings policies; and

4) Establish, at a minimum, bi-weekly performance monitoring by the IP of the facility's IPC. Documentation of this monitoring will be subject to sampling by the OSDH, with documentation to be provided by the IP on forms provided or approved by the Department. Monitoring should reflect all shifts.

5) Submissions will be directed to the Long Term Care Service at ltc@health.ok.gov.

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[1] Current rules require NFs and SNFs to have their IP complete specialized training in infection prevention and control **[42 CFR 483.80(b)(4)].**

[2] Health Care Personnel (HCP) are defined as paid and unpaid persons serving in health care settings who have the potential for direct or indirect exposure to patients or infectious materials.

The Phases of Reopening

Facilities must consider the State of Oklahoma's current phase, according to the White House Guidelines Opening Up America Again, the **Oklahoma COVID-19 Alert System**, local and facility related data as a part of a comprehensive reopening plan. Each facility must be aware to identify:

- Case status in surrounding community
- Case status in the nursing home(s)
- Staffing levels
- Access to adequate testing for residents and staff
- Personal protective equipment supplies
- Local hospital capacity

These factors should help guide reopening decisions, and drive creative ways to facilitate visitation.

For all facility types, a facility's status in the phases of reopening is based on the presence of COVID-19 in the facility for more than 14 days and the color coded risk level specified for the facility's County in the Oklahoma COVID-19 Alert System; a four-tiered risk measurement tool with corresponding color categories that identify the current COVID-19 risk level in each county. A County's **weekly** risk level and case rate **trends are posted every Friday** on the Department's website here: https://coronavirus.health.ok.gov/covid-19-alert-system. To see the weekly report on the trend in county risk level data, open the report linked on the COVID-19 Alert System web page.

Phase	Color	Case Rates per 100,000 pop.	Risk Level
One	Red	More than 14.39 cases / 100,000 plus triggers**	High
--------	Orange	More than 14.39 cases / 100,000	Moderate
Two	Yellow	1.43 to 14.39 cases / 100,000	Low
Three	Green	Less than 1.43 cases / 100,000	New Normal

** Colors indicate Risk Levels. Details and labels are shown for County.

If a County resides in a Region that has met one or more of the thresholds listed below that County will be elevated one Risk Level.

1. Region has reached maximum hospital capacity (defined as activation of contracted beds pursuant to state hospital surge plan or 100% of the average of licensed and staffed beds) AND at least 50% of Contracted hospital beds under surge plan are filled; or
2. Average days of statewide PPE on hand and available is < 5 days; or
3. Percent of ventilators available is <5% statewide.

To view daily updates of county case trends, go to *Case Status by Date of Onset* (Epi Curve) here: https://looker-dashboards.ok.gov/embed/dashboards-next/67. Select the county within the district map, and **select the case count number for the county**.

Facility Reporting Requirements

LTC facilities will be required to report to the Oklahoma State Department of Health Long-Term Care Department, weekly, related to the facility's practices, plans, and projects to address non-alignment with the phased reopening and State Alert system, if the facility is not allowing visitation. (E.g. If a facility is not allowing visitation and is in green based the Alert System Phase, while the state is in Phase 3).

Reporting by facilities when their operational status does not align with the Oklahoma COVID Alert system status, and the State reopening phase will address at minimum:

- Staffing levels.
- Availability and supply of PPE for adherence to CDC guidance, and proper PPE use for infection control as described at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.
- Local hospital ability to accept referrals/transfers.
- Cohort capabilities/status of residents with dedicated staff in the case of suspected or positive cases.
- Testing ability/ access to testing
- Suspected COVID-19 exposure among residents or staff with pending testing.
- COVID-19 exposure (Resident or Staff testing positive for COVID-19).

No specific format is required until the Department establishes a web form. Send the notice to ltc@health.ok.gov and identify the facility name and license number in the subject line. When the Department publishes a web form for submittal, it will be the required form and route for submission.

The following describes each phase a facility goes through if a facility has a COVID-19 exposure or if the general criteria for the Phase is met.

Reopening Phase 1	
Federal Guidance	All Vulnerable Individuals should Shelter In Place. When in Public maximize physical distance from others. Social settings of more than 10 people, where appropriate distancing may not be practical, should be avoided unless precautionary measures are observe. Avoid SOCIALIZING in groups of more than 10 people in circumstances that do not readily allow for appropriate physical distancing MINIMIZE NON-ESSENTIAL TRAVEL and adhere to CDC guidelines regarding isolation following travel
Expectations	Close COMMON AREAS where personnel are likely to congregate and interact, or enforce strict social distancing protocols. Minimize NON-ESSENTIAL TRAVEL and adhere to CDC guidelines regarding isolation following travel. VISITS TO SENIOR LIVING FACILITIES AND HOSPITALS should be prohibited. Those who do interact with residents and patients must adhere to strict protocols regarding hygiene.
LTC Actions	NO VISITATION. Vigilant infection control during periods of heighted virus spread in the community and potential for healthcare system, which may include factors such as staffing, hospital capacity, Personal Protective Equipment (PPE), and testing.
Considerations	Vulnerable Population Safety; adequacy of staffing; PPE supply; Infection control measures, and testing capability; staff training on policies, PPE, and infection control and prevention to foster safe resident care. Routine family/responsible party communication from the LTC facilities.

Reopening Phase 1 *continued*	
Below are additional considerations during reopening Phase 1.	
Consideration	**Mitigation Steps**
Visitation	**No In-Person Visitation, except for:** ▪ Compassionate care situations restricted to end-of-life and psycho-social needs; and ▪ Compassionate care visitors are screened upon entry and additional precautions are taken, including social distancing and hand hygiene. ▪ Any allowed visitors are screened prior to access and must wear a facemask or cloth face covering for the duration of their visit. The facility must provide a facemask or cloth face covering to the visitor, in the event they do not have one, to ensure universal source control. ▪ Facility must have policies and procedures in place for visitation protocols, and should notify residents/family/representatives of any changes in visitation protocol. ▪ Facility will have policies in place for virtual visitation, whenever possible, to include: ○ offered to all residents at a frequency not less than twice weekly, on a schedule that accommodates the resident and their virtual visitors to the greatest extent possible. ○ Access to communication with friends, family, and their spiritual community. Access to the Long-Term Care Ombudsman.
Essential/Non-Essential Healthcare Personnel	▪ Restricted entry of non-essential healthcare personnel. Non-essential personnel may be allowed into the building following an infection control risk analysis by the facility. All healthcare personnel are screened upon entry and additional precautions are taken, including hand hygiene, donning of appropriate PPE as determined by the task; and at a minimum wearing a facemask for the duration of their visit.
Essential Family/ Caregiver(s)	▪ No Visitation during an outbreak. Facilities must establish policies and procedures on how to designate and utilize Essential caregiver(s) (EC). ○ The resident must be consulted in reference to their wishes of their designated EC. The EC cannot visit a resident during the resident's quarantine, when a resident is symptomatic; unless the visit is for compassionate care.

Reopening Phase 1 *continued*	
Below are additional considerations during reopening Phase 1.	
Consideration	**Mitigation Steps**
Non-Medically Necessary Trips	▪ Telemedicine should be utilized whenever possible. ▪ Non-medically necessary trips outside the building should be avoided. ▪ For medically necessary trips away from of the facility: ○ The resident must wear a cloth face covering or facemask; and The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment. ○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. ○ Transportation equipment shall be sanitized between transports. Where the resident left the facility unsupervised, quarantine for 14 days upon return if asymptomatic and/or place under enhanced observation with frequent screening for signs and symptoms. Facilities may require supervised movement in the facility for up to 14 days.
Communal Dining	▪ Communal dining not recommended but must be limited (for COVID-19 negative or asymptomatic residents only). ▪ Residents may eat in the same room with social distancing (people at tables must be spaced by at least 6 feet). ▪ No more than 10 individuals in a dining area at one time. If staff assistance is required, appropriate hand hygiene must occur between residents.
Screening	▪ Resident screening each shift. It should be clearly documented in the facility policies when shift screenings should occur and how it is tracked. It is not required that residents be woken up if asleep during an overnight shift as long as residents are evaluated at least twice in a 24 hour period. Staff screening at the beginning and end of each shift.
Universal Source Control & Personal Protective Equipment (PPE)	▪ All facility staff, regardless of their position, wear a facemask* while in the facility. ▪ All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. ▪ Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel). ▪ New admissions or readmissions from a hospital setting should quarantine for 14 days.

Reopening Phase 1 *continued*	
Below are additional considerations during reopening Phase 1.	
Consideration	**Mitigation Steps**
Cohorting & Dedicated Staff**	▪ Dedicated space in facility and dedicated staff for cohorting and managing care for residents who are symptomatic or testing positive with COVID-19. ▪ Plan to manage new admissions and readmissions with an unknown COVID- 19 status. ▪ Plan to manage residents who routinely attend outside medically necessary appointments (e.g., dialysis). ▪ Restrict group activities but some activities may be conducted (for COVID-19 negative or asymptomatic residents only) with social distancing, hand hygiene, and use of a cloth face covering or facemask. ▪ Engagement through technology is preferred to minimize opportunity for exposure. ▪ Facilities should have policies in place to engage virtually, where possible, in activities that improve quality of life (e.g. church service, art classes, concerts, etc.).
Testing	▪ Staff and residents shall be tested as directed by the Department if any symptoms are detected or if a positive case of COVID-19 has been identified, as described in Appendix B.
Survey Activity	▪ Investigation of complaints alleging there is an immediate serious threat to the residents' health and safety (known as Immediate Jeopardy). ▪ Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings. ▪ Focused infection control surveys. ▪ Initial survey to certify that the provider has met the required conditions to participate in the Medicare. ▪ Any other survey as authorized or required by CMS. ▪ State based priorities, such as hot spots.

Reopening Phase 1 *continued*	
Below are additional considerations during reopening Phase 1.	
Consideration	**Mitigation Steps**
Visitation	**In-Person and Virtual Visitations are allowed. The facility should:** ○ See CMS' *Frequently Asked Questions (FAQs) on Nursing Home Visitation*, which offers and promotes creative and flexible options for providers when balancing resident's health and safety needs versus social isolation. ○ Essential Caregiver(s) and Compassionate care visitation to support end-of-life and psycho-social needs; and ○ Essential Caregivers and Compassionate care visitors are screened upon entry and additional precautions are taken, including social distancing and hand hygiene. ○ Each facility has established a visitation policy that has been communicated with residents, representatives/family ○ Any allowed visitors are screened prior to access and must wear a facemask or cloth face covering for the duration of their visit. The facility must provide a facemask or cloth face covering to the visitor, in the event they do not have one, to ensure universal source control. ○ Facility may have virtual visitation available to include: ○ offered to all residents at a frequency not less than twice weekly, on a schedule that accommodates the resident and their virtual visitors to the greatest extent possible. ○ Access to communication with friends, family, and their spiritual community. ▪ Virtual and/or In-person Access to the Long-Term Care Ombudsman at resident/representative request with screening per facility policies. **Ombudsman** will be permitted entry and will be subject to the screening, hygiene and face covering requirements for visitors. Facilities will share with Ombudsman, upon request, if they have any active cases of COVID in the building before entrance. The facility will share, upon request, the policy/procedure implemented for visitation. ▪ Facility must have policies and procedures in place for visitation protocols, and should notify residents/family/representatives of any changes in visitation protocol.

Reopening Phase 1 *continued*	
Below are additional considerations during reopening Phase 1.	
Consideration	**Mitigation Steps**
Essential/Non-Essential Healthcare Personnel	▪ The facility may allow Non-essential personnel into the building based on the facility's infection control risk analysis. ▪ All healthcare personnel are screened upon entry and additional precautions are taken, including hand hygiene, donning of appropriate PPE as determined by the task; and at a minimum wearing a facemask for the duration of their visit.
Essential Family/ Caregiver(s)	▪ Facilities must establish policies and procedures on how to designate and utilize Essential caregivers (EC). ○ The resident must be consulted in reference to their wishes of their designated EC(s). ▪ The EC(s) cannot visit a resident during the resident's quarantine, when a resident is symptomatic. ▪ The EC(s) must follow social distancing, use of PPE, or other COVID-19 related rules of the facility. (Failure to follow could result in revocation of EC status)
Non-Medically Necessary Trips	▪ Telemedicine should be utilized whenever possible. ▪ Non-medically necessary trips outside the building should be avoided/ carefully consider the needs of the resident. ▪ For medically and non-medically necessary trips away from of the facility: ○ The resident must wear a cloth face covering or facemask; and The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment. ○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. ○ Transportation equipment shall be sanitized between transports.
Communal Dining	Communal dining Consideration: ▪ Residents may eat in the same room with social distancing (people at tables must be spaced by at least 6 feet). ▪ No more than 10 individuals in a dining area at one time. ▪ If staff assistance is required, appropriate hand hygiene must occur between residents.
Screening	▪ Resident screening each shift. It should be clearly documented in the facility policies when shift screenings should occur and how it is tracked. It is not required that residents be woken up if asleep during an overnight shift as long as residents are evaluated at least twice in a 24 hour period. ▪ Staff screening at the beginning and end of each shift.

Reopening Phase 1 *continued*	
Below are additional considerations during reopening Phase 1.	
Consideration	**Mitigation Steps**
Universal Source Control & Personal Protective Equipment (PPE)	▪ All facility staff, regardless of their position, wear a facemask* while in the facility. ▪ All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. ▪ Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel).
Cohorting & Dedicated Staff**	▪ Dedicated space in facility and dedicated staff for cohorting and managing care for residents who are symptomatic or testing positive with COVID-19. ▪ Plan to manage new admissions and readmissions with an unknown COVID- 19 status. ▪ Plan to manage residents who routinely attend outside medically necessary appointments (e.g., dialysis).
Group Activities	▪ Residents should **not** be restricted to their rooms to avoid feelings of isolation. Allow resident interactions and movement with social distancing and use of a cloth face covering, except for those residents with confirmed or suspected COVID infections. ▪ Consider group activities that observe social distancing, hand hygiene, and use of a cloth face covering or facemask. ▪ Engagement through technology is preferred to minimize opportunity for exposure. ▪ Facilities should have policies in place to engage virtually, where possible, in activities that improve quality of life (e.g. church service, art classes, concerts, etc.).
Testing	▪ Staff and residents shall be tested as directed by the Department if any symptoms are detected or if a positive case of COVID-19 has been identified, as described in Appendix B.
Survey Activity	▪ Investigation of complaints alleging there is an immediate serious threat to the residents' health and safety (known as Immediate Jeopardy). ▪ Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings. ▪ Focused infection control surveys. ▪ Initial survey to certify that the provider has met the required conditions to participate in the Medicare. ▪ Any other survey as authorized or required by CMS. ▪ State based priorities, such as hot spots.

Reopening Phase 2	
Federal Guidance	All Vulnerable Individuals should Shelter In Place. When in Public maximize physical distance from others. Social settings of more than 10 people, where appropriate distancing may not be practical, should be avoided unless precautionary measures are observe. Avoid SOCIALIZING in groups of more than 10 people in circumstances that do not readily allow for appropriate physical distancing MINIMIZE NON-ESSENTIAL TRAVEL and adhere to CDC guidelines regarding isolation following travel
Expectations	VISITATION TO SENIOR CARE FACILITIES AND HOSPITALS should be allowed. Those who do interact with residents and patients must adhere to strict protocols regarding hygiene.
LTC Actions	Virtual visitation implemented and routine planning for resident and family interaction; Planning to ensure adequate staffing levels, maintain adequate PPE to adhere fully to CDC guidance for proper PPE use for infection control; Policy development in collaboration with residents and family members, resident council, ombudsman, and other advocates and partners.
Considerations	Vulnerable Population Safety; adequacy of staffing; PPE supply; Infection control measures, testing capability and activity; staff training on policies, PPE, and infection control and prevention to foster safe resident care. Routine family/responsible party communication from the LTC facilities (at least twice weekly), ability of local hospitals to accept referrals/transfers, 14 days since resolution of symptoms for the last positive or suspected case identified in the facility; staff mastery of infection control practices. CDC guidance and CMS guidance for designated provider types.

Reopening Phase 2	
Below are additional considerations during reopening Phase 2.	
Consideration	**Mitigation Steps**
Visitation	▪ In-Person and Virtual Visitation are allowed: ○ See CMS' *Frequently Asked Questions (FAQs) on Nursing Home Visitation*, which offers and promotes creative and flexible options for providers when balancing resident's health and safety needs versus social isolation. ○ All visitation is allowed to include compassionate care situations, end- of-life visitation, visitation for residents with significant changes in condition, psycho-social or medical issues, and Essential Family/Caregiver(s) visitation; ○ Screening must occur per facility policy prior to indoor/outdoor interaction with vulnerable residents in addition to precautions of social distancing and hand hygiene.

Reopening Phase 2	
Below are additional considerations during reopening Phase 2.	
Consideration	**Mitigation Steps**
	▪ Any allowed visitors are screened upon entry and additional precautions are taken, including social distancing and hand hygiene. A facemask or cloth face covering for the duration of their visit. The facility must provide a facemask or cloth face covering to the visitor, in the event they do not have one, to ensure universal source control. ▪ Facility will have policies in place for virtual and in-person visitation. ▪ Facility may have virtual visitation available to include: ○ offered to all residents at a frequency not less than twice weekly, on a schedule that accommodates the resident and their virtual visitors to the greatest extent possible. ○ Access to communication with friends, family, and their spiritual community. ▪ Each facility must have policies and procedures in place for visitation protocols, and should notify residents/family/representatives of any changes in visitation protocol. ▪ Each facility will develop a visitation policy which addresses the following, at minimum: ○ Visitation schedule, hours, and location. ○ Infection control practices including proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors and social distancing. ○ Use of PPE. ○ Visitation in designated areas to ensure safe distancing, proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors. Note: each facility must manage their capacity to enable visits, based on considerations, such as, staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits. ○ Residents with limited mobility will be accommodated in their rooms. Facilities may specify entry and exit supervision and precautions for the roommate. ○ Preference should be given to outdoor visitation opportunities like parking lot visits or outbuildings with distancing. ▪ Access to the Long-Term Care Ombudsman – Ombudsman In-Person visitation with screening per facility policies. **Ombudsman** will be permitted entry and will be subject to the screening, hygiene and face covering requirements for visitors. Facilities will share with Ombudsman, upon request, if they have any active cases of COVID in the building before entrance. The facility will share, upon request, the policy/procedure implemented for visitation. **Compassionate Care visits must be:**

Reopening Phase 2	
Below are additional considerations during reopening Phase 2.	
Consideration	**Mitigation Steps**
	▪ By coordination with the nursing home based on current policies and procedures in place to manage infection control practices and social distancing precautions. ▪ In designated areas only to ensure safe distancing, proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors. Note: each facility must manage their capacity to enable visits, based on considerations, such as, staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits. ▪ Consider preferences given to outdoor visitation opportunities using parking lots, canopied areas and outbuildings with distancing (weather permitting). ▪ All Visitors are screened prior to access. ▪ Visitors unable to pass the screening or comply with infection control practices to include masks shall refrain from visiting.
Essential/Non-Essential Healthcare Personnel	▪ Non-essential healthcare personnel entry allowance (including the entry of barbers and beauticians). ▪ All Essential and Non-Essential healthcare personnel are screened upon entry and additional precautions are taken, including hand hygiene, donning of appropriate PPE as determined by the task; and at a minimum wearing a facemask for the duration of their visit.
Essential Family/ Caregiver(s)	▪ Facilities must establish policies and procedures on how to designate and utilize Essential caregiver(s) (EC). ○ The resident must be consulted in reference to their wishes of their designated EC(s). ○ The EC(s) must follow facility policies and procedures that address, hand hygiene, social distancing, and facemask ▪ The EC cannot visit a resident during the resident's quarantine, when a resident is symptomatic.

Reopening Phase 2	
Below are additional considerations during reopening Phase 2.	
Consideration	**Mitigation Steps**
Non-Medically Necessary Trips	▪ Telemedicine should be utilized whenever possible. ▪ Non-medically necessary trips outside the building should be in consideration of individual resident psycho-social needs. ▪ For medically necessary trips away from of the facility: ○ The resident must wear a cloth face covering or facemask; and ○ The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment. ○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. ○ Transportation equipment shall be sanitized between transports.
Communal Dining	▪ Controlled communal dining is allowed. ▪ Residents may eat in the same room with social distancing (people at tables need to be spaced by at least 6 feet). ▪ If staff assistance is required, appropriate hand hygiene must occur between residents as well as use of appropriate PPE.
Screening	▪ Residents screening each shift. It should be clearly documented in the facility policies when shift screenings should occur and how it is tracked. It is not required that residents be woken up if asleep during an overnight shift as long as residents are evaluated at least twice in a 24 hour period. ▪ Staff screening at the beginning and end of their shift.
Universal Source Control & PPE	▪ All facility staff, regardless of their position, will wear a facemask* while in the facility. ▪ All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. ▪ Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel), and remain in effect until further notice).
Cohorting & Dedicated Staff**	▪ Dedicated space in facility for cohorting with dedicated staff and managing care for residents who become symptomatic or test positive with COVID-19; ▪ Continue routine or enhanced screening may be appropriate for new/readmissions with an unknown COVID- 19 status and residents who routinely attend outside medically necessary appointments (e.g., dialysis).

Reopening Phase 2	
Below are additional considerations during reopening Phase 2.	
Consideration	**Mitigation Steps**
Group Activities	▪ Residents should not be restricted to their rooms to avoid feelings of isolation. Allow resident interactions and movement with social distancing and use of a cloth face covering, except for those residents with confirmed or suspected COVID infections. Residents in quarantine status may be provided dedicated time or space for out of room activity. ▪ Small group activities may occur with social distancing (6 ft spacing), hand hygiene, and use of a cloth face covering or facemask.
Testing	▪ See guidance for testing in Appendix B. ▪ Facility shall report ongoing testing efforts to the Long Term Care Service of the OSDH as requested.
Phase Regression	▪ A facility will continue to monitor for the presence of COVID-19 in their buildings. This will occur through resident screening each shift, and staff screening before and after each shift, and leveraging the data points requested by the CDC as reported through the NHSN system. ▪ The facility Infection Preventionist and infection control and prevention team are critical assets in identifying the facility's Phase of opening. If the facility must return to Phase 1, and 14 days have passed since the last residents symptoms resolved, with no additional residents or staff testing positive for COVID-19, the facility has demonstrated the ability to mitigate the spread of COVID-19 and may return to Phase 2 of the reopening process.
Survey Activity	▪ Investigation of complaints alleging Immediate Jeopardy OR actual harm to residents. ▪ Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings or actual harm. ▪ Focused infection control surveys. ▪ Initial certification surveys. ▪ Any other survey as authorized or required by CMS. ▪ State based priorities, such as hot spots.

Reopening Phase 3	
Federal Guidance	VULNERABLE INDIVIDUALS can resume public interactions, but should practice physical distancing, minimizing exposure to social settings where distancing may not be practical, unless precautionary measures are observed. HIGH-RISK POPULATIONS should consider minimizing time spent in crowded environments VISITS TO SENIOR CARE FACILITIES AND HOSPITALS Those who interact with residents of Senior Care Facilities, hospitals, and patients must be diligent regarding hygiene. LARGE VENUES (e.g., sit-down dining, movie theaters,

Reopening Phase 3	
	sporting venues, places of worship) can operate under physical distancing protocols.
Expectations	VISITS TO SENIOR CARE FACILITIES AND HOSPITALS.
LTC Actions	In person visitation with screening in conjunction with virtual visitation and routine planning for resident and family interaction, adequate staffing levels, adequate PPE to adhere fully to CDC guidance for proper PPE use for infection control; Policy development in collaboration with residents and family members, resident council, ombudsman, and other advocates and partners.
Considerations	Vulnerable Population Safety; adequacy of staffing; PPE supply; Infection control measures, testing capability and activity; staff training on policies, PPE, and infection control and prevention to foster safe resident care. Routine family/responsible party communication from the LTC facilities (at least twice weekly), ability of local hospitals to accept referrals/transfers, 14 days since resolution of symptoms for the last positive or suspected case identified in the facility; staff mastery of infection control practices. Cohort capabilities, CDC guidance and CMS guidance for designated providers and resident quality of life.

Reopening Phase 3 *continued*	
Below are additional considerations during reopening Phase 3.	
Consideration	**Mitigation Steps**
Visitation -	▪ All residents should have the ability and option to have In-Person Visitation with the exception of those residents in quarantine for known or suspected exposures to COVID-19 (The facility must also consider quality of life and end of life care needs). ▪ See CMS' *Frequently Asked Questions (FAQs) on Nursing Home Visitation*, which offers and promotes creative and flexible options for providers when balancing resident's health and safety needs versus social isolation. ▪ Each facility must have policies and procedures in place for visitation protocols, and should notify residents/family/representatives of any changes in visitation protocol. ▪ Each facility must develop a visitation policy which addresses the following, at minimum: ○ Visitation schedule, hours, and location. ○ Number of visitors and visits. ○ Infection control practices including proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors and social distancing. ○ Use of PPE. ○ Visitation in designated areas to ensure safe distancing, proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors. Note: each facility must determine their capacity to manage visits, based on considerations, such as, staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits. ○ Residents with limited mobility will be accommodated in their rooms. Facilities may specify entry and exit supervision and precautions for the roommate. ○ Preference should be given to outdoor visitation opportunities like parking lot visits or outbuildings with distancing. ▪ All visitors are screened upon entry and/or prior to indoor or outdoor visitation with residents. ▪ Visitors unable to pass the screening and comply with infection control practices like masks shall refrain from visiting. ▪ Each facility will have policies in place for virtual visitation, to include: ○ Offering to all residents at a frequency not less than twice weekly, on a schedule that accommodates the resident and their virtual visitors to the greatest extent possible. ○ Access to communication with friends, family, and their spiritual community. ▪ Access to the Long-Term Care Ombudsman – Ombudsman In-Person visitation with screening per facility policies.

Reopening Phase 3 *continued*	
Below are additional considerations during reopening Phase 3.	
Consideration	**Mitigation Steps**
	○ **Ombudsman** will be permitted entry and will be subject to the screening, hygiene and face covering requirements for visitors. Facilities will share with Ombudsman, upon request, if they have any active cases of COVID in the building before entrance. The facility will share, upon request, the policy/procedure implemented for visitation.
Essential/Non-Essential Healthcare Personnel and Contractors	▪ Entry of non-essential healthcare personnel and contractors to include barbers and beauticians. ▪ All Essential and Non-Essential healthcare personnel including contract personnel are screened upon entry and additional precautions including: ○ hand hygiene, donning of appropriate PPE as determined by the task; and ▪ at minimum wearing a facemask for the duration of their visit.
Essential Family/ Caregiver(s)	▪ No visitation restrictions unless a resident is quarantined or symptomatic for COVID-19. ▪ Facilities must establish policies and procedures on how to designate and utilize Essential caregiver(s) (EC). ○ The resident must be consulted in reference to their wishes of their designated EC(s). ▪ The EC(s) must follow facility policies and procedures that address, hand hygiene, social distancing, and facemask.
Non-Medically Necessary Trips	▪ Non-medically necessary trips outside the building should be in consideration of resident psycho-social needs. It is recommended residents with high-risk co-morbidities continue to avoid non- medically necessary trips outside the building; with overall decisions made collaboratively by the resident, their family/representative, a nursing home representative, and the resident's physician. ▪ For medically necessary and non-medically necessary trips away from of the facility: ○ The resident must wear a cloth face covering or facemask; and ○ The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment. ○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. ○ Transportation equipment shall be sanitized between transports. Observe for 14 days upon return with frequent screening for signs and symptoms. Facilities may require supervised movement in the facility for up to 14 days.

Reopening Phase 3 *continued*	
Below are additional considerations during reopening Phase 3.	
Consideration	**Mitigation Steps**
Communal Dining	▪ Modified Communal dining. ▪ Residents may eat in the same room with social distancing (number of people at tables must be spaced at least 6 feet). ▪ If staff assistance is required, appropriate hand hygiene must occur between residents.
Screening	▪ Resident screening daily. It should be clearly documented in the facility policies when daily screening should occur and how it is tracked. ▪ Staff screening at the beginning and end of their shift.
Universal Source Control & PPE	▪ All facility staff, regardless of their position, will wear a facemask* while in the facility. ▪ All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. ▪ Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel), and will remain in effect until further notice.
Cohorting & Dedicated Staff**	▪ Dedicated space in facility for cohorting with dedicated staff and managing care for residents who become symptomatic or test positive with COVID-19; ▪ Plan to manage new/readmissions with an unknown COVID- 19 status and residents who routinely attend outside medically necessary appointments (e.g., dialysis).
Group Activities	▪ Communal group activities are allowed with social distancing, hand hygiene, and use of a cloth face covering or facemask. ▪ Residents in quarantine status should be provided dedicated time or space for out of room activity with the exception of those residents with confirmed or suspected COVID infections. ▪ Consider group activities that observe social distancing, hand hygiene, and use of a cloth face covering or facemask. ▪ See CMS' *Frequently Asked Questions (FAQs) on Nursing Home Visitation*, which offers and promotes creative and flexible options for providers relating to visitations and communal activities.

Reopening Phase 3 *continued*	
Below are additional considerations during reopening Phase 3.	
Consideration	**Mitigation Steps**
Testing	▪ See guidance for testing in Appendix B. ▪ Facility shall report ongoing testing efforts to the Long Term Care Service as requested.
Phase Regression	▪ A facility will continue to monitor for the presence of COVID-19 in their buildings. This will occur through resident screening daily and staff screening before and after each shift and leveraging the data points requested by the CDC as reported through the NHSN system. ▪ The facility Infection Preventionist and infection control and prevention team are critical assets in identifying the facility's Phase of opening. ▪ If the facility must return to Phase 1, and 14 days have passed since resolution of all cases with no additional residents or staff testing positive for COVID-19, the facility has demonstrated the ability to mitigate the spread of COVID-19 and may return to Phase 2 of the reopening process.
Survey Activity	▪ All complaint and revisit surveys required to identify and resolve any non- compliance with health and safety requirements. ▪ Standard (recertification) surveys and revisits. ▪ Focused infection control surveys. ▪ Initial certification surveys. ▪ Any other survey as authorized or required by CMS. ▪ State based priorities, such as hot spots.

* Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays. See CDC's *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*.

**Some assisted living centers are attached to nursing facilities or are a part of a continuum of care community or senior living campus with a commonly shared kitchen. In the current public health mitigation environment, facilities should not routinely share direct care, dietary, or environmental services staff who may have contact with residents or tenants in other segments of the senior living operations. If there are identified cases of COVID-19 in other service delivery areas of the campus, there should be no sharing of staff between those care systems.

Appendix A: Infection Preventionist

CDC recommends for nursing homes that "**Facilities should assign at least one individual with training in [infection prevention and control] IPC to provide on-site management of their COVID-19 prevention and response activities** because of the breadth of activities for which an IPC program is responsible, including developing IPC policies and procedures, performing infection surveillance, providing competency-based training of HCP, and auditing adherence to recommended IPC practices." More broadly, the CDC refers all health care providers and shared or congregate housing providers to their *Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings*, which describes those IPC standards.

Federal regulations for NFs, SNFs [42 CFR 483.80], require the designation of an IP with the IPC plan while ICF/IIDs [42 CFR 483.470(l)(1)] require that facilities maintain an ongoing surveillance program of communicable disease control and investigation of infections and an active training program. State rules require infection control policies and procedures in nursing facilities at OAC 310:675-7-17.1. There are no specific infection control standards for residential care and assisted living facilities. There is a resident right established in all long term care provider rules referring to 63 O.S. § 1-1918(B) which provides that residents have a *right to receive adequate and appropriate medical care consistent with established and recognized medical practice standards within the community* [OAC 310:680-19-2(a)(5), residential care; and 310:663-15-1, assisted living centers].

Based on field observations and the continued spread of COVID-19 among staff and residents in some facilities, it is important that each facility have someone with training in IPC to monitor their facility consistent with the CDC guidance and that this person is regularly engaged to provide the required oversight of the following elements described by the CDC:

- infection surveillance,
- competency-based training of HCP,
- audits of adherence to recommended IPC practices, and
- audits of adherence to recommended PPE practices and hand hygiene.

This concern is heightened as the restrictions on visitations and outings are lessened.

CDC's Nursing Home Infection Preventionist Training Course

Target Audience: This training was developed for the individual(s) responsible for IPC programs in nursing homes. However, it includes content that will be helpful for: physicians, physician assistants, registered nurses, licensed practical/vocational nurses, nursing home administrators, program managers, and other health educators. The average time to complete each module ranges from 30 to 90 minutes. The total time to complete the course is estimated at 20 hours.

Program Description:
This course will provide infection prevention and control (IPC) training for individuals responsible for IPC programs in nursing homes so they can effectively implement their programs and ensure adherence to recommended practices by front-line staff. The course will include information about the core activities of an effective IPC program, with a detailed explanation of recommended IPC practices to prevent pathogen transmission and reduce healthcare-associated infections and antibiotic resistance in nursing homes. Additionally, this course will provide helpful implementation resources (e.g., training tools, checklists, signs, and policy and procedure templates)

Verification: The End of Training Plan Verification and CE Information is a downloadable PDF with

directions to obtain your continuing education credits through the Training and Continuing Education Online (TCEO) website: https://tceols.cdc.gov/. *This PDF includes the access code and instructions to access the required post- course evaluation and examination.*

The Launch button will only appear after you have completed all 23 modules and sub-modules of the Nursing Home Infection Preventionist Training Course. Please select Launch to open and save the PDF.

The American Health Care Association/National Center for Assisted Living's Infection Prevention Control Officer Course, is an alternative and approved training. Other equivalent and Department approved training is allowed.

Residential Care and Assisted Living Facilities do not have an existing requirement for an infection control plan. However, we previously asked in our guidance to all long term care providers that they perform a COVID-19 infection control assessment using tools provided by the OSDH. This new requirement expands that assessment and provides additional assurance that appropriate infection prevention and control measures are in place and are being monitored. We asked facilities to audit themselves and provided tools for this in our telephone audits. For consultant nurses that will be the designated infection preventionist, they will likely have the highest level of training in infection control. These are essential health care personnel visits.

The nurse staffing requirements for LTC other than nursing, skilled nursing and ICF/IIDs are shown below, followed by CDC sources for IP and IPC.

CHAPTER 605. ADULT DAY CARE CENTERS

The requirement for an RN is that they are required only if needed. Since Adult Day Center participants leave every day visitation may not be applicable.

310:605-9-1. Admission

……

(d) If a participant is not under a physician's care nor is taking any medications, the center may substitute a nursing assessment by a registered nurse for the medical assessment required in subsection (b) of this Section. In this case, the center may also verify the medical information with family or friends of the participant. If the nursing assessment reveals medical problems, the participant shall not be admitted to the center without the medical assessment.

310:605-11-1. Staffing requirements

Each adult day care center shall have a staff adequate in number, and appropriately qualified and trained to provide the essential services of the center.

……

(2) Each center shall employ additional staff, such as nurses, therapists, consultants, drivers, etc., as needed.

310:605-13-2. Additional Services

Adult day care centers shall provide the following as indicated by the center's program goals and the individual needs of the participants served:

(1) Health Monitoring.

(A) The health, functional, and psychosocial status of each participant shall be observed for significant changes and documented in the participant's record at least monthly by the designated professional staff. Each family and/or physician shall be notified of such changes.

CHAPTER 663. CONTINUUM OF CARE AND ASSISTED LIVING

310:663-5-4. Conduct of assessment

(a) The assessments shall be completed by appropriate participation of health professionals trained in the assessment process.
(b) All assessments must be coordinated and signed by a registered nurse or the resident's personal physician.

310:663-9-1. Nurse

Each assisted living center shall provide adequate staffing as necessary to meet the services described in the assisted living center's contract with each resident and in compliance with the provisions of the Oklahoma Nursing Practice Act, 59 O.S. Supp. 1997 Section 567.1 et seq. Nurse staffing shall be provided or arranged:

(1) registered nurse supervision of skilled nursing interventions;

310:663-9-2. Medication staffing

(a) Each assisted living center shall provide or arrange qualified staff to administer medications based on the needs of residents. Medications shall be reviewed monthly by a registered nurse or pharmacist and quarterly by a consultant pharmacist.

CHAPTER 680. RESIDENTIAL CARE HOMES

310:680-11-1. Requirements

Residential care homes shall employ sufficient personnel appropriately qualified and trained to provide the essential services of the home.

(1) Sufficient number of persons.

……

(D) All residential care homes shall have a signed, written agreement with a registered nurse to act as a consultant. Documentation of the use of the nurse consultant shall be maintained in the home.

Resources:

CDC, Preparing for COVID-19 in Nursing Homes: https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

CDC, Preventing the Spread of COVID-19 in Retirement Communities and Independent Living Facilities (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/community/retirement/considerations.html

CDC, Considerations When Preparing for COVID-19 in Assisted Living Facilities: https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html

CDC, COVID-19 Guidance for Shared or Congregate Housing: https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html

CDC, Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

CDC, Nursing Home Infection Preventionist Training Course; Learn best practices for infection prevention and control in nursing homes. Free CE; Self-paced online course: Nursing Home Infection Preventionist Training Course

Guidance for Group Homes for Individuals with Disabilities: https://www.cdc.gov/coronavirus/2019-ncov/community/group-homes.html

Appendix B: Testing Guidance

Facilities will develop testing protocols for residents and staff based on their IPC plan and the latest CDC guidance for testing in their facility type. The Equal Employment Opportunity Commission's guidance, issued April 23, 2020 makes clear that employers can require employees submit a specimen for COVID-19 testing where it is job-related and consistent with business necessity. See https://www.eeoc.gov/wysk/what-you-should-know-about-covid-19-and-ada-rehabilitation-act-and-other-eeo-laws

Baseline testing of all residents and staff in nursing and skilled nursing facilities was completed on June 5, 2020, consistent with CMS guidance.[3] Baseline testing is now underway for adult day care, residential care, assisted living, and intermediate care facilities for individuals with developmental or intellectual disabilities with no COVID-19 exposure. Baseline testing performed by, or in coordination with, the OSDH, is required in all facilities but will not be required prior to reopening.

The use of point-of-care COVID-19 testing for the screening of essential/non-essential healthcare personnel, contractors, and visitors is allowed but not required.

Testing Results that Suspend the Provisions of this Plan for Visitation and Outings

The provisions of this plan for visitation and outings are suspended in any facility with COVID-19 exposure from any resident or staff member who tests positive for COVID-19 and was present in the facility during the time when they could have exposed the facility. In response, the Department will assess the case, perform or aide in contract tracing, may direct limited scope testing or a facility wide test of all residents and staff. Movement to phase 2 must be followed by resolution of the last resident case [4] plus 14 days, with no additional symptomatic staff or residents.

Where there has been a suspected COVID-19 exposure of a resident or staff member and testing is pending, facilities may cease or further restrict visitation and outings, based on their risk assessment, while test results are pending.

Testing Guidelines for Nursing Homes

See the following CDC guidance for testing residents and healthcare personnel:

- *Testing Guidelines for Nursing Homes*: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
- *Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2*: https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html

[3] CMS Memo QSO-20-30-NH for nursing home reopening provides that there should be "capacity for all nursing home staff … to receive a single baseline COVID-19 test, with re-testing of all staff continuing every week (note: State and local leaders may adjust the requirement for weekly testing of staff based on data about the circulation of the virus in their community)." This guidance also calls for "An arrangement with laboratories to process tests. The test used should be able to detect SARS-CoV-2 virus (e.g., polymerase chain reaction (PCR)) with greater than 95% sensitivity, greater than 90% specificity, with results obtained rapidly (e.g., within 48 hours). Antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection" (page 2).

[4] See the CDC's *Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings* (Interim Guidance) at https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

Definitions

Cloth face coverings	Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing.
Compassionate Care Visits	Per CMS, "does not exclusively refer to end-of-life situations. For example, for a resident who was living with their family before recently being admitted to a nursing home, the change in their environment and sudden lack of family can be a traumatic experience. Allowing a visit from a family member in this situation would be consistent with the intent of the term "compassionate care situations." Similarly, allowing someone to visit a resident whose friend or family member recently passed away, would also be consistent with the intent of these situations."
Doffing	Taking off personal protective equipment.
Donning	Putting on personal protective equipment.
Essential Caregiver	An individual who was previously actively engaged with the resident or is committed to providing companionship and/or assistance with activities of daily living.
Facility-onset case	Following the definition from CMS (QSO-20-30-NH): "a COVID-19 case that originated in the facility; not a case where the facility admitted an individual from a hospital with known COVID-19 positive status, or an individual with unknown COVID-19 status that became COVID-19 positive within 14 days after admission."
Long-Term care facilities	Includes residential care facilities (RCF), assisted living facilities (ALF), adult day care (ADC), nursing facilities (NF), skilled nursing facilities (SNF), intermediate care facilities (ICF), Intermediate care facilities for individuals with developmental or intellectual disabilities (ICF/IID).
Source Control	Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing.
Staff	Per the CDC, " [Staff] include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g. clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel."
State-authorized personnel	Individuals who have a legal duty to provide specified services to residents of long-term care facilities. They include, but are not limited to: representatives of the Office of the State long-Term Care Ombudsman Program, the Office of State guardian and the Legal Advocacy Service; and community-service providers or third parties serving as agents of the State of Oklahoma.
Virtual Visitation	Requires the use of audio-visual technology to make contact**.** This type of visitation may include video conferencing, telephone communication (e.g. Zoom, Google meets, FaceTime).