

VDH Nursing Home Guidance for Phased Reopening

Introduction and Scope

On May 18, 2020, CMS released a [memo](#) to address the reopening of nursing homes in phases. Reopening means easing some of the restrictions that have been put in place to protect residents and staff during the early part of the COVID-19 pandemic, and moving in a stepwise manner toward more normal operations. CMS encouraged state leaders to collaborate and decide how these and other criteria or actions should be implemented in their state. The Virginia Department of Health Offices of Epidemiology and Licensure and Certification, in conjunction with state leadership, created Virginia-specific guidance aimed at providing practical strategies for nursing homes to implement phased and safe reopening plans. **Revisions to this guidance may occur as more information becomes available.**

This guidance applies only to nursing homes. Additional guidance regarding phased reopening for assisted living and memory units can be found [here](#).

If you have any questions, contact your [local health department](#) (LHD) or hai@vdh.virginia.gov.

Additional Guidance

This document supplements the following VDH guidance documents previously disseminated:

- [Virginia COVID-19 Long-Term Care Facility Task Force Playbook](#)
Playbook on how to access various staffing, supplies, infection control expertise, and other resources to support responses to COVID-19 cases and outbreaks
- [VDH Guidance for LTCFs](#)
Comprehensive information on training, supply inventory, PPE conservation strategies, and responding to cases
- [VDH Nursing Home Reopening Guidance Frequently Asked Questions](#)
Provides answers to frequently asked questions related to the guidance

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Summary of Changes as of September 8, 2020

- Page 9, Added link to VDH Recommendations for Transfer of Patients from Hospital to LTCF
- Page 9, Revised testing recommendations based on new CMS requirement
- Page 9, Added newly released CDC guidance on antigen testing

Summary of Changes as of August 24, 2020

- Page 15, added link for updated NHSN data collection form for completion of LTCF COVID-19 Module; clarified access to adequate testing recommendations for phase progression

Summary of Changes as of August 8, 2020

- Pages 9-11, changed time frame when testing can be repeated for asymptomatic individuals from 8 weeks to 3 months; more information regarding this change can be found in the [CDC Decision Memo](#)
- Page 12, updated close contact definition; added exposure to infected person's secretions to be consistent with the updated VDH definition.

Summary of Changes as of July 17, 2020

- Page 15, added link for updated NHSN instructions for completion of LTCF COVID-19 Module; clarified PPE supply recommendations for phase progression

1. Recommendations For Progression Through Phases

Checklist For Facility to Enter Phase I

More information can be found in Appendices [1](#) and [2](#)

- City or county has been in Forward Virginia Phase I for at least 14 days
- No nursing home-onset cases in residents for the past 14 days
- Infection prevention and control (IPC) measures have been implemented
 - An individual with training in IPC to provide onsite management of all COVID-19 prevention and response activities has been assigned
 - Space in the facility that can be used to monitor and care for residents with COVID-19 has been designated
 - Screening of residents for any symptoms consistent with COVID-19 infection with documentation is occurring
 - Screening of staff for any symptoms consistent with COVID-19 infection with documentation is occurring
 - Universal source control and social distancing have been implemented
- Facility is reporting to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module weekly
 - Facility has conferred rights to VDH in NHSN
 - Facility has adequate staffing as reported in NHSN
 - Facility has access to adequate personal protective equipment (PPE) as reported in NHSN
 - Facility has access to adequate testing as reported in NHSN
- Fit-testing for respirator use for staff providing direct care for COVID-19 positive residents has been conducted
- Facility testing plan has been developed
- A plan has been developed to manage new admissions and readmissions where COVID-19 status is unknown
- Phase I Attestation has been sent to the LHD

Checklist For Facility to Enter Phase II

More information can be found in Appendices [1](#) and [2](#)

- City or county has been in Forward Virginia Phase II for at least 14 days
- Nursing home has been in Reopening Phase I for at least 14 days
- Baseline testing of all residents and all staff has been conducted; predetermined plan for refusals was followed
 - Testing is occurring per recommendations in Section 5
 - No nursing home-onset cases in residents for the past 14 days
 - No new cases in staff for the past 14 days
- Facility is reporting to the NHSN LTCF COVID-19 Module weekly
 - Facility has adequate staffing as reported in NHSN
 - Facility has access to adequate PPE as reported in NHSN
 - Facility has access to adequate testing as reported in NHSN
- Infection prevention and control assessment (IPCA) has been completed
 - IPC measures have been maintained or implemented based on the assessment
- Phase II Attestation has been sent to the LHD

Checklist for Facility to Enter Phase III

More information can be found in Appendices [1](#) and [2](#)

- City or county should be in Forward Virginia Phase III for at least 14 days
- Nursing home has been in Reopening Phase II for at least 14 days
- Testing is occurring per recommendations in Section 5
 - No nursing home-onset cases in residents for the past 14 days
 - No new cases in staff for the past 14 days
- IPC measures have been maintained

- Facility is reporting to the NHSN LTCF COVID-19 Module weekly
 - Facility has adequate staffing as reported in NHSN
 - Facility has access to adequate PPE as reported in NHSN
 - Facility has access to adequate testing as reported in NHSN
- Facility has a plan to implement a Respiratory Protection Program
- Phase III Attestation has been sent to the LHD

2. Triggers For Phase Regression

1. If a facility identifies a **nursing home-onset COVID-19** case in the facility, the facility goes back to Phase I (even if the surrounding community is in a different Forward Virginia Phase)
 - a. A “nursing home-onset COVID-19 case” refers to COVID-19 cases that originated in the nursing home, and not cases where the nursing home admitted individuals from a hospital with a known COVID-19 positive status, or unknown COVID-19 status but became COVID-19 positive within 14 days after admission. **This only applies to residents. Staff cases do not lead to Phase Regression.**
 - i. Note: A resident that previously tested positive and now retests positive, is not considered a NH-onset case. It is unknown at this time whether an individual can be re-infected. This guidance may be updated as we learn more information on viral persistence and risk for reinfection.
2. If the city or county the facility is located in **regresses to a previous Forward Virginia Phase**, the facility must also regress to the same phase for mitigation steps.

3. Reopening Guidance for All Phases

Symptom Screening

- Resident
 - Resident screening every shift.
 - Symptomatic residents should be tested.
- Staff
 - Staff screening at the beginning of shift.
 - Symptomatic staff should be tested and sent home.

Universal Source Control and PPE.

- All staff, regardless of their position, will wear a cloth face covering or facemask while in the facility.
 - Cloth face coverings should NOT be worn by staff instead of a respirator or facemask if PPE is required.
- Residents should wear a cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility.
 - Exceptions for anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- All staff and essential healthcare personnel (HCP) wear appropriate PPE when they are interacting with residents and in accordance with [PPE optimization strategy guidance](#).
- Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel), and will remain in effect for the duration of the pandemic.

Cohorting Plan

- Designate a portion of the facility (e.g., a wing, ward, floor or end of a hallway) to care for residents with COVID-19
 - The cohorting area should be physically separated from the rest of the care areas in the facility with clear signage
 - Positive and negative residents should not share common areas or bathrooms
 - Equipment should be dedicated to each cohort (positive and negative)
 - If equipment must be shared, make a plan to clean and disinfect equipment
 - Planning for cohorting should include considerations for possible movement of residents and furloughing of staff in response to testing results. See Section 6 for additional guidance.
- When cohorting residents, and if facility space allows, it is recommended to cohort known COVID-19 positive residents, cohort new admissions with an unknown status, and cohort current, healthy asymptomatic residents, separately from each other with designated staffing for each group. Facilities *might consider* creating three types of units to help with cohorting staff and preserving PPE:
 - Warm (unknown COVID-19 status, symptomatic residents who tested negative for COVID-19, and roommates of COVID-19 positive residents or others considered exposed)
 - Ideally all rooms in the warm zone should be single rooms
 - Ensure careful planning of staff cohorting in warm zone
 - Hot (positive COVID-19 residents)
- Assign dedicated HCP to work only on the COVID-19 care unit
 - Designate separate space (e.g., breakrooms, bathrooms) for staff
 - Cohort staff to care for positive or negative residents

Implementing Resident Cohorting Plan

The predetermined resident cohorting plan might not be feasible based on the number of positive residents and the types of rooms available, matching resident gender for room assignments, or a high census. If cohorting is not possible, two other alternatives might be considered:

1. Temporary physical barriers/screens/curtains that separate residents by at least 6 feet
2. Transport COVID-19 residents to a dedicated facility (if available and after consulting with LHD)

Relocating Residents

A safe move requires planning. If widespread testing is being conducted in the facility, the facility should not move residents until test results are available, but should be prepared to assess relocation once results are received. If a facility decides to relocate residents who tested negative, the following should occur:

- Residents should be quarantined for 14 days in a private room (if available) on [transmission - based precautions](#).
- Close daily monitoring for COVID-19 signs and symptoms.
- If a resident becomes symptomatic, they should be retested.

Decision to Allow New Admissions or Readmissions of Residents

Per [VDH Guidance for LTCFs](#), closure of facilities to new admissions may be recommended as a standard part of VDH disease control measures. However, any decision to close and/or accept new admissions or readmissions has to be made based on a risk assessment exercised and tailored to the situation. The decision to close a facility to new admissions should be made in consultation with the LHD

and shall continue for at least 7 days. The following criteria should be met when making a decision on accepting new admissions or readmissions:

1. The number of COVID-19 cases identified in the facility (staff and residents) is decreasing.
2. No evidence of widespread transmission of COVID-19 in the facility.
3. Facility is compliant with IPC best practices.
4. Enough space for cohorting positive versus negative residents, and an observational unit for new admissions is available.
5. Adequate staffing, PPE, and other supplies.
6. The facility has a plan to manage new admissions and readmissions.

4. Recommended Mitigation Steps and Considerations By Phase

In addition to implementing the reopening guidance for all phases described in this document, the following recommendations should be followed by the reopening phase.

Consideration	Phase I	Phase II	Phase III
Visitation	<p>Visitation is generally prohibited, except for compassionate care situations. In those limited situations, visitors are screened and additional precautions are taken, including social distancing, and hand hygiene (e.g., use alcohol-based hand rub upon entry). All visitors must wear a cloth face covering or facemask for the duration of their visit.</p> <p>Types of visitation may continue under limited controlled conditions coordinated by the NH in consideration of social distancing and universal source control (e.g., window visits, outside visits). Limited visitation is at the discretion of each NH based on their temporary visitation policy and capacity for implementation.</p>		<p>Visitation is allowed with screening and additional precautions including ensuring social distancing and hand hygiene (e.g., use alcohol-based hand rub upon entry). All visitors must wear a cloth face covering or facemask for the duration of their visit.</p>
Dining	<p>Communal dining is limited to COVID-19 negative or asymptomatic residents or residents who meet criteria for discontinuation of transmission-based precautions. Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet).</p>		
Social and group activities/ outings	<p>Restrict group activities, but some activities may be conducted (for COVID-19 negative or asymptomatic residents, or residents who meet criteria for discontinuation of transmission-based precautions) with social distancing, hand hygiene, and use of a cloth face covering or facemask.</p>	<p>Group activities, including outings, limited (for asymptomatic or COVID-19 negative residents, or residents who meet criteria for discontinuation of transmission-based precautions) with no more than 10 people and social distancing among residents, appropriate hand hygiene, and use of a cloth face covering or facemask.</p>	<p>Group activities, including outings, allowed (for asymptomatic or COVID-19 negative residents, or residents who meet criteria for discontinuation of transmission-based precautions) with no more than the number of people where social distancing among residents can be maintained, appropriate hand hygiene, and use of a cloth face covering or facemask.</p>

<p>Non-essential staff (salon specific guidance listed below)</p>	<p>Restrict entry of non-essential staff.</p>	<p>Allow entry of limited numbers of non-essential healthcare personnel/contractors as determined necessary by the facility, with screening and additional precautions including social distancing, hand hygiene, and cloth face covering or facemask.</p>	<p>Allow entry of non-essential healthcare personnel/contractors as determined necessary by the facility, with screening and additional precautions including social distancing, hand hygiene, and cloth face covering or facemask. Allow entry of volunteers, with screening and additional precautions including social distancing, hand hygiene, and cloth face covering or facemask.</p>
<p>Resident trips outside the facility for non-medical necessary reasons</p>	<p>Non-medically necessary trips off facility property should be avoided. Telemedicine should be utilized whenever possible.</p>	<p>Might be allowed to asymptomatic or COVID-19 negative residents or residents who meet criteria for discontinuation of transmission-based precautions, only in addition to social distancing, appropriate hand hygiene, and use of a cloth face covering or facemask.</p>	
<p>Testing</p>	<p>See Section 5</p>		

<p>Salons</p>	<p>Entry of a beautician or barber is prohibited.</p>	<p>Entry of a beautician or barber is generally prohibited but if a facility deems necessary to allow entry of a beautician or barber, follow salon guidance listed in Phase III</p>	<ul style="list-style-type: none"> ● 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. ● The beautician or barber must remain in the salon area and avoid common areas of the facility. ● Salons must limit the number of residents in the salon at one time to accommodate ongoing social distancing. ● Staged appointments should be utilized to maintain distancing and allow for infection control. ● Salons must properly sanitize equipment and salon chairs between each resident; and the beautician or barber must perform proper hand hygiene. ● No hand-held dryers. ● Salons must routinely sanitize high-touch areas. ● Residents must wear a face mask during their salon visit.
<p>Onsite gym or fitness center</p>	<p>Gym access is limited to COVID-19 negative or asymptomatic residents or residents who meet criteria for discontinuation of transmission-based precautions, but residents may use gym equipment with social distancing (limited number of people in the gym and spaced by at least ten feet), hand hygiene, and cloth face covering or facemask. Gym equipment should be properly disinfected between each resident.</p>		
<p>Onsite physical therapy</p>	<ul style="list-style-type: none"> ● Physical therapy should be conducted in the resident's room taking into consideration wearing full PPE if the resident is on Transmission-Based Precautions. ● Facilities should create a plan to gradually reintroduce healthcare services, emphasizing those that are time sensitive and prioritizing patients with urgent needs. 	<ul style="list-style-type: none"> ● During phases II and III, access to an onsite physical therapy room should be limited to COVID-19 negative or asymptomatic residents or residents who meet criteria for discontinuation of transmission-based precautions, but residents may use physical therapy equipment with social distancing (limited number of people in the room and spaced by at least 10 feet), hand hygiene, and cloth face covering or facemask. ● Staff should wear a face mask as well as a gown and gloves while conducting physical therapy. Gown and gloves should be changed between residents. ● Equipment should be properly cleaned and disinfected between each use. ● The use of telehealth and its potential expansion should be maximized wherever appropriate. 	

<p>New resident admission and readmission placement</p>	<ul style="list-style-type: none"> ● Accepting new admissions or readmission should be made in consultation with the LHD. ● VDH has posted recommendations for hospitalized patients being discharged to a LTCF ● Residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautions should go to the designated COVID-19 care (hot) unit. ● Residents who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit UNLESS the resident has persistent COVID-19 symptoms (e.g., persistent cough). Those with persistent symptoms should be placed in a single room (and/or on a warm unit), be restricted to their rooms, and wear a facemask during care activities until all their symptoms are completely resolved. ● New admissions and readmissions whose COVID-19 status is unknown or residents with a single negative test should be placed in a single room, if available, and/or on a warm unit. <ul style="list-style-type: none"> ○ All recommended COVID-19 PPE should be worn during care of residents. ○ Carefully consider staff cohorting on the warm unit. ○ Residents could be transferred out of the warm unit to a cold unit, or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission).
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5. Testing Recommendations

These recommendations are made based on the currently available data and subject to change as more information becomes available.

- Follow testing requirements outlined in the [Interim Final Rule \(IFC\), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care \(LTC\) Facility Testing Requirements and Revised COVID19 Focused Survey Tool](#)
- More information about antigen testing can be found in the below CDC resources
 - [Considerations for Use of SARS-CoV-2 Antigen Testing in Nursing Homes](#)
 - [Considerations for Interpreting Antigen Test Results in Nursing Homes](#)
 - [Interim Guidance for Rapid Antigen Testing for SARS-CoV-2](#)

6. Responding To Test Results

Resident Placement and Infection Prevention		
	Tested Positive	Tested Negative
<p>Symptomatic at the time of testing</p>	<ul style="list-style-type: none"> ● Should be cohorted on a COVID-specific (hot) unit/facility ● Transmission-based precautions until discontinuation criteria has been met 	<ul style="list-style-type: none"> ● Isolate away from both COVID positive and COVID negative residents, if possible (warm unit) ● Retesting might be considered for further disposition guidance[^]
<p>Asymptomatic at the time of testing</p>	<ul style="list-style-type: none"> ● Should be cohorted on a COVID-specific (hot) unit/facility ● Transmission-based precautions until discontinuation criteria has been met 	<ul style="list-style-type: none"> ● Cohort with COVID negative residents (cold unit)

*If exposed to a confirmed COVID-19 case (roommate or HCP): Retest resident

Staff Work Exclusion		
	Tested Positive*	Tested Negative
Symptomatic at the time of testing	<ul style="list-style-type: none"> Exclude from work until all Return to Work Criteria are met 	<ul style="list-style-type: none"> If an alternative diagnosis is provided, criteria for return to work should be based on that diagnosis If no alternative diagnosis, exclude from work until all Return to Work Criteria are met Retesting might be considered for further evaluation
Asymptomatic at the time of testing	<ul style="list-style-type: none"> Exclude from work until all Return to Work Criteria are met Retest if/when become symptomatic 	<ul style="list-style-type: none"> No work exclusions* HCP should continue to monitor for signs and symptoms If HCP develops even mild symptoms, they must cease patient care activities, leave work and be retested

*The decision to let asymptomatic staff who were exposed to a confirmed COVID-19 case and tested negative to work ONLY in the case of severe staff shortage. For more information refer to [CDC Strategies to Mitigate HCP Shortages](#).

7. Appendix 1. Interpretation of Criteria For Phase Progression

A LHD might recommend a longer waiting period (e.g., 28 days) before a facility progresses to the next Reopening Phase. This could apply to facilities that:

1. Have had a significant outbreak of COVID-19 cases
2. Have had a history of noncompliance with infection prevention and control measures
3. Have issues maintaining adequate staffing levels, or any other situations the LHD believes may warrant additional oversight or duration before being permitted to relax restrictions.

Forward Virginia

A nursing home's reopening should lag behind the surrounding community's reopening by 14 days. Recommendation for a city or county to be in a specific Forward Virginia phase prior to the nursing home will act as a surrogate gate keeping criteria for case status in the surrounding community (of which the facility is part) and local hospital capacity.

A LHD might recommend the facility delay progressing to the next phase if a substantial increase in transmission occurs in the surrounding community. The LHD would communicate this with the facility with rationale and provide a threshold regarding when the facility would be eligible to progress.

Nursing Home-Onset Case

A "nursing home-onset COVID-19 case" refers to COVID-19 cases that originated in the nursing home, and not cases where the nursing home admitted individuals from a hospital with a known COVID-19

positive status, or unknown COVID-19 status but became COVID-19 positive within 14 days after admission. **This only applies to residents.**

A facility should immediately report a nursing home-onset COVID-19 case to their LHD and submit the Phase Change Attestation Form.

Definition of Staff

Guidance in this document that refers to “staff” include, but are not limited to, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, emergency medical service personnel, contractual staff not employed by the 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). Definition based on [CDC definition](#) of healthcare personnel.

Implementing IPC Measures

Facilities should work with their [local health departments](#) to determine infection prevention and control measures that should be implemented. General guidance can be found [here](#). Responding to test results to inform IPC measures might include but not limited to: cohorting approaches, work exclusions for positive staff, and [Transmission-Based Precautions](#) for positive residents.

National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module

Requirements for nursing homes to report data to the NHSN LTCF COVID-19 Module became effective on May 8, 2020 when CMS published their [interim final rule](#) with comment. More information can be found [here](#). Facilities are [required to confer rights](#) (share data) in NHSN to the VDH group prior to entering Phase I. Instructions for conferring rights can be found [here](#).

A facility should **not** move to the next phase if they answer **yes** to any of the following questions in the previous week’s reporting period:

- Does your organization have a shortage of Nursing Staff?
- Does your organization have a shortage of Clinical Staff?
- Does your organization have a shortage of Aides?

An updated [Table of Instructions](#) has been posted for answering PPE questions in NHSN. A facility should answer the following questions based on the NHSN instructions to reflect adequate PPE using [conventional capacity](#). A facility should **not** move to the next phase if they answer **no** to any of the following questions in the previous week’s reporting period:

- Does your facility have access to COVID-19 testing while the resident is in the facility?
- Do you have enough N95 masks for one week?
- Do you have enough surgical masks for one week?
- Do you have enough eye protection (including goggles or face shields) for one week?
- Do you have enough gowns for one week?
- Do you have enough gloves for one week?
- Do you have enough alcohol-based hand sanitizer for one week?

NHSN updated their [data collection form](#) to add new testing questions regarding facility access and capacity for COVID-19 viral testing of residents and facility personnel. A facility should **not** move to the next phase if they answer **no** to any of the following questions in the previous week's reporting period:

- Does the LTCF have the ability to perform or to obtain resources for performing COVID-19 viral testing (nucleic acid or antigen) on all current residents within the next 7 days, if needed?
- Does the LTCF have the ability to perform or to obtain resources for performing COVID-19 viral testing (nucleic acid or antigen) on all staff and/or facility personnel within the next 7 days, if needed?

Facility Testing Plan

Widespread testing aims at early detection and isolating new cases to prevent COVID-19 from entering and spreading in a facility. Every facility should develop and execute the VDH recommendations for testing. Testing for nursing home residents and staff performed at public health laboratories will be available for a limited time. Facilities should make a long-term testing plan to support widespread testing. At a minimum, the plan should address the following:

1. Testing Laboratory

Facilities should have access to a private or commercial laboratory that will perform direct viral detection testing. Serology (antibody) testing should not be used to inform diagnosis or patient care or cohorting decisions. Information regarding the different types of tests and the available testing laboratories can be found [here](#). Determine whether staff can be tested at the nursing home or whether they will be tested offsite and how results will be shared with the facility and health department.

2. Testing Frequency

Recommendations in this document should be followed. More information can be found [here](#).

3. Testing Supplies

Ensure all resources are available, including staff, PPE, and laboratory supplies, and use the [Regional Healthcare Coalition](#) if PPE shortages occur.

4. Specimen Collection

Facility should have an adequate number of staff identified and trained to collect specimens. Specimen collection should be performed in each resident's room with the door closed. An airborne infection isolation room is not required. For rooms with multiple residents, specimen collection should be performed on one individual at a time in a room with the door closed and no other individuals present. More information can be found [here](#).

5. Financial Implications

VDH and the Virginia National Guard have partnered to conduct Point Prevalence Surveys (PPS) in Virginia's nursing homes to test all symptomatic and asymptomatic residents and staff, at no cost to the facility. These testing events may serve as a facility's baseline test. For subsequent serial testing, it is expected that the cost of serial testing will be reimbursed by the Department of Medical Assistance Services and CMS for residents covered by Medicaid and Medicare. The costs for testing will be covered for symptomatic residents with insurance coverage through other payers, but coverage for regular testing of asymptomatic residents will vary pay payer.

PPS may also serve as baseline tests for nursing home staff. It is the responsibility of nursing homes to secure resources to support regular staff COVID-19 testing.

6. Tracking

Determine a process that captures which residents and staff were tested or were unable to be tested and the results from each test. A template tracking tool (e.g., line list) is located [here](#).

7. Refusals or altered ability to make a decision

Include a procedure for addressing residents or staff that decline or are unable to be tested. If a resident or staff member refuses to be tested, the facility should:

1. Educate the refusing individual on the importance of testing in providing protection to other facility residents and facility staff.
2. Answer any questions posed by the refusing individual.
3. Address any concerns about testing raised by the refusing individual.
4. Have a plan in place for how to handle staff who refuse to be tested. This may require consultation with employment law experts and/or Human Resources personnel.

Baseline Testing

Testing of all residents and all staff should be conducted before a facility is permitted to progress to Phase II. Governor Northam committed to providing public health resources to conduct baseline testing in all Virginia nursing homes through the use of CARES Act stimulus money and support from the Virginia National Guard. Facilities following the testing guidance for Phase I will satisfy this recommendation. VDH decided to require this prior to starting Phase II, instead of Phase I, due to the practicality of testing all staff and all residents statewide in a short period of time. Facilities in Phase I still have to implement many of the same restrictions that are required before entering Phase I. Also, other criteria must be met to enter Phase I that will speak to a facility's ability to prevent transmission. A LHD might recommend baseline testing prior to entering Phase I based on facility-specific factors.

Infection Prevention and Control Assessment (IPCA)

An assessment of infection prevention practices to identify and mitigate gaps should be performed prior to a facility entering Phase II. The assessment may be conducted remotely (e.g., by telephone or video chat) or onsite by members from various state or federal agencies including but not limited to VDH (OLC and LHD), CDC, or HHS Health and Medical Task Force.

[CDC](#) and [CMS](#) have released complementary assessment tools that nursing homes and their state partners can use to evaluate their current infection prevention and control practices and identify areas for improvement. These tools provide a systematic review of infection control practices for COVID-19 in nursing homes. The items assessed support the key strategies of: keeping COVID-19 out of the facility, identifying infections as early as possible, preventing spread of COVID-19 in the facility, assessing and optimizing personal protective equipment (PPE) supplies, and identifying and managing severe illness in residents with COVID-19.

The areas assessed include:

- Visitor restriction
- Education, monitoring, and screening of staff
- Education, monitoring, and screening of residents
- Ensuring availability of PPE and other supplies
- Ensuring adherence to recommended infection prevention and control (IPC) practices
- Communicating with the health department and other healthcare facilities

Respiratory Protection Program

Establish a written plan for implementing a [respiratory protection program](#) that is compliant with the OSHA respiratory protection standard for employees, if not already in place, as per [CDC guidance](#). The program should include medical evaluations, training, and fit-testing.

8. Appendix 2. Communication with Local Health Department (LHD)

Reporting Testing Results

Per the Virginia *Regulations for Disease Reporting and Control* ([12 VAC 5-90-80](#)), licensed nursing homes should report suspected and confirmed cases of COVID-19 to their LHD.

Attestation

The Phase Change Attestation Form can be submitted via [REDCap](#) or via [paper](#) (fax or email). LHD contact information is available [here](#). If you are having trouble reaching your LHD, please email hai@vdh.virginia.gov.

Facilities should self-assess their readiness to move into subsequent phases, and should submit a Phase Change Attestation Form to their LHD when they meet all the criteria to move from one phase to another. The purpose of submitting the Phase Change Attestation is as a means of communication. We encourage facilities to seek consultation from their local health department when moving from phase to phase. The LHD will acknowledge receipt of the form in writing (electronically or otherwise) within two business days. When a LHD acknowledges receipt of the Attestation Form, this does not mean the LHD approves of the facility's plans. The LHD might recommend a facility should not progress based on city/county data or facility-specific factors; the LHD may also ask the facility for more information.

Facilities should also submit a Phase Change Attestation Form indicating the need to regress pursuant to the guidelines.