

## VDH COVID-19 Interim Guidance for Group/Congregate Residential Settings

Last Updated: February 17, 2021

Note: Document revision history is available at the end of this document.

### **Introduction**

The Virginia Department of Health has updated this guidance to reflect important steps congregate residential programs can take to prevent the spread of coronavirus disease 2019 (COVID-19). This document is intended to provide advice and recommendations to those responsible for managing any of a number of general group or congregate residential settings, such as shelters for persons experiencing homelessness or domestic violence, juvenile detention facilities, group homes, behavioral/developmental health or rehabilitation units, and any other place where groups congregate for extended periods of time and stay overnight. VDH recommends that the facility follow other guidance from licensing bodies, as applicable.

The guidance is intended for settings in which the staff of the facility provide some oversight relative to the health and safety of the residents. It is not intended for other group housing settings, such as apartments or condominiums, where there might be shared community spaces. Persons responsible for those other group settings who find some of the recommendations to be useful may choose to apply them.

The keys to preventing COVID-19 from spreading in any group are maintaining a distance of 6 feet between people as much as possible, promoting frequent handwashing and good respiratory hygiene (including consistent use of masks), being able to rapidly identify potential COVID-19, and utilizing isolation and quarantine measures appropriately to prevent further transmission.

It is important for facility directors to keep up with the latest guidelines from the [Virginia Department of Health](#) and the [Centers for Disease Control and Prevention \(CDC\)](#) as information continues to evolve about the pandemic. Each director plays a key role in continuing to assess the health of staff and residents and implement measures to prevent disease. The recommendations below describe considerations for preparedness, for routine operations, and for response to cases of COVID-19.

### **Facility Preparation**

Directors of congregate residences need to continuously assess their setting and revise operational plans to keep them consistent with the latest guidance and be able to provide services safely. A facility should plan to promote healthy behaviors, maintain a healthy environment, identify illness compatible with COVID-19, and implement necessary preventive measures. The numbers of persons present might need to be limited to those who are essential. The unique medical and behavioral health needs of residents should be considered and each resident encouraged to have a plan for what to do if illness occurs. All changes in procedures need to be communicated to staff, volunteers, residents, and family members as appropriate, and potentially using multiple means (e.g., printed materials and internet) and a culturally appropriate manner. Training needs should be assessed and provided for. Some specific information to include in assessments and plans include:

### **Structural/Environmental Considerations:**

- Identify an area where everyone can safely be screened for symptoms before entering the facility.
- Identify another area where anyone who develops symptoms suggestive of COVID-19 can be placed until they can be sent home (e.g., staff too ill to drive themselves) or moved to another location to be evaluated and receive care for their illness.
- Identify single rooms with doors that can be used for medical isolation of residents identified with symptoms of COVID-19 or who have confirmed COVID-19, but do not require hospitalization. Ideally, these rooms should have an attached private bathroom.
- Identify single rooms with doors with an attached private bathroom or of a specific larger room or area that can be used for quarantine of those identified as close contacts of a COVID-19 case.
- Identify single rooms with doors and an attached private bathroom that can be used for routine intake quarantine of new admissions to the facility before entering the facility's general population (e.g., being placed with a roommate, etc.). Newly admitted residents should be screened before admission and tested using pre-identified testing procedures if symptoms of COVID-19 are present.
  - If implementing quarantine of new admissions, these persons should be quarantined **separately** from other individuals who are quarantined because of contact with a COVID-19 case.
  - Placement of persons being readmitted, such as following a hospital stay, should be assessed on a case-by-case basis and will depend on the level of infection control precautions recommended for the care of the individual at the time of return to the facility.
- Identify services and activities that might need to be limited, discontinued, or provided in an alternate manner (e.g., phone, virtual sessions) based on the ability to maintain appropriate distances (6 feet or more), including in activity areas, dining areas, common areas, etc.
- Plan for increased cleaning and disinfection, including at least twice per day, if possible, in shared areas, on commonly touched surfaces, and in bathrooms.
- Identify a list of healthcare facilities where residents can receive care for COVID-19. Prepare for the potential need to transport an ill person for testing or non-urgent medical care, when the use of buses, taxis, and ride-sharing is discouraged.
- Work with building maintenance to determine if ventilation rates or the percent of outdoor air that is circulating can be increased. Consider opening windows and doors in common areas to increase ventilation, if doing so does not pose a safety or health risk.
- Set up physical barriers, such as sneeze guards, or extra tables or chairs, to protect front desk/check-in staff who will have interactions with residents, visitors, and the public.

#### **Supplies and materials:**

- Assure adequate supplies for hand hygiene, including soap, paper towels, and hand sanitizer, and also tissues, waste baskets, masks (also known as cloth face coverings), cleaning and disinfection supplies, and gloves and other forms of personal protective equipment (PPE) as needed.
- Assess the capability of known residents to use masks and their ability to provide one for themselves. Make a plan for how masks will be provided for persons in the facility who cannot provide one themselves and how to ensure physical distancing for those unable to use a mask.
  - Masks should be worn by everyone aged >2 years while in the facility to the extent possible. Masks should not be placed on children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance. (Note: non-medical cloth masks are **not** PPE).

- Assess the facility and the activities and services provided to determine where and how exposures to the virus would be most likely to occur and who will require PPE.
  - Ensure staff are able to receive education on proper donning and doffing practices for use of PPE ([www.cdc.gov/coronavirus/2019-ncov/downloads/A\\_FS\\_HCP\\_COVID19\\_PPE.pdf](http://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf))
  - Staff should wear disposable gloves when in direct contact with (touching) a resident or his/her belongings. Staff should be trained on the appropriate use of gloves and the importance of hand washing before putting on and after taking off gloves. Gloves should always be changed and discarded and never be used for touching more than one person. CDC has an infographic that can be used as a reminder to wash hands after removing gloves ([www.cdc.gov/handhygiene/campaign/provider-infographic-6.html](http://www.cdc.gov/handhygiene/campaign/provider-infographic-6.html)).
  - If services provided contain a clinical/medical element, additional PPE is needed. If the risk of splashes/sprays or exposure to blood or body fluids exists, then PPE, including gowns, eye protection, and a facemask in addition to gloves, is recommended ([www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19-PPE.pdf](http://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19-PPE.pdf)).
  - If the situation arises in which staff are providing medical care to residents with suspected or confirmed COVID-19 and close contact (within 6 feet) cannot be avoided, staff should at a minimum, wear eye protection (goggles or face shield), an N95 or higher level respirator (or a medical facemask with a face shield if respirators are not available or staff are not fit tested), disposable gown, and disposable gloves.
    - It is important for staff to not touch the item of PPE while wearing it and to not touch their face. If the item or face is touched, hand hygiene needs to be practiced immediately.

#### **Staff planning:**

- In this guideline, the term ‘staff’ could refer to full-time, part-time, contract, temporary employees or volunteers. That is, anyone working in the facility to provide services to residents.
- Ensure that the facility has flexible sick leave and absentee policies that encourage staff to stay home if sick. The facility should also have a plan for operations if absenteeism increases to a degree that it could interfere with provision of services.
- Determine what to do with staff at [high risk for severe illness](#) from COVID-19 and if there are tasks they can perform that minimize interactions and contact with others.
- Ensure all staff have a basic understanding of COVID-19. A basic overview of COVID-19 is available [here](#).
  - Ensure all staff and residents are familiar with the [signs and symptoms of COVID-19](#), which can range from mild to severe symptoms.
    - Symptoms can be variable and include fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, sore throat, new loss of taste or smell, congestion or runny nose, nausea or vomiting, diarrhea, and other symptoms.
    - Older adults with COVID-19 may show atypical symptoms, such as new or worsening malaise (tiredness or discomfort), new dizziness or increased falls, or mental status change such as confusion.
  - Staff should also be familiar with the signs that someone needs emergency medical attention immediately, including having trouble breathing, persistent pain or pressure in the chest, new confusion or inability to awaken, or bluish lips or face, and know what actions they are expected to take if someone exhibits any of those signs.

- Educate staff on the [public health recommendations](#) for how long to isolate a person suspected or confirmed to be infected with the virus that causes COVID-19 (i.e., have symptoms suggestive of the disease or test positive for the virus) and quarantine their close contacts (described further below) in the event a COVID-19 case occurs in the facility.
- Advanced planning will be required to ensure coverage of new roles and responsibilities that will be important in the current context. These may include ensuring sufficient staff to perform more frequent cleaning/decontamination of surfaces, identification of staff to oversee infection control to ensure consistent implementation, and identifying who will be responsible for acting as a point of contact during any public health investigations. Prepare for the potential need to provide education and/or resources to assist staff with stress management.
- If cases are identified in the facility, the [local health department](#) may collaborate with the facility to make infection control and laboratory testing recommendations and to assist with case and contact investigation activities. Depending on the number of cases of COVID-19 reported, health departments in Virginia may not be able to perform timely follow-up of all cases and tracing of their close contacts and may need to prioritize certain contact tracing and case investigations based on [CDC guidance](#). Even if they do not receive a call from the health department, anyone diagnosed with COVID-19 (confirmed with a lab test or diagnosed by a healthcare provider) should isolate at home or within the facility in an area dedicated for isolation of COVID-19 cases, and notify any individuals they had close contact with while contagious. Close contacts should follow quarantine recommendations and monitor their health for 14 days after their last contact.
- Strongly encourage staff and residents aged 6 months or older to get vaccinated for influenza (flu). Flu vaccination is even more important this year because signs and symptoms of COVID-19 and flu are similar and many people at higher risk for flu complications are also at higher risk for severe COVID-19. Encourage COVID-19 vaccination as staff and residents meet eligibility criteria for available vaccine.

### **Steps to Take Routinely When the Facility is Open**

- To the extent possible, conduct daily screening of each person residing or arriving at the facility for [signs and symptoms of COVID-19 infection](#).
  - Although some people with COVID-19 do not develop symptoms, screening can still be helpful to identify those with symptoms, and this is particularly important for congregate residential settings where COVID-19 could spread rapidly. If screening is conducted, it should be performed in a way that protects confidentiality and privacy.
  - Do not admit any person who is ill, has tested positive for COVID-19 in the past 10 days, or who has not completed their full quarantine period (described further in [Steps to Take if COVID-19 Occurs in the Setting](#)) after having been exposed to COVID-19 in the last 14 days.
  - Staff should follow [VDH guidance for screening and monitoring](#). That is, they should check their temperature and make sure they are fever-free and have no other symptoms before reporting to work. They should stay home and inform their supervisor if they are ill or if they have tested positive within the past 10 days or been exposed to someone suspected or confirmed to have COVID-19 within the prior 14 days (quarantine considerations are described further in [Steps to Take if COVID-19 Occurs in the Setting](#)).
  - Restrict or eliminate visitors and the use of volunteers to those who are essential and limit their interactions with others in shared areas to the extent possible.
  - Posting signs from [CDC](#) or [VDH](#) is recommended, making it clear that no one with any of those signs or symptoms should enter the facility.

- Residents should be screened by 1) taking their temperature using a temporal thermometer AND asking if they have felt like they have had a fever in the past day; 2) asking if they have a new or worsening cough that day; and 3) asking if they have any of the following symptoms: shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.
  - Anyone answering Yes to the above or having a fever (>100.4°F) should put on a mask and be directed to the area designated for persons with symptoms of COVID-19 or kept in their private room with the door closed until medical evaluation can be arranged.
  - Temperature takers should keep as much distance from the person whose temperature is being taken as they can, wear a mask and provide one to the other person to wear, wash their hands with soap and water or use alcohol-based hand sanitizer (at least 60% alcohol) regularly, and use gloves if available.
- Ensure that older adults and people of any age with certain [underlying medical conditions or disabilities](#), such as chronic heart, lung, or kidney diseases, diabetes, obesity, cancer, or sickle cell disease, including staff and residents, understand they are at high risk for severe disease from this virus and should refrain from entering the facility or be extra vigilant about wearing a mask and maintaining at least a 6-foot distance from others while there.
- If possible, consider quarantining all new intakes for 14 days before they enter the facility's general population. This practice is referred to as routine intake quarantine. If implementing, these persons should be quarantined **separately** from other individuals who are quarantined because of contact with a COVID-19 case. They should be moved to an area where ill individuals are housed if they develop any signs or symptoms of COVID-19 during the 14-day period.
- Anyone in the facility should wear a mask (with the exceptions for those aged 2 years or younger and those unable to tolerate it or remove it without assistance) and maintain physical distancing.
  - Residents should wear masks any time they are not in their individual room or on their bed in a shared sleeping area.
- Identify ways to maintain distance in sleeping quarters, such as by placing beds at least 6 feet apart and setting scheduled times for use of bathrooms and showers. Limit staff entering residents' rooms. Consider checking in with residents using other means, such as phone, where possible.
- Residents should be instructed that sinks could be an infection source and should avoid placing toothbrushes and other personal items directly on counter surfaces. Personal items should have limited contact with bathroom surfaces. They can be kept in a bag and brought by the resident into the bathroom when needed.
- Do not allow any group activity that puts participants within 6 feet of each other. Encourage individual activities and form smaller groups that can maintain distancing of 6 feet or more between each person. The small groups would function in separate spaces and not intermingle. Consider restricting or eliminating group activities or altering their schedules to maintain distancing and minimize interactions.
- Restrict singing, cheering and other activities that can project respiratory droplets or any activity that requires close contact (within 6 feet for a total of 15 minutes or longer in a 24-hour period).
- Provide meals and snacks in small group spaces or at staggered times and places to avoid crowding. Space tables as far apart as space allows. Do not allow the sharing of dishes, cups, glasses, or utensils or snacking from shared bowls.

- Staff in food service should handle non-disposable items with gloves and wash them with dish soap in hot water or in the dishwasher and wash their hands after handling the items or disposing of trash.
- Ensure staff of each group monitors participants for any indications of fever or signs or symptoms compatible with COVID-19 and that staff and residents are prepared to report any illness they experience and to implement the plan for removal from the group and arrangements for illness care.
- Teach and encourage proper hand and respiratory hygiene practices.
  - Provide [signage](#) for regular and routine handwashing with soap and water upon entry into the facility, before meals and snacks, after blowing or touching noses, coughing, or sneezing, after toileting or changing diapers, and at other scheduled times during the day.
  - Encourage coughing into tissues followed by immediate disposal of the tissue and handwashing. In the absence of tissues, coughing into the crook of elbows followed by handwashing is acceptable. Provide tissues and hand sanitizer to the extent product is available. Remind staff and residents to avoid touching eyes, nose, and mouth.
- Provide supplies needed for good hygiene, including handwashing stations with soap and water, paper towels, and lined no-touch trash cans.
- Establish a schedule for use and cleaning of common areas. Consider reducing use of these areas.
- Institute routine cleaning and disinfection of surfaces, especially those that are frequently touched. Include surfaces in bathrooms, dining areas, common areas, shared resident care equipment when applicable, and all sections of the facility.
  - Shared areas, commonly touched surfaces, and bathrooms should be cleaned and disinfected regularly at least twice a day using an appropriate product following instructions for surface contact time. Refer to [List N](#) on the EPA website for EPA-registered disinfectants that have qualified for use against SARS-CoV-2, the virus that causes COVID-19.
  - Empty trash often, wearing gloves then washing hands afterward. Ensure bathrooms are stocked with soap and paper towels or an automated hand dryer. Consider posting signs reminding everyone to wash their hands.
- Maintain a log of staff and residents that is updated daily and includes identification and contact information, symptom status, group assignments and location within the facility.
- Ensure all staff and residents know and follow expected communication protocols to inform the facility director about any health concerns in the facility. The director must, in turn, communicate appropriately with local health and licensing or other regulatory officials.
  - [Notify the health department](#) if individuals with known or suspected COVID-19 are identified, if severe illness is identified, or if clusters (≥2 staff and/or residents) are identified with similar symptoms.
  - Electronically report outbreaks affecting staff through the [VDH/Department of Labor and Industry \(DOLI\)](#) portal. Submit an initial report when 2 or more cases in staff are identified and continue to report all cases until the LHD has determined the outbreak has been closed. Report outbreaks affecting only residents directly to the [local health department](#).
  - Others within the facility must also be notified if a case occurs there.

### **Steps to Take if COVID-19 Occurs in the Setting**

- Continue the practices outlined above.



- Facility directors must report outbreaks and clusters of cases of COVID-19 to their [local health department](#). They may also contact the local health department any time they have concerns about illness in the facility.
  - The health department might collect information such as the number of staff and residents in the setting, number ill, symptoms and dates of illness, locations of illness within the facility, as well as measures in place to limit the spread of disease.
  - Depending on the circumstances, especially if 2 or more persons are ill within the facility, the health department might recommend laboratory testing of ill persons and provide additional advice to limit the spread of the virus. Discussion with the local health department will determine the extent to which services can continue to be provided if multiple cases occur.
  - Depending on the number of cases of COVID-19 reported, health departments in Virginia may not be able to perform timely follow-up of all cases and tracing of their close contacts and may need to prioritize certain contact tracing and case investigations based on [CDC guidance](#). Even if they do not receive a call from the health department, anyone diagnosed with COVID-19 (laboratory-confirmed or diagnosed by a healthcare provider) should isolate at home or within the facility in an area dedicated for isolation of COVID-19 cases, and notify any individuals they had close contact with while contagious. Close contacts should follow quarantine recommendations and monitor their health for 14 days after their last contact.
- Be alert for illness among additional staff or residents. Any [person with suspected or confirmed COVID-19](#) must be isolated at home or within the facility in an area dedicated for isolation of COVID-19 cases.
  - Pre-determine who will contact healthcare providers to discuss illness that develops and receive advice regarding whether further medical evaluation is needed.
  - Follow guidance on caring for ill individuals provided below (pages 8-10).
- If COVID-19 is suspected or confirmed, VDH recommends that all close contacts be identified and managed according to facility policy. A **close contact** is defined as a person who has been within 6 feet of someone with COVID-19 for a total of 15 minutes or more in a 24-hour period, who has been exposed to respiratory secretions of a person with COVID-19 (coughed or sneezed on, shared glass or utensil, kissed), or who provides care for or lives with someone with COVID-19.
  - The safest recommendation is for close contacts to stay away from others (quarantine) for 14 days after their last contact with a person with COVID-19.
  - Facility directors may assess the services provided in the program and the health of program participants to determine if options to shorten the quarantine period will be allowed there. These options are not available for healthcare providers or people in healthcare settings and are not recommended in group settings serving vulnerable populations.
  - The options for shortening quarantine that are available for household members or other close contacts who are not able to stay home/away from others for 14 days after their last exposure to a person with COVID-19 and who do not have symptoms are\*:
    - Counting their date of last exposure as Day 0, they may leave home after Day 10; or
    - If PCR or antigen testing is available, they can get tested and leave home after Day 7 if the PCR or antigen test performed on or after Day 5 is negative. If they receive a negative test result before Day 7, they should not leave home yet.
  - Close contacts who do not have symptoms of COVID-19 and who have either recovered from COVID-19 or been fully vaccinated for COVID-19 might not need to quarantine. See [here](#) for more information.

- All close contacts, no matter which quarantine period option they are following, must monitor for symptoms and follow all recommendations (e.g., wear a mask, stay at least 6 feet away from others, wash hands frequently, and avoid crowds) for the full 14 days after the last exposure. If the person develops any COVID-19 symptoms within the 14 days after their exposure, they should immediately isolate themselves at home and contact the local health department or their healthcare provider.

\*These options to end quarantine earlier than 14 days after exposure do not currently apply to healthcare workers or people in healthcare settings. People with certain jobs (e.g., [critical infrastructure workers](#) other than education sector workers) should stay home (quarantine) if they have been exposed, but they may be allowed to go to work if the business cannot operate without them. They can only go to work if they do not have any symptoms and if additional precautions are taken to protect them and the community. Learn more about VDH's recommendations for [potential exposures for critical infrastructure workers](#).

- A person with mild to moderate COVID-19 who is not severely immunocompromised is assumed to be no longer infectious and can be [released from isolation](#) when the following criteria are met:
  - *For those with symptoms:*
    - At least 10 days have passed since symptoms first appeared **and**
    - At least 24 hours have passed since resolution of fever without the use of fever-reducing medication **and**
    - Other symptoms have improved (loss of taste or smell might persist for weeks or months after recovery and this should not delay the end of isolation)
  - *For those who never showed symptoms:*
    - 10 days have passed since the date of first positive COVID-19 diagnostic test **and**
    - No COVID-19 symptoms developed
  - CDC and VDH no longer routinely recommend a test-based strategy to determine when to discontinue isolation except among those who are severely ill or significantly immunocompromised.
  - A person with COVID-19 who has a weakened immune system should check with a healthcare provider to determine when they can be around others.
- Illness cared for off-site:
  - An ill staff member who develops signs or symptoms of COVID-19 should be sent home. If unable to drive, the ill staff member should go to the designated area set aside for ill persons until someone can come take him or her home.
  - For any resident with identified next of kin/close contacts willing to provide care, remove the ill person from the group setting and place him or her in the designated area for sick individuals until released to the outside caregivers.
  - Persons may return to the facility once they meet the criteria above for release from isolation.
- Illness cared for on-site:
  - A resident with symptoms or a positive diagnostic test for COVID-19 who will be cared for in the facility should be placed in a private room, with a closed door and separate bathroom if possible.
    - The ill/infected resident should stay in that area and not leave it unless medically necessary. If he or she must leave the area, the nose and mouth need to be covered with a medical mask or, if supplies are limited, a cloth mask.



- Roommates and other close contacts should be moved to a designated quarantine area for the recommended quarantine period and should monitor their health for 14 days.
- Meals should be provided in that private room and care provided there.
- Frequency of room cleaning by staff should be reduced to limit staff exposure.
- Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. If the number of cases increases, the facility needs to designate an area for symptomatic persons separate from an area for well persons. Staff should be designated to work in one of the areas and not travel between the two. Only essential staff should be allowed to enter COVID-19 designated care areas (e.g., exclude food services) and should practice hand hygiene and don proper PPE before entry, as described below. Signs should be posted to clearly identify which areas are for symptomatic and which for non-ill individuals.
- Keep beds and persons 6 feet apart in every living area to the extent possible. Have residents sleep in a direction that maximizes the space between their heads (i.e., head-to-toe or toe-to-toe).
- Staff should limit interactions with ill/infected residents to the extent possible, maintaining the 6-foot distancing space. Persons with health conditions that put them at increased risk of serious illness should avoid close contact.
  - Before caring for a person suspected or confirmed to have COVID-19, staff should be trained on the proper use of PPE, including donning and doffing procedures and hand hygiene ([www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html))
  - If within 6 feet of a person suspected or confirmed to have COVID-19, and especially if providing medical care, staff should wear eye protection (goggles or face shield), an N95 respirator (or facemask that covers the nose and mouth if respirators are not available), a disposable gown, and disposable gloves.
    - Discuss problems with PPE supply with an infection control consultant or the local health department.
  - Staff who do not interact closely (e.g., within 6 feet) with sick residents and are not responsible for environmental cleaning should wear non-medical masks but do not need to wear personal protective equipment (PPE).
  - The ill person should be asked to cover his or her mouth while within 6 feet of a staff person using a medical mask (facemask) or, if supplies are limited, a cloth mask.
  - Cloth masks are **not** considered personal protective equipment and should not be used as an alternative to respirators or facemasks when those are recommended and supplies are still available. If shortages of facemasks exist, facemasks should be prioritized for healthcare providers and non-medical masks can be used for residents with respiratory symptoms. Non-medical masks should not be placed on children aged less than 2 years, anyone who has trouble breathing, or is unconscious, incapacitated or otherwise unable to remove the mask without assistance.
  - When leaving the room of an ill/infected resident, remove gloves, gown, perform hand hygiene, and then remove eye protection and facemask or respirator. Put disposable items in the no-touch trash can that should be provided near the exit from the isolation area, put washable items in a plastic bag and place where items to be laundered are placed, and wash hands with soap and water for 20 seconds.

- Staff should continue to monitor their own health as well as that of the residents and self-isolate if symptoms of COVID-19 develop.
- If symptoms worsen in a resident and inpatient care is needed, the facility should alert the EMS team and the hospital before the patient is transported. Once inpatient care is no longer necessary, the facility should implement its plan to receive the resident back into the facility. That might mean placing the resident into a separate isolation room or in the area in which persons with COVID-19 symptoms are being isolated within the facility if the person still requires transmission-based precautions at the time of readmission.
- Care in the separated, isolated environment should continue until they meet the criteria above for release from isolation.
- Management of operations if transmission of COVID-19 is identified in the facility:
  - Continue and enhance routine prevention and hygiene practices as outlined above.
  - Staff and residents facility-wide should be notified of the situation, while maintaining confidentiality.
  - All residents in the facility should be confined to their rooms and meals served in the rooms.
    - Anyone who has to move from their room should wear a mask that covers the nose and mouth while outside their room.
  - All group activities, communal dining, and visitation or new admissions should be cancelled, and physical distancing enforced.
  - Adhere to [cleaning and disinfection guidance](#) outlined by CDC for when someone in the building or facility has COVID-19.
  - Work with the local health department for public health guidance.

### **Resources from CDC**

Guidance for Shared and Congregate Housing at [www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html](http://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html)

Interim Guidance for Homeless Service Providers to Plan and Respond to Coronavirus Disease 2019 (COVID-19) at [www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html](http://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html)

Checklist for Homeless Service Providers During Community Re-opening at [www.cdc.gov/coronavirus/2019-ncov/php/homeless-service-providers.html](http://www.cdc.gov/coronavirus/2019-ncov/php/homeless-service-providers.html)

Screening Clients for COVID-19 at Homeless Shelters or Encampments at [www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/screening-clients-respiratory-infection-symptoms.html](http://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/screening-clients-respiratory-infection-symptoms.html)

### **Revision History**

Revisions were made on February 17, 2021 to reflect the following:

- Recommended encouraging staff and residents to receive COVID-19 vaccination as they become eligible for available vaccine.

- Updated language to reflect CDC's revised guidance that quarantine may not be required for persons who have no symptoms and either had COVID-19 and recovered or have been fully vaccinated.

Revisions were made on December 15, 2020 to reflect the following:

- Updated the requirements for facilities to notify the Department of Labor and Industry through the DOLI portal. Specifically, facilities must initially report when two or more cases are identified in staff and must continue reporting all cases until the LHD closes the outbreak.

Revisions were made on December 11, 2020 to reflect the following:

- Changed the term "social distancing" to "physical distancing".
- Updated language to reflect that the local health department might not be able to contact every case or contact during periods of high burden.
- Updated language to reflect CDC's revised guidance about quarantine with new options for potentially shortening the quarantine duration for some individuals.

Revisions were made on October 28, 2020 to reflect the following:

- Updated language to change from 'cloth face coverings' to 'masks'
- Inserted requirement to notify Department of Labor and Industry and added link to DOLI reporting portal
- Updated definition of close contact

Revisions were made on August 27, 2020 to reflect the following:

- Clarified that the guidance is intended for facilities where staff provide oversight of resident health and safety. Changed 'program recipients' to 'residents'. Broadly defined staff.
- Suggested alternate means of providing services that may be considered (phone, virtual)
- Recommended that plans include maintaining a list of healthcare facilities and means of transport of ill persons in non-urgent situations
- Recommended that building maintenance increase ventilation rates and percent of outside air
- Noted the potential need for staff resources for stress management
- Deleted use of barriers and full PPE during routine temperature screening
- Added some detail about glove use for kitchen and housekeeping staff
- Added recommendation to strongly encourage flu vaccination

Revisions were made on August 6, 2020 to reflect the following:

- Moved the Revision History to the end of the document
- Clarified and personalize some language in response to feedback received from community partners (e.g., to change 'client' to 'program recipient')

Revisions were made on August 2, 2020 to reflect the following:

- Reformatted guidance to create sections related to planning and preparedness
- Updated guidelines on isolation duration

Revisions were made on May 28, 2020 to reflect the following:

- Added a new section on factors to consider before reopening (for programs that have been closed during the first few months of the pandemic) and recommended against widespread testing of staff and clients upon re-opening.
- Updated screening guidance for residents and staff.
- Expanded guidance on PPE for staff who are providing medical care for ill residents.
- Expanded guidance for cleaning and disinfection for the facility (e.g., cleaning of bathrooms twice daily).

Revisions were made on May 4, 2020 to reflect the following:

- Added an expanded list of symptoms of COVID-19 that should be considered when screening staff and participants.
- Updated guidance regarding discontinuation of home isolation (minimum of 10 days) if using a symptom-based or time-based strategy.

Revisions were made on April 20, 2020 to reflect the following:

- Incorporated CDC's recommendation for people to wear cloth face coverings in public settings where physical distancing of at least 6 feet cannot be maintained, especially in areas with significant community transmission.
- For discontinuation of home isolation, recommending a test-based strategy for persons in congregate residential programs because testing is becoming more widely available and the consequences of further spread in a congregate setting is higher than in a private home setting.