OKLAHOMA
State Department
of Health

**Phased Reopening in Long-Term Care Facilities**
**Revised July 17, 2020**

**Summary of Changes:**

- Appendix B, Testing Guidance, is updated to revise language related to COVID-19 case rates and movement between phases. This revised plan for *Phased Reopening in Long-Term Care Facilities* incorporates the Oklahoma COVID-19 Alert System; a four-tiered risk measurement tool with corresponding color categories that identify the current COVID-19 risk level found here: https://coronavirus.health.ok.gov/covid-19-alert-system.
- 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 varying limitations 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.

We emphasize that visitation restrictions will vary by facility and will depend on staffing levels, supply of PPE, local hospital ability to accept referrals/transfers, the facility's ability to cohort residents with dedicated staff in the case of suspected or positive cases, suspected COVID-19 exposure among resident or staff with pending testing, and COVID-19 exposure (a resident or staff member testing positive for COVID-19).

As Oklahoma progresses in the battle against COVID-19, the State has begun to safely open back up. As different sectors have begun to open, the Governor's Solution Task Force has continued to closely monitor the incidence and prevalence of the virus. Based on this information, and various guidance being issued by the Centers for Disease Control and Prevention and the Centers for Medicare and Medicaid Services, the State believes that long-term care facilities can move into a new normal, which would allow for visitation, outings and third-party vendors to enter the facility. The Plan that follows offers recommendations for the spectrum of long term care providers, which includes residential care and assisted living facilities (RCFs and ALFs), adult day care (ADC), nursing and skill nursing facilities (NFs and SNFs), and intermediate care facilities for individuals with developmental or intellectual disabilities (ICF/IIDs).

This plan provides a phased approach for nursing facilities that may be used as a template for other long term care providers while they incorporate CDC guidance for their unique communities.

While public health mitigation efforts remain critically important, especially in long-term care settings where residents may be more vulnerable to virus exposure, the state acknowledges that it is equally important to consider the quality of life and dignity of the residents of long-term care facilities. Based on recent guidance from the Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Control (CDC), the state 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. This guidance is based on currently available best-practice recommendations and evidence and may be updated as additional information becomes available.

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 template 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

Facilities may use discretion to be more restrictive in certain areas, where deemed appropriate through internal policies.

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**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. 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;

[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.

- 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.

**The Phases of Reopening**

For all facility types, a facility's status in the phases of reopening is based on the absence 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 | Orange or Red | More than 14.39 cases / 100,000 | Moderate to High |
| Two | Yellow | 1.43 to 14.39 cases / 100,000 | Low |
| Three | Green | Less than 1.43 cases / 100,000 | New Normal |

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**.

**The Infection Preventionist role includes monitoring case trends.**

**All facilities shall report their Phase status to the Long Term Care Service only when their Phase status does not align with the County alert status. After a facility reports a phase not in alignment with a county, they do not need to provide a weekly report of that continuing non-alignment.**

Reporting by facilities when their Phase status does not align with the County alert status will address one or more of the following criteria as the basis:

- Inadequate staffing levels.
- Inadequate supply of PPE to adhere fully to CDC guidance for proper PPE use for infection control as described at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.
- Inability of local hospital to accept referrals/transfers.
- Inability to cohort residents with dedicated staff in the case of suspected or positive cases.
- 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.

**Phase 1**

Phase 1 is designed for vigilant infection control during periods of heighted virus spread in the community and potential for healthcare system limitations, which may include factors such as staffing, hospital capacity, Personal Protective Equipment (PPE), and testing.

County alert level is orange or red.

| Consideration | Mitigation Steps |
|---|---|
| Visitation | Visitation generally prohibited, except for:<br>▪ Compassionate care situations restricted to end-of-life and psycho- social needs; and<br>▪ Compassionate care visitors are screened upon entry and additional precautions are taken, including social distancing and hand hygiene.<br>▪ 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.<br>▪ Facility will have policies in place for virtual visitation, whenever possible, to include:<br>○ 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.<br>○ Access to communication with friends, family, and their spiritual community.<br>○ 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.<br>▪ 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. |
| Non-Medically Necessary Trips | ▪ Telemedicine should be utilized whenever possible.<br>▪ Non-medically necessary trips outside the building should be avoided.<br>▪ For medically necessary trips away from of the facility:<br>○ The resident must wear a cloth face covering or facemask; and<br>○ The facility must share the resident's COVID-19 status with the |

| Consideration | Mitigation Steps |
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| | transportation service and entity with whom the resident has the appointment.<br>○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required.<br>○ Transportation equipment shall be sanitized between transports.<br>○ 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).<br>▪ Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet).<br>▪ No more than 10 individuals in a dining area at one time.<br>▪ 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.<br>▪ 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.<br>▪ 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.<br>▪ Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel).<br>▪ New admissions or readmissions from a hospital setting should quarantine for 14 days. |
| 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.<br>▪ Plan to manage new admissions and readmissions with an unknown COVID-19 status.<br>▪ 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.<br>▪ New admissions or readmissions in quarantine status, with the exception of those in quarantine for known or suspected COVID-19 exposure, may be provided dedicated time or space for out of room activity. |

| Consideration | Mitigation Steps |
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| | ▪ 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.<br>▪ Engagement through technology is preferred to minimize opportunity for exposure.<br>▪ 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).<br>▪ Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings.<br>▪ Focused infection control surveys.<br>▪ Initial survey to certify that the provider has met the required conditions to participate in the Medicare.<br>▪ Any other survey as authorized or required by CMS.<br>▪ State based priorities, such as hot spots. |

**Phase 2**

Facility may decide to initiate Phase 2 upon alignment with the following metrics:

- 14 days since resolution of symptoms for the last positive or suspected case identified in the facility.
- Adequate staffing levels.
- Adequate supply of PPE to adhere fully to CDC guidance for proper PPE use for infection control as described at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.
- Ability of local hospital to accept referrals/transfers.
- Capable of cohorting residents with dedicated staff in the case of suspected or positive cases.
- Facilities may use discretion to be more restrictive in areas, where deemed appropriate through internal policies, even if they have moved to this Phase.
- County alert level is yellow.

| Consideration | Mitigation Steps |
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| Visitation | ▪ Visitation may be allowed in limited and controlled situations<br>○ 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.<br>○ Visitation is allowed for compassionate care situations to include end-of-life and residents with significant changes in condition including psycho-social or medical issues.<br>○ Compassionate Care visits shall be limited as follows: |

| Consideration | Mitigation Steps |
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| | ▪ By appointment only as coordinated by the nursing home based on their ability to manage infection control practices and proper social distancing.<br>▪ Only 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 limited 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.<br>▪ Facilities may limit the number of visitors for each resident per week and per occurrence.<br>▪ Preference should be given to outdoor visitation opportunities using parking lots, canopied areas and outbuildings with distancing.<br>▪ All Visitors are screened prior to access.<br>▪ Visitors unable to pass the screening or comply with infection control practices like masks shall refrain from visiting.<br>▪ Facility will have policies in place for virtual visitation, whenever possible, to include:<br>○ 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.<br>○ Access to communication with friends, family, and their spiritual community.<br>○ Access to the Long-Term Care Ombudsman. |
| Essential/Non-Essential Healthcare Personnel | ▪ Limited entry of non-essential healthcare personnel based on risk analysis by the facility infection control team, including the entry of barbers and beauticians. If barbers and beauticians are determined a low risk for entry, the following mitigation steps should be followed.<br>○ Salons may open so long as the beautician or barber is properly screened when entering the facility and must wear a mask for the duration of time in the facility.<br>○ The beautician or barber must remain in the salon area and avoid common areas of the facility.<br>○ Salons must limit the number of residents in the salon at one time to accommodate ongoing social distancing.<br>○ Staged appointments should be utilized to maintain distancing and allow for infection control.<br>○ Salons must properly sanitize equipment and salon chairs between each resident; and the beautician or barber must perform proper hand hygiene.<br>○ No hand-held dryers.<br>○ Salons must routinely sanitize high-touch areas.<br>○ Residents must wear a facemask during their salon visit.<br>▪ All healthcare personnel are screened upon entry and additional precautions |

| Consideration | Mitigation Steps |
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| | 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. |
| Non-Medically Necessary Trips | ▪ Telemedicine should be utilized whenever possible.<br>▪ Non-medically necessary trips outside the building should be avoided.<br>▪ For medically necessary trips away from of the facility:<br>○ The resident must wear a cloth face covering or facemask; and<br>○ The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment.<br>○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required.<br>○ Transportation equipment shall be sanitized between transports.<br>○ 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 | ▪ Controlled communal dining is allowed.<br>▪ Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet).<br>▪ A limited number of individuals in a dining area at one time, not to exceed 50 percent of capacity unless that would be less than 10 people.<br>▪ 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.<br>▪ 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.<br>▪ 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.<br>▪ Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel), and remain in effect until further notice.<br>▪ New Admissions should quarantine for 14 days. |
| 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;<br>▪ Plan to manage new/readmissions with an unknown COVID- 19 status and residents who routinely attend outside medically necessary appointments (e.g., dialysis). |

| Consideration | Mitigation Steps |
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| 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. New admissions or readmissions in quarantine status may be provided dedicated time or space for out of room activity.<br>▪ Small group activities may occur with social distancing, hand hygiene, and use of a cloth face covering or facemask and no more than 10 people.<br>▪ Facilities must restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss). |
| Testing | ▪ See guidance for testing in Appendix B.<br>▪ 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.<br>▪ The facility will continue to progress through the different phases of adjusting restrictions until one staff or resident is confirmed positive for COVID-19 and another has symptoms, at which time, the facility will return to the Phase 1.<br>▪ 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.<br>▪ Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings or actual harm.<br>▪ Focused infection control surveys.<br>▪ Initial certification surveys.<br>▪ Any other survey as authorized or required by CMS.<br>▪ State based priorities, such as hot spots. |

**Phase 3**

Facilities may decide to initiate Phase 3 upon alignment with the following metrics:

- 14 additional days since resolution of symptoms for the last COVID-19 positive or suspected case identified in the facility.
- Adequate staffing levels.
- Adequate supply of PPE to adhere fully to CDC guidance for proper PPE use for infection control as described at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.
- Ability of local hospital to accept referrals/transfers.

- Capable of cohorting residents with dedicated staff in the case of suspected or positive cases.
- Facilities may use discretion to be more restrictive in certain areas, where deemed appropriate through internal policies, even if they have moved to this Phase.
- County alert level is green.

| Consideration | Mitigation Steps |
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| Visitation - | ▪ All residents should have the ability to have limited visitation with the exception of those residents in quarantine for known or suspected exposures to COVID-19.<br>▪ 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.<br>▪ Each facility should develop a limited visitation policy which addresses the following, at minimum:<br>○ Visitation schedule, hours, and location.<br>○ Number of visitors and visits.<br>○ Infection control practices including proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors and social distancing.<br>○ Use of PPE.<br>○ 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 limited 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.<br>○ Residents with limited mobility will be accommodated in their rooms. Facilities may specify entry and exit supervision and precautions for the roommate.<br>○ Facilities may limit the number of visitors for each resident per week and per occurrence.<br>○ Preference should be given to outdoor visitation opportunities like parking lot visits or outbuildings with distancing.<br>▪ All visitors are screened upon entry.<br>▪ Visitors unable to pass the screening or comply with infection control practices like masks shall refrain from visiting.<br>▪ Facility will have policies in place for virtual visitation, whenever possible, to include:<br>○ 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.<br>○ Access to communication with friends, family, and their spiritual community.<br>○ Access to the Long-Term Care Ombudsman. |

| Consideration | Mitigation Steps |
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| | ▪ **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 | ▪ Limited entry of non-essential healthcare personnel and contractors to include barbers and beauticians. See salon guidance below for mitigation steps.<br>▪ All healthcare personnel and contractors 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. |
| Non-Medically Necessary Trips | ▪ Non-medically necessary trips outside the building should be limited. 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 representative, a nursing home representative, and the resident's physician.<br>▪ For medically necessary and limited non-medically necessary trips away from of the facility:<br>○ The resident must wear a cloth face covering or facemask; and<br>○ The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment.<br>○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required.<br>○ Transportation equipment shall be sanitized between transports.<br>○ 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. |
| Communal Dining | ▪ Modified Communal dining.<br>▪ Residents may eat in the same room with social distancing (limited number of people at tables to ensure space of at least 6 feet).<br>▪ 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.<br>▪ 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.<br>▪ 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.<br>▪ Additional universal source control recommendations can be found |

| Consideration | Mitigation Steps |
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| | 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;<br>▪ 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.<br>▪ New admissions or readmissions 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.<br>▪ Facilities should restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss).<br>▪ 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. |
| Salons | ▪ Salons may open so long as the beautician or barber is properly screened when entering the facility and must wear a mask for the duration of time in the facility.<br>▪ The beautician or barber must remain in the salon area and avoid common areas of the facility.<br>▪ Salons must limit the number of residents in the salon at one time to accommodate ongoing social distancing.<br>▪ Staged appointments should be utilized to maintain distancing and allow for infection control.<br>▪ Salons must properly sanitize equipment and salon chairs between each resident; and the beautician or barber must perform proper hand hygiene.<br>▪ No hand-held dryers.<br>▪ Salons must routinely sanitize high-touch areas.<br>▪ Residents must wear a face mask during their salon visit. |
| Testing | ▪ See guidance for testing in Appendix B.<br>▪ 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.<br>▪ The facility will remain in Phase 3 until one staff or resident is confirmed positive for COVID-19 and another has symptoms, at which time, the facility will return to the Phase 1.<br>▪ 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 |

| Consideration | Mitigation Steps |
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| | 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.<br>▪ Standard (recertification) surveys and revisits.<br>▪ Focused infection control surveys.<br>▪ Initial certification surveys.<br>▪ Any other survey as authorized or required by CMS.<br>▪ 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.

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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**

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(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.

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(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.**

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(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.

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**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/guidance-retirement-response.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_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Fcontrol-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 external icon

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

## Appendix B: Testing Guidance

**Testing**

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/eeoc/newsroom/wysk/wysk_ada_rehabilitaion_act_coronavirus.cfm.

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.

Antibody Testing

Antibody testing from a sampling of staff and residents in facilities in the county may occur at a scope and frequency to be determined by the Department.