

COVID-19 Toolkit

INFORMATION FOR LONG-TERM CARE FACILITIES

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COVID-19 TOOLKIT FOR LONG-TERM CARE FACILITIES

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Minnesota Department of Health: What We Do

At Minnesota Department of Health (MDH), one of our responsibilities is investigating, tracking, and controlling infectious disease outbreaks. Facilities like yours (nursing home, assisted living, certified board and care), are at unique risk for an outbreak of respiratory illness, particularly COVID-19, though these outbreaks can also be caused by a variety of other pathogens.

We are here to help with a case or an outbreak at your facility, including answering questions and determining the best strategies for outbreak control. We will also document the data to better understand disease burden and trends.

When to Report Symptoms or Cases of COVID-19

MN State law at MN Rule 4604.7050 (<https://www.revisor.mn.gov/rules/4605.7050/>) includes:

“Any pattern of cases, suspected cases, or increased incidence of any illness beyond the expected number of cases in a given period...” shall be reported immediately to MDH. This includes suspected outbreaks or unusual disease activity at your facility. Notify MDH immediately (within 24 hours) about any of the following:

- Severe respiratory infection associated with hospitalization or sudden death of a resident.
- Clusters of ≥ 2 residents and/or staff with respiratory symptoms or with known or suspected COVID-19.
- Individual residents or staff are identified with confirmed or suspected COVID-19
- Increase in the number of residents transferred to acute care hospitals for any cause over baseline. An increase of EMS transfers has sometimes been the first indication of a COVID-19 outbreak in a facility.

COVID-19 may be reported using the [MDH: COVID-19 Case Report Form](https://www.health.state.mn.us/diseases/coronavirus/hcp/covidreportform.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/covidreportform.pdf>) or by phone at 651-201-5414 or 877-676-5414.

We will notify your local public health department as needed.

How to Use this Toolkit

This packet is intended for use to plan for a potential COVID-19 case or during an outbreak at your facility. Use this toolkit to implement measures to prevent and control disease spread in your facility, and to collect data that will help you to track respiratory illness and COVID-19 in residents and staff. Please contact MDH with questions or concerns regarding illnesses at your facility. We also recommend LTC providers utilize the [Center Medicare and Medicaid Services Provider Toolkit](https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit) (<https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit>).

Part I: Preparing for COVID-19 in Long-term Care Facilities

COVID-19 cases have been reported in all 50 states and Washington, D.C., with widespread community transmission in many areas. Given the high likelihood of spread once COVID-19 enters a LTC facility, facilities must act immediately to protect residents, families, and staff from serious illness, complications, and death. [CDC: Nursing Home and Long Term Care Facility Checklist \(https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html).

Administration concepts

Being ready for and responding to a COVID-19 case in your facility takes leadership, organization, plans, supplies, and policy. Leaders in LTC facilities should develop back-up plans for implementation if the Administrator of DON becomes ill or requires quarantine. Are there in-house support that could immediately assume the role (other licensed administrators, clinical leadership)? Key leadership should also address personal risk factors such as caregiving responsibilities, or childcare at home, to ensure risk can be minimized.

A balance must be struck between having adequate on-site leadership to provide staff and policy support, and having too many leaders on-site interacting and increasing the potential that multiple leaders will be out ill at the same time.

Leadership should review the facility's incident command structure and emergency plans and decide what aspects fit for the COVID-19 and what may need modification. If you do not have an incident command structure, consider developing formal teams to guide efforts such as staff support, communication, and infection control. Having a process and clear line of communication and authority are vital to a successful plan and response.

Command planning should account for the following areas:

- **Command** – Who is in charge and has authority to make decisions? What is the back-up plan if they become ill? If you are part of a parent company or organization, determine who could step in as on-site leadership in case of key leadership quarantine. Implement a nonclinical rotation of leadership on-site during off hours. These leaders can address issues, audit practices, and be a resource for staff questions and concerns.
- **Communications** – How can leadership be reached including off-hours? What is the communication plan/process to communicate with staff, residents, and families?
- **Coordination** – Who is the facility working with in the community and region to take advantage of assets, training, and other resources? This should include MDH regional personnel as well as your local emergency manager, local public health department, and your healthcare coalition (including your Regional Healthcare Preparedness Coordinator).
- **Space** – How will the facility most effectively utilize its space to provide care for one or multiple residents with COVID-19? How can space be used for staff to assure appropriate areas for doffing and donning of PPE and to assure that break rooms and other areas remain 'clean'?
- **Staff** – Facility must have staffing redundancies so that if staff become ill on shift or receive a positive test result (particularly when multiple staff are tested and could be pulled off shift on short notice) contingencies are in place. Staff training and appropriate fit-testing for N95

respirators should be included in the staff planning. What support can be provided for staff that have childcare or other issues? What will be the plan for getting staff connected with testing if required, and to make determinations about return to work?

- **Supplies** – What supplies are needed, including PPE, training supplies, additional resident linens or care supplies if duplicate carts/resources will be needed in the COVID-19 resident care areas? Disposable trays and utensils are other examples of supplies that may specifically be needed for the care of COVID-19 residents.
- **Special considerations** – What are the policies and processes for COVID-19 resident care? What special training may be needed or changes to usual operations to accommodate safely the care of COVID-19 residents? Memory care residents may also require specific plans and policy.

Be prepared to receive feedback on the emergency plans and policies and adapt as circumstances change. Regulatory and reimbursement changes can significantly affect your options as you plan and respond. Assign someone to monitor regulation changes and recommend change regarding internal facility policies and procedures.

One of the key aspects of the response is to manage staff expectations and to maintain open communications to reduce fear, to receive feedback, and to adjust plans and policy as the situation warrants. Flexibility and scalability is critical across the long-term event.

Keep COVID-19 from entering your facility

The greatest COVID-19 risk comes from the movement of persons into and out of your facility. Anyone who leaves and then returns to your facility can potentially bring COVID-19 into your facility.

Restrict visitors

- **Restrict all visitors from entry into the facility.** This includes spouses, immediate family, and nonessential health care workers. The only exception is for compassionate care situations (e.g., end of life).
- When a resident spends time with a visitor for a compassionate visit, even if outdoors on facility grounds, they must remain at least six feet apart.
- Restrict all volunteers and nonessential health care personnel (HCP), including consultant services (e.g., barber).
- Develop processes to help residents and family members remain connected, including facilitating resident access to virtual visits by phone and other electronic devices.
- Assist families with placement of electronic monitoring devices if requested.
- Make a plan to ensure regular communication with families and residents.

Actively screen staff

Actively screen all staff for fever and symptoms of illness before starting each shift. In addition to facility staff, conduct health screening for other essential health care personnel including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyors, chaplain at end of life, mortician, etc. [Active screening means that a trained person should

physically monitor temperature of staff entering the building and ask questions regarding other COVID-related symptoms.]

- Conduct active assessment for fever (measured temperature >100.0°F) or subjective fever (chill, feeling feverish).
- Ask about new symptoms of illness (e.g., measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell).
- Consider further evaluation for fever <100.0°F, or other symptoms not attributable to another diagnosis, including, nausea, vomiting, diarrhea, abdominal pain, runny nose, and fatigue.
- Staff of LTC facilities are a priority group for COVID-19 testing in Minnesota and symptomatic staff should be tested as soon as possible.
- A sample paper form for documenting staff screening is provided in Appendix A.
- An electronic staff screening tool is available on the LTC COVID-19 Toolkit Resource Page. This Microsoft Excel-based tool can be used by facilities to meet the Centers for Medicaid and Medicare Services requirements for employee monitoring.

Staff should not work while sick. If illness develops while at work, staff must immediately separate themselves from others, alert their supervisor, and leave the workplace.

- MDH will be in contact with you if there is a confirmed case in your facility. Find more on this in the section “Conduct staff risk assessment and monitoring.”

All staff should wear a mask at all times when in the facility and practice strict hand hygiene.

- Employees participating in universal masking initiatives will wear different facemasks, depending on their potential exposure to residents with COVID-19 and their job responsibilities. Medical grade surgical masks should be prioritized for direct-care personnel if they are in short supply.

Institute use of eye protection (e.g., face shield, goggles, safety glasses with side shields) during all resident care encounters, when personal protective equipment (PPE) supplies allow. Use of appropriate PPE can reduce staff exposures that might occur before detection of a COVID-19 case (e.g., when working with infected but asymptomatic resident) that might lead to exclusion from work.

All staff should practice social distancing (≥6 feet from others) when in break rooms or common areas. There have been clusters of staff illness in health care settings associated with lack of social distancing in nonresident care areas.

Limit and monitor resident transport out of facility

Cancel all field trips to locations outside of the facility.

Special considerations should be given to residents who must leave the facility for medically necessary purposes (e.g., hemodialysis).

- Residents should wear an alternative (cloth) facemask when they leave their room and when traveling via resident transport services.

- Develop a process to ensure communication about inter-facility transfer (including EMS) of residents with confirmed or suspected COVID-19. Communicate with any transport services ahead of time if a resident with suspected or confirmed COVID-19 needs transport.
- Screen residents for fever and new respiratory symptoms (cough, shortness of breath) when going offsite for dialysis or other medical appointments and within one hour of returning to the facility.
- Alert the receiving facility ahead of time if there is COVID-19 in the facility. Dialysis centers may adjust the resident's schedule due to possible exposure to COVID-19.
- If a resident with respiratory symptoms, or who is COVID-19 positive, needs dialysis, work with the dialysis center to develop a plan. The goal is to put in place infection control measures, and to adjust the resident's dialysis schedule to accommodate the dialysis center's protocol of treating residents with respiratory symptoms or COVID-positive status.

If a resident leaves the facility to stay with a family member, exposures to persons with COVID-19 cannot be ruled out. Upon the resident's return, the resident must be quarantined in a private room with a private (not shared) bathroom. The CDC defines quarantine as the separation of people who may have been exposed to a contagious disease. With coronavirus, the **recommended period to self-quarantine is 14 days**.

- Because of the quarantine implications, we recommend that residents do not leave the facility campus during this time of COVID-19 community transmission (e.g., when the source of COVID-19 infection cannot be traced). This does not mean residents cannot go outside for fresh air. Residents should wear a cloth mask as tolerated when they go outside and should maintain social distancing.

Appendix A: Staff Health Screening Log

Make a plan for action

Utilize your All Hazard Plan/Emergency Operations Plan

Federally certified skilled nursing facilities should implement their All Hazard Plan/Emergency Operations Plan as required by the Emergency Preparedness Rule. Find details at [CMS: Appendix Z—Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance \(https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Appendix-Z-EP-SOM-February-2019.pdf\)](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Appendix-Z-EP-SOM-February-2019.pdf).

Complete the COVID-19 Action Plan for health care facilities

The [MDH: COVID-19 Action Plan for Congregate Settings \(https://www.health.state.mn.us/diseases/coronavirus/hcp/icpaction.pdf\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/icpaction.pdf) can be used to identify who on your staff will be responsible for taking certain COVID-19-specific actions and by what date.

- The tool will also lead to recognition of actions where you have not yet defined steps or a responsible person.

- Everyone in the organization, including organizational leadership, needs to be involved in creating, supporting, and disseminating the COVID-19 Action Plan.
- If you need infection prevention and control assistance in your preparation, [MDH: Infection Control Assessment and Response Program \(ICAR\)](https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/icar/index.html) (<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/icar/index.html>) website has resources and contact information.
- Engage in conversations with residents, their families, and their primary care providers to ensure all residents have opportunity to develop POLST and advanced directives. Providers should address COVID-specific risk factors and care decisions to ensure the resident's wishes are followed in case of infection.

Know what PPE you need and how much you have available

PPE is a cornerstone of efforts to prevent transmission of COVID-19 within a LTC facility. LTC facilities must have access to recommended PPE and provide clear guidance and training for staff on optimization of PPE supplies.

Cloth/alternative masks are not PPE and should not be worn by HCP when PPE is indicated. [MDH: Personal Protective Equipment Crisis Standards of Care for Long Term Care, Skilled Nursing Facilities, Assisted Living, and Other Non-Acute Care Facilities for COVID-19 \(PDF\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html>)

Ensure adequate amount of PPE supplies are available. Track amount of PPE supplies on hand and update daily.

- Use the [CDC: Personal Protective Equipment \(PPE\) Burn Rate Calculator](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html>) to assess PPE supply.
- Get support from your health care coalition (HCC) [MDH: Health Care Coalitions](https://www.health.state.mn.us/communities/ep/coalitions/index.html) (<https://www.health.state.mn.us/communities/ep/coalitions/index.html>).

Initiate measures to optimize current supply.

- Consider extended use and reuse of facemasks and eye protection, and prioritization of gowns for certain resident-care activities, by using MDH guidance, [MDH: Strategies for Optimizing the Supply of Personal Protective Equipment](https://www.health.state.mn.us/diseases/coronavirus/hcp/optimizingppe.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/optimizingppe.pdf>).

When supplies become critically low (0–3 days left), complete a PPE Request Form, which facilities can access through their HCC (link above).

- In completing this form, there is no guarantee your request will be filled. Requests will go through a needs prioritization process. A facility can request PPE again if needed.
- Facilities should continue to work with their PPE vendors to obtain PPE.

Educate staff who provide direct care, including contractors, on PPE donning and doffing.

- For residents on Transmission-based Precautions (e.g., those with confirmed or suspected COVID-19), focus staff education on what to wear and when (gowns, facemask, eye protection, and gloves). Reinforce hand hygiene.

- Post visual references like CDC's donning and doffing instruction sheets where they can be seen by staff. [CDC: Using Personal Protective Equipment \(PPE\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>), Appendix B
- Use signs for resident doors to remind staff when COVID-19 precautions are needed. [MDH: Enhanced Respiratory Precautions Essential Personnel Only - Keep Door Closed](https://www.health.state.mn.us/diseases/coronavirus/hcp/ppepresign.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/ppepresign.pdf>)

Plan for staff illness and shortages

Consider how to implement staffing support strategies before the first case of COVID-19 occurs in the facility. Infected health care workers have been a common source of virus entry into facilities, and keeping ill health care workers out of work, including those who are mildly ill, is key to preventing outbreaks.

Staffing needs might arise before a positive case is detected. Use the contact sheet in Appendix C to prepare for contacting local resources.

Broad approaches to sustain strong staffing include:

- Conduct active staff screening with all staff prior to their start of shift (described above).
- Staff should not work while sick. If illness develops while at work, staff must immediately separate themselves from others, alert their supervisor, and leave the workplace.
- Remind staff to stay home when ill.
- Implement sick leave policies that are nonpunitive, flexible, and consistent with public health measures that allow ill health care workers to remain out of work.
- Identify minimum staffing needs, and prioritize critical services over nonessential ones. Consider health status of residents, functional limitations, disabilities, and essential facility operations.
- Develop and/or revise plans to mitigate staffing shortages, and establish plans for contingency staffing. As transmission becomes more widespread in a community, facilities might face staffing shortages. If an outbreak occurs, facilities are at risk for staffing shortages.
- Contact your HCC (link on page 9) for guidance on altered standards of care in case residents need acute care and hospital beds are not available.

Appendix B: PPE Posters

Appendix C: Planning Worksheet for Staffing Shortages in Long-Term Care

Train and empower staff members

Emphasize infection prevention and control (IPC) protocols

Place supplies in locations that support adherence to recommended IPC practices.

Consider gathering feedback from staff to identify barriers and facilitators to implementing best practice.

Conduct COVID-19-specific IPC training for staff, including how to:

- Practice strict hand hygiene and social distancing.
- Appropriately put on (don), take off (doff), and care for facemasks, eye protection, and other PPE.
- Implement Transmission-based Precautions, including training, demonstration, and observation of donning and doffing.

Audit staff IPC practices, including hand hygiene and use of facemasks and other PPE. A sample tool is in Appendix D.

Provide situational awareness and empower employees to make good choices

Develop a plan for regular communication with staff, including communication of COVID-19 cases in the facility and expectations of employees.

Educate staff and residents about COVID-19, actions the facility is taking to protect them, and why they are important.

- Include review of visitor restrictions, with clear instructions regarding admission of essential health care service providers.
- Emphasize the importance of social distancing, hand hygiene, respiratory hygiene and cough etiquette, and universal use of face coverings.
- Discuss the possible implications of staff working at multiple locations. Spread of COVID-19 has been documented via staff who have worked at a positive COVID-19 facility, and who have then worked at another facility either while ill or before developing symptoms.

Empower employees to make decisions that will keep them, residents, and coworkers safe.

- Remind employees not to work while ill and provide sick leave policies that are nonpunitive, flexible and consistent.
- Conduct active health screening.
- Ensure that staff know when to use what PPE so that they feel protected in the workplace.

Safeguard your staff's mental well-being

- Create a peer-to-peer buddy system for residents and one for staff so that everyone can have someone to check in with daily.
- Assess residents for depression and anxiety or other behavioral issues. Make connections to mental health services for those who need additional support.
- Facilitate access to mental health care and mental health crisis resources for residents and staff as needed.
- MDH resource: [MDH: Disaster Mental/Behavioral Health \(https://www.health.state.mn.us/communities/ep/behavioral/covid19.html\)](https://www.health.state.mn.us/communities/ep/behavioral/covid19.html)

Plan to group (“cohort”) residents based on COVID-19 status

Make a plan for COVID-19-positive residents

Grouping of residents, or “cohorting,” should be done when possible to separate COVID-19-positive residents from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of robust IPC practices. The better you plan and include the resident, the better this temporary move. When considering which wing or area to select, take care to avoid relocating residents with dementia or memory care needs if possible, since any change in routine/transfer may be more difficult for residents in this group. Provide residents being transferred with the contact information for the Office of Ombudsman for Long-Term Care.

Although not feasible in all facilities, consider some of the following approaches:

- Dedicate a unit or part of a unit as the care location for residents with COVID-19, including those with or without current symptoms of illness. This unit should be used for COVID-19-positive residents that do not require a higher level of care such as hospitalization. Examples include a block of rooms at the end of a hallway, separate wing, or separate floor.
- Anticipate ways to close off units to prevent spread of the virus from ill residents to non-ill residents (e.g., for symptomatic COVID-19, recovered COVID-19 residents, non-COVID-19 suspected residents).
- Confine symptomatic residents and exposed roommates to their rooms. If they must leave their room, ensure the resident is wearing a mask.
- Provide dedicated equipment for COVID-19 areas, as able.
- When possible, consider air flow, ensuring that air moving away from the COVID-19 unit is not entering non-COVID-19 areas. When cohorting residents at the end of a hallway, if possible, make sure air is moving in the direction of negative to positive residents, not the other way around.
- Plan for residents’ personal belongings to be transported and/or protected during any temporary relocation.

To minimize transmission risk, facilities should assign dedicated staff to work on a COVID-19 unit, who are NOT assigned to work in other areas of the facility, if at all possible.

- If staffing shortages do not allow for dedicating staff to specific units, facilities should be strategic to prevent spread of the virus between units. Plan to provide care to residents that are non-COVID-19 suspect first, followed by suspected COVID-19 residents and then symptomatic COVID-19 residents.
- Have staff practice donning and doffing and performing hand hygiene appropriately between residents and units to ensure they are familiar with the concepts prior to having a positive COVID-19 case.

Establish an observation area for new admissions and readmissions with unknown COVID-19 status

Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after admission/readmission. Testing at the end of this period could be considered to increase certainty that the resident is not infected.

- If an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved from their rooms to this location while undergoing evaluation.
- All recommended PPE (facemask, eye protection, gown, and gloves) should be worn during care of residents under observation, if PPE supplies allow. At minimum, facemask and eye protection should be worn.

Identify infections early

Conduct active health screening and surveillance of residents

Actively screen all residents for fever and respiratory symptoms of illness at least daily. Twice daily is best practice. Screen each shift for ill residents.

- Actively monitor all residents for fever (>100.0°F or subjective) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If positive for fever or symptoms, screen each shift and implement Transmission-Based Precautions.
- Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, headache, vomiting, abdominal pain, diarrhea, or altered mental status.
- Routine use of pulse oximetry to screen for new or worsening hypoxia may identify infected residents. If a pulse oximeter is available, daily screening is recommended. Guidance on the use of pulse oximetry is available from [MDH: Pulse Oximetry and COVID-19](https://www.health.state.mn.us/diseases/coronavirus/hcp/pulseoximetry.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/pulseoximetry.pdf>).
- Chart all clinical measurements and symptoms for each resident. An active surveillance sheet is available in Appendix E.
- Use cumulative data to conduct active surveillance. Record daily the number of residents that have been transferred to acute care, even for nonrespiratory disease, by using a sheet like the one in Appendix E. In some LTC facilities, an increasing number of transferred residents has preceded confirmation of COVID-19 in the facility.
- All residents positive for fever or symptoms should be isolated, placed under Transmission-based Precautions, and tested for COVID-19. Clinicians are encouraged to test for other causes of respiratory illness in addition to COVID-19.

Isolate and restrict incoming residents discharged from hospitals, or other facilities, to their room for 14 days.

- Assess newly admitted residents with respiratory symptoms that include cough, fever, or shortness of breath for known exposure to a person with COVID-19 in the 14 days prior to illness onset, or recent admission to facilities with COVID-19 cases. Ask discharging facility whether diagnostic testing has been conducted for COVID-19.

Make a plan for testing with a local health care organization or MDH

Maintain a very low threshold for testing of ill residents and staff. Facilitate specimen collection and testing as soon as possible.

- Contact local provider group or health system to arrange for testing of residents and staff. Arrange for possible facility-wide testing or drive-through in the case of high number of residents or staff becoming ill in a short timeframe.
- If you do not have access to laboratory services through a local provider group, work with MDH to facilitate testing. MDH can provide swabs and process specimens. The facility must use staff or other services (e.g., local public health) to collect nasal swabs from residents and staff.
- Find out more about laboratory testing at
MDH: Evaluating and Testing for Coronavirus Disease 2019 COVID-19
<https://www.health.state.mn.us/diseases/coronavirus/hcp/eval.html>,
MDH: Long-term Care Testing
<https://www.health.state.mn.us/diseases/coronavirus/hcp/ltc.html> and
CDC: Testing for Coronavirus (COVID-19) in Nursing Homes
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>.

Appendix E: Active Daily Resident Monitoring for COVID-19 Symptoms

Notify MDH early and rapidly

Notify MDH immediately (within 24 hours) about any of the following:

- Severe respiratory infection associated with hospitalization or sudden death of a resident
- Clusters of ≥ 2 residents and/or staff with respiratory symptoms or with known or suspected COVID-19
- Individual residents or staff identified with **confirmed or suspected** COVID-19
- Increase in the number of residents transferred to acute care hospitals for **any** cause over baseline. An increase of EMS transfers has sometimes been the first indication of a COVID-19 outbreak in a facility.

COVID-19 may be reported using the MDH: COVID-19 Case Report Form
<https://www.health.state.mn.us/diseases/coronavirus/hcp/covidreportform.pdf>
or by phone at 651-201-5414 or 877-676-5414.

Prevent unseen spread of COVID-19 in your facility

Educate residents and families

Provide education for residents and families regarding necessary restrictions and keep them informed of the status of the facility.

At this time, residents in LTC facilities should not participate in any group activities, regardless of the COVID-19 transmission status of an individual LTC facility or its surrounding community. Facilities should use creative methods to provide socialization, such as virtual activities. Facilities should also continue individualized activities.

When a resident leaves their room, they should wear an alternative facemask if tolerated and should maintain social distancing of at least six feet from other residents at all times.

Residents with respiratory symptoms should remain in their rooms except for medically necessary appointments. Immunocompromised individuals should wear a mask if they have a lingering cough, when they are around any other people.

When a resident leaves their room, they should wear an alternative facemask as tolerated and should maintain social distancing of at least six feet from other residents at all times.

Residents with respiratory symptoms should remain in their rooms except for medically necessary appointments.

No residents with signs or symptoms of a respiratory infection, or with confirmed diagnosis of COVID-19 (regardless of symptoms) may eat in dining rooms. For dining, LTC facilities should apply social distancing methods, such as ensuring residents sit at separate tables at least six feet apart.

Staff actions

All staff should wear a mask at all times when in the facility and practice strict hand hygiene. Medical-grade surgical masks should be prioritized for direct care personnel if they are in short supply.

Institute use of eye protection (e.g., face shield, goggles, safety glasses with side shields) during all resident care encounters as a way to reduce COVID-19 exposure risk to staff. Eye protection is recommended for all routine long-term care encounters when PPE supplies allow. Use of appropriate PPE can reduce staff exposures that might lead to exclusion from work.

Universal use of all recommended PPE for the care of all residents on COVID-19 affected units (or facility-wide depending on the situation) is recommended when PPE supply allows, even if only a single case among residents or staff is identified in the facility. This is important, since there can be unrecognized infection among residents.

All staff should practice social distancing (≥6 feet from others) when in break rooms or common areas. There have been clusters of staff illness in health care settings associated with lack of social distancing in nonresident care areas.

Ancillary services and disinfection guidelines

Implement environmental infection control measures. Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.

Clean and disinfect frequently touched surfaces. Routine cleaning is the everyday cleaning practices that businesses and communities normally use to maintain a healthy environment. Surfaces frequently touched by multiple people, such as door handles, bathroom surfaces, and handrails, should be cleaned with soap and water or another detergent at least daily. More frequent cleaning and disinfection may be required based on area and level of use. Cleaning *removes* dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs, but it reduces the number of germs on a surface.

Disinfect surfaces with an EPA-registered disinfectant with a label indicating effectiveness against human coronavirus or emerging viral pathogens. High-touch surfaces include but are not limited to: door handles, railings, light switches, remotes, phones, call buttons, medical equipment (lifts, thermometers, pulse oximeter), etc. All products listed on [EPA: List N: Disinfectants for Use against SARS-CoV-2](https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2) (<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>) meet EPA's criteria for use against SARS-CoV-2, the virus that causes COVID-19.

- **Soft (Porous) Surfaces:** For soft (porous) surfaces such as carpeted floor, rugs, drapes, and furniture, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces.
- **After Cleaning:** If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.

Implement CDC recommendations

- **[CDC: Environmental Infection Control](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#infection_control)**
(https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#infection_control);
- **[CDC: Cleaning and Disinfection for Community Facilities](https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html)**
(<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html>)

Food Services. Ensure adequate staff are trained to prepare meals in accordance with resident dietary needs/restrictions.

Ensure there are adequate numbers of dietary staff to order and receive food. Facilities should review and revise how they interact with vendors to receive supplies in order to prevent any potential transmission of the virus. For example, do not have supply vendors transport supplies inside the facility. Have them dropped off at a dedicated location (e.g., loading dock).

In addition, do not use food service staff to deliver trays into isolation rooms. Use of health care staff is appropriate to save PPE.

For additional food safety guidance, see [MDH: Food Safety During an Emergency](https://www.health.state.mn.us/people/foodsafety/emergency/covid.html) (<https://www.health.state.mn.us/people/foodsafety/emergency/covid.html>)

Supply Chain. Providers should plan for access to durable medical supplies such as oxygen.

See the [World Health Organization: Oxygen Supply Document](https://www.who.int/publications-detail/oxygen-sources-and-distribution-for-covid-19-treatment-centres) (<https://www.who.int/publications-detail/oxygen-sources-and-distribution-for-covid-19-treatment-centres>)

Access to Care. There are resources available in Minnesota to ensure access to affordable care, and insurance. [MDH: Resources to Find Low-Cost Health Care and Insurance](https://www.health.state.mn.us/diseases/coronavirus/materials/lowcost.html) (<https://www.health.state.mn.us/diseases/coronavirus/materials/lowcost.html>)

IT Services. Providers should ensure they have adequate IT resources available to support connections with families and medical providers. [CMS: Long-term Care Telemedicine Telehealth Toolkit](https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf) (<https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf>)

Reimbursement for emergency expenses

Department of Human Services

- Expedited reimbursement for costs related to COVID-19 MN is available to licensed Medicaid nursing facility (NF) providers for incremental increases in costs for staffing, PPE, and other necessary supplies.
- Information was sent to all MN Medicaid-enrolled nursing facility providers in March 25 and March 31 emails.
- [DHS: online recording COVID-19 expedited reimbursement webinar for NF providers](https://www.youtube.com/watch?v=OO_fHyNUTJk) (https://www.youtube.com/watch?v=OO_fHyNUTJk)
- [DHS: click on COVID Form A-Z](https://nfportal.dhs.state.mn.us/PortalLogin.aspx?ReturnUrl=%2f) (<https://nfportal.dhs.state.mn.us/PortalLogin.aspx?ReturnUrl=%2f>) to request reimbursement and COVID FAQs
- Facilities are generally limited to one reimbursement application form submission per month; invoices must be included with the provider's reimbursement request to DHS.
- If you have questions after reviewing the March emails, COVID FAQ document, Form A-EZ instructions, and the YouTube webinar email DHS.NFRP.CostReport@state.mn.us

Minnesota Department of Health COVID-19 Health Care Response Grant

- Total \$150 million for healthcare response expenses
- Rolling program
- Highly competitive
- [MDH: Health Care Response Grant application form](https://www.health.state.mn.us/facilities/ruralhealth/funding/grants/covidlong.html) (<https://www.health.state.mn.us/facilities/ruralhealth/funding/grants/covidlong.html>)
- May be best for programmatic changes or longer-term staffing and site expenses

FEMA Public Assistance

- Stafford Act Funds – 75% federal and 25% state cost-share
- Must be eligible nonprofit (including health care entity) or public entity

- Homeland Security and Emergency Management (HSEM) will hold information sessions in early May
- Emergency expenses could be related to staffing, also pays for state-level actions such as National Guard activation, resource purchases, etc.
- More information on COVID-19 at [Fema: Public Assistance Policy and Guidance](https://www.fema.gov/public-assistance-policy-and-guidance) (<https://www.fema.gov/public-assistance-policy-and-guidance>)

CARES Act Provider Relief Fund

- The federal government distributed \$30 billion to Medicare providers in April. \$26 billion of this was delivered to providers' bank accounts on April 10, 2020. The remaining \$4 billion of the expedited \$30 billion distribution was sent on April 17.
- There was no application process for this; nearly all Medicare-enrolled nursing facilities were eligible. Almost all nursing facilities in MN are Medicare providers and received these funds in April.
- The CARES Act Provider Relief Fund provides grants, not loans, so they do not need to be repaid.
- [HHS: Provider Relief Fund](https://www.hhs.gov/provider-relief/index.html) (<https://www.hhs.gov/provider-relief/index.html>)

Federal Provider Relief Fund Program

- [HHS: Cares Act Provider Relief Fund FAQs](https://www.hhs.gov/sites/default/files/20200425-general-distribution-portal-faqs.pdf) (<https://www.hhs.gov/sites/default/files/20200425-general-distribution-portal-faqs.pdf>)

Economic Injury Disaster Loan

- Low-interest loan with portions that may not need to be repaid.
- [Economic Injury Disaster Loan comparisons](https://www.msn.com/en-us/money/smallbusiness/ppp-loans-vs-eidl-which-is-right-for-your-small-business/ar-BB12ljg8) (<https://www.msn.com/en-us/money/smallbusiness/ppp-loans-vs-eidl-which-is-right-for-your-small-business/ar-BB12ljg8>)

Paycheck Protection Program

- [Treasury: PPP Fact Sheet](https://home.treasury.gov/system/files/136/PPP--Fact-Sheet.pdf) (<https://home.treasury.gov/system/files/136/PPP--Fact-Sheet.pdf>)

The Accelerated and Advance Payment Program

- Financial hardship relief for Medicare providers during the COVID-19 pandemic.
- [CMS: Accelerated and Advance Payment Fact Sheet](https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf) (<https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf>)
- [NF providers must apply via their Medicare Administrative Contractor \(MAC\). For most MN NF providers the MAC is National Government Services: Accelerated Payments information](https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/job-aids-manuals/advance%20payments%20to%20providers%20of%20part%20b%20services/!ut/p/z1/1VTbcpswEP2V5AMYSQiQeJS5GRODsUspvHhkUDxqbexxsD35-4pJpnFNY5ppXqoHGMHZs3vOrgRK8A2UDT_JNW_lruEbtS9Ka2mw0EPIgVFCxxCyyGUGiWns) (https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/job-aids-manuals/advance%20payments%20to%20providers%20of%20part%20b%20services/!ut/p/z1/1VTbcpswEP2V5AMYSQiQeJS5GRODsUspvHhkUDxqbexxsD35-4pJpnFNY5ppXqoHGMHZs3vOrgRK8A2UDT_JNW_lruEbtS9Ka2mw0EPIgVFCxxCyyGUGiWns)

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Employee Retention Credit

- The refundable tax credit is 50% of up to \$10,000 in wages paid by an eligible employer whose business has been financially impacted by COVID-19.
- More information available online: [IRS: Employee Retention Credit available for many businesses financially impacted by COVID-19 | Internal Revenue Service](https://www.irs.gov/newsroom/irs-employee-retention-credit-available-for-many-businesses-financially-impacted-by-covid-19) (<https://www.irs.gov/newsroom/irs-employee-retention-credit-available-for-many-businesses-financially-impacted-by-covid-19>)

DHS COVID-19 Communicative Technology Grants for Virtual Social and Telehealth Visits

- Medicaid-certified nursing facilities are eligible to receive up to \$3,000 in Civil Money Penalty (CMP) funds to purchase communication technology. This technology is intended to enable residents to conduct “virtual” visits with family and friends and to participate in telehealth visits. This program was initiated in response to the restrictions placed on visitors to nursing homes, in order to prevent the spread of COVID-19.
- These funds may be used by nursing facilities to purchase tablets, iPads, and similar devices, as well as some types of accessories.
- Additional information about the grant is available in the [Frequently Asked Questions document \(PDF\) \(https://mn.gov/dhs/assets/COVID-19-Application-FAQ-final-508_20200416_tcm1053-430718.pdf\)](https://mn.gov/dhs/assets/COVID-19-Application-FAQ-final-508_20200416_tcm1053-430718.pdf) prepared by CMS and the [Minnesota-Specific Instructions \(PDF\) \(https://mn.gov/dhs/assets/Minnesota-specific-addendum_tcm1053-430883.pdf\)](https://mn.gov/dhs/assets/Minnesota-specific-addendum_tcm1053-430883.pdf).
- Qualified Minnesota nursing facilities that are interested in participating in this grant opportunity are asked to read the Minnesota-Specific Instructions and submit a completed [CMP COVID-19 Communicative Technology Application \(PDF\) \(https://mn.gov/dhs/assets/UPDATED-COVID-19-Application-template-final-508_20200428_tcm1053-430719.pdf\)](https://mn.gov/dhs/assets/UPDATED-COVID-19-Application-template-final-508_20200428_tcm1053-430719.pdf) via email to DHS at: [DHS.NFRP.CostReport@state.mn.us \(mailto:munna.yasiri@state.mn.us\)](mailto:DHS.NFRP.CostReport@state.mn.us).
- Applications will be reviewed to verify that they are complete and requests fall within the parameters established by CMS. Successful applicants will receive an approval letter from DHS with further instructions.

- [Information on this funding opportunity and how to apply is online \(https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/nursing-homes/\)](https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/nursing-homes/):
 - On the page, go to “Initiatives,” then click to expand the link entitled “Civil Monetary Penalty (CMP) Initiatives” to view the posting. The listing is mid-page, once you expand the link.
 - For technical assistance with your application, or questions regarding this funding opportunity or the MN CMP Program, please [contact DHS staff liaison \(mailto:munna.yasiri@state.mn.us\)](mailto:munna.yasiri@state.mn.us).

Part II: Responding to COVID-19 Cases in Long-term Care Facilities

Use a line list to track residents with COVID-19

A “line list” should be developed to keep track of the names, facility location, and health status of all residents with signs or symptoms consistent with COVID-19. A template line list is provided in Appendix F.

Appendix F: Template Line List for Residents with Signs and Symptoms of COVID-19

Assess current and anticipated supply of PPE

When supplies are critically low (0-3 days left), complete a PPE Request Form, which facilities can access through their HCC.

- In completing this form, there is no guarantee your request will be filled. Requests will go through a needs prioritization process. A facility can request PPE again if needed.
- State and federal assets are not a long-term solution. Facilities that do not implement conservation strategies, or cannot substantiate high burn rates, may not be eligible for resupply.
- Facilities should continue to work with their PPE vendors to obtain PPE.

Continue to optimize use of PPE in the facility. Although additional PPE might be available, it will be important to conserve as able.

Assess staffing availability

Think about staffing availability, both internal and external, as soon as possible. Once COVID-19 arrives in a facility, several factors might impact staff availability, including:

- Exclusion of ill staff members, with suspected COVID-19 or other clinical illnesses. No staff should work while sick.
- Exclusion of staff with confirmed COVID-19, regardless of whether they have signs or symptoms of illness. If all staff are tested, some may test positive. Even if they are not sick, they must stay out of work for a minimum of 10 days.

- Some staff might be asked by MDH to stay out of work after experiencing unprotected exposure to a resident or coworker with confirmed COVID-19 disease. This work exclusion might last as long as 14 days after the staff member's last contact with the positive person.
- Staff with a household contact or intimate partner who is COVID-19 positive will be asked by MDH to stay out of work.
- Staff that work at multiple facilities may be asked by MDH to stay out of work because of an unprotected exposure at another work location.
- A cycle of fear and miscommunication can occur among people working in LTC. This may contribute to staff absenteeism among staff not exposed to COVID-19, and those who should continue to work after experiencing low-risk exposures to residents or coworkers with COVID-19.

Use the contact sheet in Appendix C to make local staffing contacts.

Appendix C: Planning Worksheet for Staffing Shortages in Long-term Care

Prevent spread of COVID-19 in your facility

Residents with respiratory symptoms in a LTC facility should be restricted to their rooms, regardless of the COVID-19 transmission status of an individual LTC facility or its surrounding community.

If a resident needs to leave their room, an alternative facemask should be used if tolerated.

Cancel all group activities, and enforce social distancing of at least six feet among residents at all times.

No residents with signs or symptoms of a respiratory infection, or with confirmed diagnosis of COVID-19 (regardless of symptoms) may eat in dining rooms. LTC facilities should adhere to social distancing, such as being seated at separate tables at least six feet apart.

Staff should perform hand hygiene before and after all resident contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.

- Use alcohol-based hand rub (60-95% alcohol) or wash hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water.
- Ensure that hand hygiene supplies are readily available to all staff in every care location.

Health care workers should wear all recommended PPE (gown, facemask, eye protection, gloves) for resident care, regardless of the presence of symptoms, in facilities with COVID-19 case, as PPE supplies allow. PPE should be prioritized for use by staff working with COVID-19-positive residents and for staff providing other direct resident care.

All staff should wear a mask at all times when in the facility and practice strict hand hygiene. Medical-grade facemasks should be prioritized for direct care personnel, if they are in short supply.

- LTC residents might not show symptoms of illness, so this PPE approach protects staff from infectious people that do not appear ill.

Ensure use of eye protection (e.g., face shield, goggles, safety glasses with side shields) during all resident care encounters as a way to reduce COVID-19 exposure risk to staff. Eye protection is recommended for all routine long-term care encounters when PPE supplies allow. Use of appropriate PPE can reduce staff exposures that might lead to exclusion from work.

Conduct end-of-shift assessments to identify PPE breaches and potential concerning exposures of staff to residents with COVID-19. A PPE breach log is shown in Appendix G.

Clean and disinfect frequently touched surfaces with EPA-registered disinfectant with a label indicating effectiveness against human coronavirus or emerging viral pathogens. High-touch surfaces include but are not limited to door handles, railings, light switches, remotes, phones, call buttons, medical equipment (lifts, thermometers, pulse oximeter), etc. All products listed on [EPA: List N: Disinfectants for Use against SARS-CoV-2 \(https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2\)](https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2) meet EPA's criteria for use against SARS-CoV-2, the virus that causes COVID-19.

Appendix B: PPE Posters

Appendix G: PPE Breach Log

Review and audit IPC practices, including hand hygiene

Review COVID-19-specific IPC training for staff, including PPE. Audit practices using the sample tool in Appendix D.

Contact MDH with questions and for assistance with IPC measures.

If you need infection prevention and control assistance, [MDH: Infection Control Assessment and Response Program \(ICAR\)](https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/icar/index.html) (<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/icar/index.html>) website has resources and contact information.

Appendix B: PPE Posters

Appendix D: Hand Hygiene & PPE Compliance Observations

Care for COVID-19 residents, and implement the cohort plan

Because LTC facilities are not just a place to receive health care, but also a home, moving residents to a new room is neither easy nor trivial. Plans to cohort, or group, residents should be carefully established in advance (see above), before testing results are received, and they should be centered on implementation of robust IPC practices.

Confirmed COVID-19 residents

Residents with COVID-19 should be placed in a single-person room with private bathroom, with the door closed for those who are symptomatic. If applicable, implement your cohorting plan to use a dedicated space, with dedicated staff, for COVID-19-positive residents. All residents

positive for COVID-19 (symptomatic and asymptomatic) should be restricted to their room in LTC facilities, except for medically necessary purposes. If it is essential to leave their room, residents should:

- Wear an alternative facemask
- Perform hand hygiene, and
- Practice social distancing (≥ 6 feet from others).

Staff who enter the room of a resident with known or suspected COVID-19 should adhere to Standard Precautions and use a facemask, gown, gloves, and eye protection as PPE supply allows. Approaches to optimize PPE should be put into place. Monitor ill residents (including documentation of temperature and pulse oximetry results) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.

Dedicated medical equipment should be used when caring for residents with known or suspected COVID-19. All nondedicated, nondisposable medical equipment should be cleaned and disinfected according to manufacturer's instructions and facility policies. Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.

Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures, but there should be a plan in place to limit the number of personnel entering the unit or rooms with COVID-19-positive residents.

Observation unit

Close off an observation unit to care for residents who are new admissions or who have been readmitted from an acute care setting. Actively screen these residents daily for fever and respiratory symptoms (i.e., cough, sore throat, shortness of breath), and have a low threshold for testing. All recommended PPE (facemask, eye protection, gown, and gloves) should be worn during care of residents under observation, if PPE supply allows. At a minimum, a facemask and eye protection should be worn.

Discontinue Transmission-based Precautions when appropriate

Depending on the ability of a facility to group COVID-19-positive and -suspected residents in an area separate from the rest of the population, it might be possible to discontinue Transmission-based Precautions for some residents with suspected and confirmed COVID-19.

Test-based strategy

If testing capacity allows, RT-PCR swab testing can guide discontinuation of Transmission-based Precautions when there is:

- Resolution of fever without the use of fever-reducing medications, AND
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), AND
- Negative results from at least two consecutive nasopharyngeal or nasal swab specimens collected ≥ 24 hours apart (total of two negative specimens).

Prolonged detection of RNA by RT-PCR can occur without presence of live virus. For this reason, additional symptom- and time-based strategies can be used to guide discontinuation of Transmission-based Precautions.

Symptom- and time-based strategies

Immune-competent individuals with symptomatic confirmed or suspect COVID-19 should remain in Transmission-based Precautions until:

- At least 10 days have passed since symptom onset, AND
- 3 days have passed since recovery, defined as fever resolution without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).

Immune-competent individuals with confirmed COVID-19 who are asymptomatic at the time of testing and remain asymptomatic during follow up, should remain in Transmission-based Precautions until at least 10 days have passed since the date of positive test.

Residents 75 years of age and older, or those with persistent symptoms, should remain in Transmission-based Precautions until:

- At least 14 days have passed since symptom onset, AND
- 3 days have passed since recovery, defined as fever resolution without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).

Residents with immunocompromising conditions (e.g., medical treatment with immunosuppressive drugs, bone marrow or solid organ transplant recipients, inherited immunodeficiency, poorly controlled HIV), should stay in Transmission-based Precautions until:

- At least 21 days have passed since symptom onset, AND
- 3 days have passed since recovery, defined as fever resolution without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).

More information can be found from [MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions](https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf>).

Conduct staff risk assessment and monitoring

MDH and health care facilities are cooperating to identify and manage staff with workplace exposure to people with confirmed COVID-19 disease. This approach calls for timely identification of these persons who have contact with a coworker, patient, or long-term care resident beginning 48 hours before onset of symptoms. Then, a structured risk assessment is conducted, with individual employees receiving recommendations for health monitoring, voluntary quarantine, and social distancing, as relevant. In addition to the information below, you can find out more from [MDH: Responding to and Monitoring COVID-19 Exposures in Health Care Settings](https://www.health.state.mn.us/diseases/coronavirus/hcp/response.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/response.pdf>).

Identify at-risk staff

Make a list of staff that had an unprotected exposure (e.g., not wearing all appropriate PPE, experienced a PPE breach) with a person (resident or coworker) that tested positive for COVID-

19. This should include people involved in direct care, food service, house cleaning, and other activities.

- The list should include all staff that interacted with the positive person from 48 hours before symptoms started until one of the following conditions is met:
 - Positive resident: All necessary PPE (i.e., Transmission-based Precautions) is put in place for the positive resident, OR the resident was transferred out of the facility
 - Positive coworker: The last day that the COVID-19 positive staff member came to work
- In other words, the exposure risk period starts 48 hours before the resident developed symptoms and ends on the date that risk of COVID-19 transmission was eliminated.

Conduct staff risk assessment

After getting a list of potentially exposed staff, work with MDH to complete the following steps:

- Conduct an initial risk assessment for everyone on the list of staff members who interacted with the positive resident or coworker. A sample risk assessment sheet is provided in Appendix H.
- Send to MDH (by encrypted email) the names and phone numbers of employees (HCW and other staff members) identified to have had medium- or high-level risk. Include the name of the person (staff or resident) with confirmed COVID-19 and the facility name on the employee list.
- Tell staff that MDH will contact those with medium- and high-risk exposures with recommendations to stay out of work and for health monitoring.

Sheets detailing these expectations can be found on the MDH website. [MDH: Risk Assessment and Public Health Management of Health Care Personnel with Potential Exposure to Residents with COVID-19 in Long-term Care, Nursing Home, and Assisted Living Settings \(PDF\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/lcassess.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/lcassess.pdf>)

Alert staff about work-related recommendations

MDH will contact staff with medium- and high-risk exposures to provide recommendations to stay out of work and for health monitoring. You can also communicate the work-related recommendations, based on your risk assessment.

No identifiable risk of exposure: These employees should continue working and should participate in their facility's routine process for health screening.

Low-risk exposure: These employees should continue working and should conduct twice daily self-monitoring of health, including temperature checks.

Medium-risk exposure: These employees should undergo voluntary quarantine and stay out of work for 14 days after the last exposure to a person with COVID-19 while not wearing all necessary PPE. They will receive daily emails from MDH for active health monitoring and will receive an email when voluntary quarantine is released (i.e., 14 days after the last unprotected exposure). These employees can be asked to return to work if they are not sick (no fever or symptoms of illness) and the facility has exhausted all other staffing options.

High-risk exposure: These employees should undergo voluntary quarantine and stay out of work for 14 days after the last exposure to a person with COVID-19 while not wearing all necessary protective equipment. They will receive daily emails from MDH for active health monitoring and will receive an email when voluntary quarantine is released (i.e., 14 days after the last unprotected exposure). These employees can be asked to return to work if they are not sick (no fever or symptoms of illness) and the facility has exhausted all other staffing options, but the State of Minnesota provides worker protections for this group of people during the voluntary quarantine period (Minnesota Statutes section 144.4196).

If an employee chooses to work during the 14-day voluntary quarantine period, they must wear a medical-grade facemask at all times when providing resident care and at all times when within six feet of any other person. **No employees may work while ill.**

Appendix H: Sample Risk Assessment for Health Care Workers Potentially Exposed to COVID-19 in Minnesota

Appendix I: Response Checklist for Long-term Care Facilities

Facilitate post-mortem testing

If a resident passes away in your facility, MDH recommends testing for COVID-19 if there are any confirmed cases in your facility or if the death is not clearly associated with another cause(s). A nasal pharyngeal (NP) swab should be collected from the deceased individual for testing prior to sending the body to the funeral home or medical examiner's office.

Facilities with cases of COVID-19

- If the deceased resident was not diagnosed with COVID-19 from a laboratory confirmed test at the time of death, a NP swab should be collected post-mortem.
- If the deceased resident has a known laboratory-confirmed COVID-19 positive test at the time of death or a swab is pending test results, no additional steps need be taken.

Facilities with no known cases of COVID-19

- If the resident had signs or symptoms of illness prior to death, an NP swab needs to be collected for COVID-19 testing prior to sending the body to the funeral home or medical examiner's office.
- If the deceased resident did not have signs or symptoms of illness prior to death, an NP swab can be collected for COVID-19 testing, but is not necessary. Facilities can choose to conduct testing of deceased residents in an effort to identify unknown presence of SARS-CoV-2 in the facility.

The specimen can be sent to MDH for COVID-19 testing free of charge. Please see

[MDH: Evaluating and Testing for Coronavirus Disease 2019 \(COVID-19\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/eval.html)

(<https://www.health.state.mn.us/diseases/coronavirus/hcp/eval.html>)

for appropriate forms and submission guidance, and call MDH (1-877-676-5414) to report the death and suspicion of COVID-19.

Use a checklist

A response checklist is provided in Appendix H. Checklists are useful to ensure that nothing is left undone. They are also helpful to guide conversations with consulting providers, public health, and infection prevention professionals.

Additionally, CDC has a checklist available: [CDC: Nursing Home Preparedness Checklist COVID-19 \(https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-nursing-homes-preparedness-checklist-3-13.pdf\)](https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-nursing-homes-preparedness-checklist-3-13.pdf).

Part III: Ideas to Inspire

Hold a COVID-19 preparedness exercise

Host a planning and training session called, “A Day in our COVID-19 Life” to get your entire team thinking about how roles, expectations, and realities would change if a COVID-19-positive resident(s) is identified. If your facility is already caring for residents with COVID-19, this might still be a useful exercise to improve the functioning of your team. Knowledge and well-defined expectations can make staff more confident in providing resident care and adhering to facility procedures.

When planning a preparedness exercise for your facility, consider the following:

- **Include all staff.** Everyone’s role will change when COVID-19 is detected, so it is important to engage all staff. Infection prevention and occupational health leaders should help to plan the exercise. Make sure that nurses, nurse assistants, and others that provide direct resident care are present, as well as staff responsible for cleaning and disinfection, waste removal, and facilities management (e.g., airflow, entry and exit ways), and nutrition. Include administrators and facility leadership. Consider inviting rounding providers and/or infectious disease consultants, to assure that your facility’s plan reflects the concepts of monitoring, triage, and transport.
- **Set up a model COVID-19 room.** This will help staff to visualize how best practices will be incorporated into your specific facility setting, and how the role of staff might change. Include all signage and materials needed to set up Transmission-based Precautions. Give hands-on training on appropriate use of PPE, including practice putting on (donning) and taking off (doffing) of gown, mask, eye protection, and gloves.
- **Work through a COVID-19-positive resident’s day.** Consider routine COVID-19 scenarios like resident care, room cleaning, waste removal, dietary needs, and transport of residents for external medical care, like dialysis. Also consider more rare scenarios that will require a planned approach and clear staff expectations to care for COVID-19 residents (e.g., CPR).
- **Identify teams.** Not every member of a staffing community will be able or comfortable doing all tasks. In addition, it is important to limit the number of staff that come into contact with COVID-19-positive residents and the amount of PPE that is used. In general, only essential staff should enter the room of residents with COVID-19. Work together to ensure that essential tasks are completed with the least risk to staff. For example, consider how meals will be delivered, waste removed, and high-touch surface cleaning be done while exposing the fewest staff possible.

- **Review the chain of command.** Make clear who staff should go to with concerns or with requests and to report materials shortages or changes in medical condition.
- **Make clinical plans.** Ahead of the preparedness session, work with rounding providers and local referral hospitals to establish triage and testing criteria and to ensure contact information is available for consultation around the clock.

Empowering LTC staff with knowledge and training

In one Minnesota LTC facility, after some staff expressed understandable fear and uncertainty around caring for COVID-19 positive residents, a group of nursing leaders took on the title “COVID Crew.” This team committed to making sure that they had the information and skill needed to keep themselves and their residents safe.

The COVID Crew took time to make sure that other staff were well-trained in PPE donning and doffing practice and received reminders about hand hygiene, mask use, and social distancing. This team also saw an opportunity to help when staffing challenges emerged in sister facilities.

Empowered by leadership recognition, knowledge, training, and practice, members of the COVID Crew took on COVID-19-positive resident care in other facilities newly experiencing outbreaks, training the existing staff so that they could feel confident as well.

Leaders: Consider these five things that you can do right now

- **Set up a Town Hall with your staff.** Be clear and honest, and listen to concerns. Downplaying COVID-19 cases and deaths would be disingenuous, could undermine your credibility, and could be perceived as your “not hearing” or being out of touch with staff concerns. There is undeniable risk when staff are in direct contact with a resident that has COVID-19. Focus on ways to best protect the staff during this interaction. Also use this time to highlight areas (e.g., social distancing, hand hygiene) that need work. Remind staff of situations where they have had successes in the past. For example, discuss a considerably difficult influenza season or a situation where you needed to prevent transmission of a multidrug-resistant organism in the facility. Highlighting successes might help to empower staff and reduce anxieties.
- **Walk the floors weekly to boost morale and show support.** Leaders, including the CEO and Medical Director, can be present, walk the floors, recognize challenges, and acknowledge the hard work of the staff. If staff are expected to work on-site when residents are ill with COVID-19, leadership can show solidarity by doing the same.
- **Model desired behaviors from the top down.** Have a head nurse demonstrate how to safely and effectively don and doff PPE, answer questions, and provide hands-on training. That same leader should provide weekly supportive oversight to ensure PPE are being used correctly.
- **Establish a buddy system.** The buddy system can be used to ensure PPE and hand hygiene are used correctly and to lend an ear during these difficult times. Physical safety as well as mental health and well-being are essential at this time.
- **Show your staff appreciation and regard for their well-being.** Send regular email updates, highlighting both challenges and successes. Treat staff with food, snacks, or care packages

(e.g., hand lotion, laundry pods, dryer sheets). Provide access to telehealth sessions with licensed therapists.

Help residents and families remain connected

- Implement virtual office hours when families can call in and staff can share the status of activities or happenings in the facility.
- Update your facility's website to share the status of the facility and include information that helps families know what is happening in their loved one's environment, such as food menus and activities residents can do while still social distancing, such as crafts, painting, etc.
- Perform assistive messaging: Staff reading emails from the family to the resident, helping residents send letters, emails or text messages with photos to their family, helping residents talk on the phone or video chat with family.
- Encourage families and residents to suggest ideas that can help keep residents connected to friends and loved ones.

Resources

MDH: COVID-19 Case Report Form

(<https://www.health.state.mn.us/diseases/coronavirus/hcp/covidreportform.pdf>)

MDH: Evaluating and Testing for Coronavirus Disease 2019 (COVID-19)

(<https://www.health.state.mn.us/diseases/coronavirus/hcp/eval.html>)

CDC: Testing for Coronavirus (COVID-19) in Nursing Homes

(<https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>)

CMS: Appendix Z—Emergency Preparedness for All Provider and Certified Supplier Types

Interpretive Guidance (<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Appendix-Z-EP-SOM-February-2019.pdf>)

MDH: COVID-19 Action Plan for Congregate Settings

(<https://www.health.state.mn.us/diseases/coronavirus/hcp/icpaction.pdf>)

MDH Infection Control Assessment and Response Program (ICAR)

(<https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/icar/index.html>)

CDC: Using Personal Protective Equipment (PPE) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>)

MDH: Enhanced Respiratory Precautions Essential Personnel Only - Keep Door Closed

(<https://www.health.state.mn.us/diseases/coronavirus/hcp/ppepresign.pdf>)

MDH: Health Care Coalitions

(<https://www.health.state.mn.us/communities/ep/coalitions/index.html>)

MDH: Strategies for Optimizing the Supply of Personal Protective Equipment

(<https://www.health.state.mn.us/diseases/coronavirus/hcp/optimizingppe.pdf>)

MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions
(<https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf>)

MDH: Risk Assessment and Public Health Management of Health Care Personnel with Potential Exposure to Residents with COVID-19 in Long-term Care, Nursing Home, and Assisted Living Settings
(PDF)(<https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcassess.pdf>)

EPA: List N: Disinfectants for Use Against SARS-CoV-2 (<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>)

CMS: 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios
(<https://www.cms.gov/files/document/qso-20-25-nh.pdf>)

CDC: Nursing Home and Long Term Care facility Checklist
(<https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html>)

DHS: online recording COVID-19 expedited reimbursement webinar for NF providers
(https://www.youtube.com/watch?v=OO_fHyNUTJk)

DHS: click on COVID Form A-Z
(<https://nfportal.dhs.state.mn.us/PortalLogin.aspx?ReturnUrl=%2f>)

MDH: Health Care Response Grant application form
(<https://www.health.state.mn.us/facilities/ruralhealth/funding/grants/covidlong.html>)

Fema: Public Assistance Policy and Guidance (<https://www.fema.gov/public-assistance-policy-and-guidance>)

HHS: Cares Act Provider Relief Fund FAQs
(<https://www.hhs.gov/sites/default/files/20200425-general-distribution-portal-faqs.pdf>)

HHS: Provider Relief Fund (<https://www.hhs.gov/coronavirus/cares-act-provider-relief-fund/index.html>)

Economic Injury Disaster Loan comparisons (<https://www.msn.com/en-us/money/smallbusiness/ppp-loans-vs-eidl-which-is-right-for-your-small-business/ar-BB12ljg8>)

Treasury PPP Fact Sheet (<https://home.treasury.gov/system/files/136/PPP--Fact-Sheet.pdf>)

CMS: Accelerated and Advance Payment Fact Sheet (<https://www.cms.gov/newsroom/press-releases/cms-reevaluates-accelerated-payment-program-and-suspends-advance-payment-program>)

MDH: Disaster Mental/Behavioral Health
(<https://www.health.state.mn.us/communities/ep/behavioral/covid19.html>)

CDC: Environmental Infection Control (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#infection_control)

MDH: Food Safety During an Emergency

(<https://www.health.state.mn.us/people/foodsafety/emergency/covid.html>)

World Health Organization: Oxygen Supply Document (<https://www.who.int/publications-detail/oxygen-sources-and-distribution-for-covid-19-treatment-centres>)

MDH: Resources to Find Low-Cost Health Care and Insurance

(<https://www.health.state.mn.us/diseases/coronavirus/materials/lowcost.html>)

CMS: Longterm Care Telemedicine Telehealth Toolkit

(<https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf>)

CDC: Nursing Home Preparedness Checklist COVID-19

(https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf)

CDC: COVID-19 Preparedness Checklist ([https://www.cdc.gov/coronavirus/2019-](https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf)

[ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf](https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf))

MDH: Personal Protective Equipment Crisis Standards of Care for Long Term Care, Skilled Nursing Facilities, Assisted Living, and Other Non-Acute Care Facilities for COVID-19 (PDF)

(<https://www.health.state.mn.us/communities/ep/surge/crisis/ppe.pdf>)

CDC: FAQ on Infection Control (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html>)

CDC: Infection Control Guidance #4 ([https://www.cdc.gov/coronavirus/2019-](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)

[ncov/hcp/infection-control-recommendations.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html))

CDC: Cleaning and Disinfection for Community Facilities

(<https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html>)

MDH: Crisis Standards of Care

(<https://www.health.state.mn.us/communities/ep/surge/crisis/index.html>)

CMS: Covid Partner Toolkit (<https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit>)

Information was sent to all MN Medicaid enrolled nursing facility providers in March 25 and March 31 emails.

Online recording of DHS COVID-19 expedited reimbursement webinar for NF providers:

(https://www.youtube.com/watch?v=OO_fHyNUTJk)

Application (COVID Form A-EZ) to request reimbursement and COVID FAQ document:

<https://nfportal.dhs.state.mn.us/PortalLogin.aspx?ReturnUrl=%2f>

Questions after reviewing the March emails, COVID FAQ document, Form A-EZ instructions and the YouTube webinar? Email <mailto:DHS.NFRP.CostReport@state.mn.us>

Appendix A: Staff Health Screening Log

This log should be completed every day through an active process. An educated staff member, with leadership oversight, should be identified to engage directly every day when staff arrive to complete this health screening form.

Date	Staff Name	Respiratory symptoms including fever, cough with shortness of breath Or 2 of these symptoms: Fever (temp ≥100°F or feeling feverish), sore throat, muscle pain, headache, chills, new loss of taste or smell. Confirmation that staff has NO:	Initials of Screener
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	
		☐ No fever, respiratory or other COVID symptoms	

Appendix B: PPE Posters

CDC: PPE Guidance

(https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf)

Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19

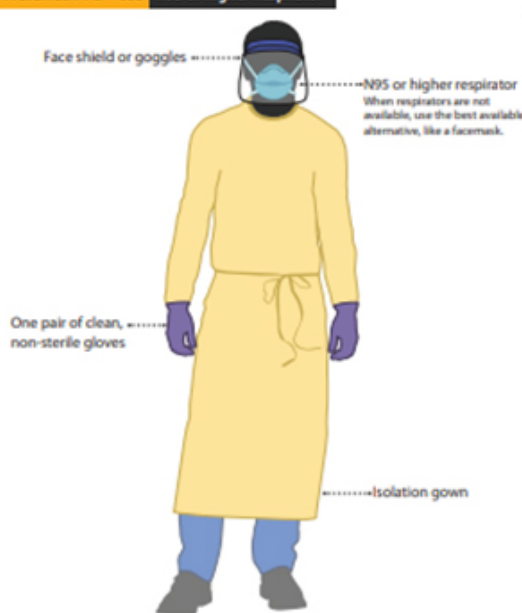
Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

- **Receive comprehensive training** on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- **Demonstrate competency** in performing appropriate infection control practices and procedures.

Remember:

- PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).
- PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.

Preferred PPE – Use N95 or Higher Respirator



Face shield or goggles

N95 or higher respirator
When respirators are not available, use the best available alternative, like a facemask.

One pair of clean, non-sterile gloves

Isolation gown

Acceptable Alternative PPE – Use Facemask



Face shield or goggles

Facemask
N95 or higher respirators are preferred but facemasks are an acceptable alternative.

One pair of clean, non-sterile gloves

Isolation gown



CS 176124-A 01/30/2020

www.cdc.gov/coronavirus

Donning (putting on the gear):

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.

1. **Identify and gather the proper PPE to don.** Ensure choice of gown size is correct (based on training).
2. **Perform hand hygiene using hand sanitizer.**
3. **Put on isolation gown.** Tie all of the ties on the gown. Assistance may be needed by another HCP.
4. **Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).** If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.*
 - » **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
 - » **Facemask:** Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. **Put on face shield or goggles.** Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. **Perform hand hygiene before putting on gloves.** Gloves should cover the cuff (wrist) of gown.
7. **HCP may now enter patient room.**

Doffing (taking off the gear):

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing.

1. **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. **Remove gown.** Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.*
3. **HCP may now exit patient room.**
4. **Perform hand hygiene.**
5. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. **Remove and discard respirator (or facemask if used instead of respirator).*** Do not touch the front of the respirator or facemask.
 - » **Respirator:** Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
 - » **Facemask:** Carefully untie (or unhook from the ears) and pull away from face without touching the front.
7. **Perform hand hygiene after removing the respirator/facemask** and before putting it on again if your workplace is practicing reuse.

*Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices.

Appendix C: Long-term Care Emergency Staffing Progression

Guidelines

The following steps indicate the progression that an organization should follow when normal means of filling shifts (bonuses, leadership assisting with direct care, 12-hour shifts vs. 8-hour shifts, hazard pay, etc.) are not sufficient:

1. Call back quarantined staff—provided they have PPE, have not tested positive, and do not have symptoms.
2. Reach out to related facilities or partners for staffing support. This should include sister facilities and hospital partners.
 - Work with organizational leadership to develop policies that are focused not only on infection control but also on staffing safety (e.g., facility staff may need to work in COVID-negative and COVID-positive buildings with appropriate PPE and donning/doffing procedures to ensure resident safety is maintained during staffing crises).
3. Contact supplemental nurse staffing agencies (SNSA) for assistance. Sign a contract with at least one, preferably more than one.
 - Ask what the ability is for these agencies to provide last-minute coverage. Check on how this availability changes during the crisis.
 - Consult this SNSA list on the [MDH Health Care Provider Directory](https://www.health.state.mn.us/facilities/regulation/directory/providerselect.html) <https://www.health.state.mn.us/facilities/regulation/directory/providerselect.html>
4. Contact your local Public Health for assistance.
5. Reach out to organizations with which you have entered into a Memorandum of Understanding (MOU) as part of your emergency preparedness planning.
6. Engage your trade association to assist in procuring staff [at LeadingAge of MN \(www.leadingagemn.org\)](http://www.leadingagemn.org) or [Care Providers of MN \(www.careproviders.org\)](http://www.careproviders.org).
7. Contact your Regional Health Care Preparedness Coordinator (RHPC) for assistance.
 - [RHPC \(https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html\)](https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html)
8. If you have a staffing need that is 48 hours or less, contact the Statewide Healthcare Coordination Center (SHCC) Minnesota Healthcare Resource Call Center (MHRCC) at 1-833-454-0149 (toll free) or 651-201-3970 (local).
 - When you call, please have specific information about your open shifts vs. filled shifts for clinical positions (RN, LPN, NA) for the next 48 hours at crisis levels.
 - Staffing agents will attempt to match your request with available clinical staff.
9. See how your county's Medical Reserve Corps (MRC) can assist. Contact the MRC Coordinator at the county with a specific request.
10. Explore

11. IF ALL OF THE ABOVE HAVE BEEN EXHAUSTED, THEN CALL THE SHCC Minnesota Healthcare Resource Call Center (MHRCC) at 1-833-454-0149 (toll free) or 651-201-3970 (local) for Crisis Management.

Planning Worksheet for Staffing Shortages in Long-term Care

Internal Staffing Options

1. Call back quarantine staff provided they have PPE, have not tested positive, and do not have symptoms.

Contacts:

Notes:

Reach out to related facilities (i.e., same company)

Communicate with related facilities to address staffing needs and options to request additional staffing.

Contacts:

Notes:

Contact Staffing Agencies- SNSA

Make inquiries of SNSA regarding available nursing staff.

Contacts:

Notes:

Contact local public health agency

Contacts:

Notes:

Reach out to organizations you have an MOU with per your Emergency Plan

Contacts:

Notes:

Engage your trade association

[Care Providers of MN \(www.careproviders.org\)](http://www.careproviders.org)

[LeadingAge of MN \(www.leadingagemn.org\)](http://www.leadingagemn.org)

Contacts:

Notes:

Contact your Regional health Care Preparedness Coordinator (RHPC):

[RHPC \(https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html\)](https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html)

Notes:

Contact the Statewide Healthcare Coordination Center/ Minnesota Healthcare Resource Call Center

If you have a staffing need that is 48 hours or less in the future, contact the Statewide Healthcare Coordination Center (SHCC) Minnesota Healthcare Resource Call Center (MHRCC) at 1-833-454-0149 (toll free) or 651-201-3970 (local).

- When you call, please have specific information about your open shifts vs. filled shifts for clinical positions (RN, LPN, NA) for the next 48 hours at crisis levels.
- Staffing agents will attempt to match your request with available clinical staff.

Notes:

Contact County's Medical Reserve Corps

Notes:

Contact Local/County Emergency Management Options

Notes:

Contact the SHCC MHRCC

If you are unsuccessful with all of the options above, utilize the SHCC Minnesota Healthcare Resource Call Center (MHRCC) at 1-833-454-0149 (toll free) or 651-201-3970 (local) for Crisis Management.

Appendix D: Hand Hygiene and PPE Compliance Observations

1. When to count hand hygiene opportunities:
 - a. Upon entry and exit of the room.
 - b. In the room after removal of gloves.
2. Staff may use alcohol hand rub or wash hands at the sink.
3. Do not guess. If your view is blocked and you cannot confirm hand hygiene, do not count.
4. Do not exceed 2 observations per staff.

Unit: _____

Date: ____/____/____

Time: _____

Observer Name: _____

HH = Hand Hygiene Compliance**PPE** = Personal Protective Equipment Compliance

Role Other: 1=unknown, 2=phlebotomy, 3=social work, 4=transport, 5=respiratory, 6=PT/OT, 7=Dietary, 8=Clergy, 9=Visitor/Family, 10=Radiology, 11=Volunteers

Observations	Role: Nurse (RN, LPN, NA, MA, student)	Role: Provider (MN, PA, NP, student)	Role: Environmental Services	Role: Other (see above)	HH Yes	HH No	Comments	PPE Yes	PPE No
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									

Adapted from Hand Hygiene Program Johns Hopkins

_____ % of Hand Hygiene Compliance

_____ % of PPE Compliance

Appendix E: Active Resident Monitoring for COVID-19 Symptoms

Monitoring for Resident COVID-19 Symptoms

Instructions: Use this sheet for fever and symptom screening. To see trends in illness, tally each column to fill in the weekly sheet (below).

Measures: Temp (Fever $\geq 100.0^{\circ}\text{F}$), SpO₂ (%), look for decreasing trends).

Symptom Key: F=fever, C=cough, S=short of breath, D=diarrhea, T=sore throat, M-mental status change

Unit:		Date: __/__/20 Time:			Date: __/__/20 Time:			Date: __/__/20 Time:			Date: __/__/20 Time:		
Name	Room	T	SpO ₂	Symptom	T	SpO ₂	Symptom	T	SpO ₂	Symptom	T	SpO ₂	Symptom
# symptomatic residents:													
Notes													

Weekly Monitoring for Resident COVID-19 Symptoms

Week of:	___/___/20 – ___/___/20							___/___/20 – ___/___/20							___/___/20 – ___/___/20						
Unit/Ward/Floor	M	T	W	TH	F	Sa	Su	M	T	W	TH	F	Sa	Su	M	T	W	TH	F	Sa	Su
Facility-wide total:																					

Reporting Illness to MDH

Find information about reporting on the MDH COVID-19 website. [MDH: Reporting COVID-19/SARS-CoV-2 Infections \(https://www.health.state.mn.us/diseases/coronavirus/hcp/report.html\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/report.html)

Notify MDH immediately (within 24 hours) about any of the following:

- Severe respiratory infection associated with hospitalization or sudden death of a resident.
- Clusters of ≥ 2 residents and/or staff with respiratory symptoms or with known or suspected COVID-19.
- Individual residents or staff are identified with confirmed or suspected COVID-19.
- Increase in the number of residents transferred to acute care hospitals for any cause over baseline.
An increase of EMS transfers has sometimes been the first indication of a COVID-19 outbreak in a facility.

Appendix F: Template Line List for Residents with Signs and Symptoms of COVID-19

Instructions: Use this sheet to track residents with signs and symptoms compatible with COVID-19.

Measures: Fever is $\geq 100.0^{\circ}\text{F}$.

Symptom Key: O=low SpO₂, F=fever, C=cough, S=short of breath, D=diarrhea, T=sore throat, M=mental status change, DP=droplet precautions

Resident Name	DOB	Unit	Room	Symptom Onset Date	Fever, and Main Symptoms	COVID-19 Test Date & Result	Resp. Panel Test Date & Result	Hospitalized Y/N	Died Y/N	Date DP Discontinued

Appendix G: PPE Breach Log

Conduct end-of-shift assessments to identify PPE breaches and potential concerning exposures of staff to residents with COVID-19. Be sure to ask about time spent with co-workers and other interactions that don't involve direct resident care.

Date	Staff Name	Confirmation that staff has NO PPE Breach:	Staff Signature	Initials of Screener
		☐ I wore all required PPE with no breach during my shift		
		☐ I wore all required PPE with no breach during my shift		
		☐ I wore all required PPE with no breach during my shift		
		☐ I wore all required PPE with no breach during my shift		
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Appendix H: Sample Risk Assessment for Health Care Workers Potentially Exposed to COVID-19 in Minnesota

Health care worker name: _____

Interview conducted by: _____ Date of interview: ____ / ____ / ____

1. Have you had any contact or were you present in the room with a person diagnosed with confirmed COVID-19 infection? ☐ Yes ☐ No

Describe contact:

2. Date of most recent exposure: ____ / ____ / ____

3. Did you wear the following personal protective equipment?

a. **Eye protection** ☐ Yes ☐ No

i. Goggles ☐ Yes ☐ No

ii. Face shield ☐ Yes ☐ No

iii. PAPR ☐ Yes ☐ No

b. **Respiratory protection** ☐ Yes ☐ No

i. N95 respirator ☐ Yes ☐ No

ii. Surgical facemask ☐ Yes ☐ No

iii. PAPR ☐ Yes ☐ No

c. **Gown** ☐ Yes ☐ No

d. **Gloves** ☐ Yes ☐ No

4. At any point in caring for the resident, did you have a breach in your PPE? ☐ Yes ☐ No

Describe breach in PPE:

*** If HCW wore eye protection, N95 or PAPR, gown, and gloves and there was no PPE breach.*

*Exposure is LOW RISK, skip to Question 9***

5. Was the resident wearing a facemask? ☐ Yes ☐ No

6. At any point in caring for the resident, was the resident's facemask removed? ☐ Yes ☐ No

Describe:

7. Did you have extensive body contact with the resident (e.g., turning the resident)? ☐ Yes ☐ No
8. Did you perform or were you in the room for any procedures that were likely to generate higher concentrations or respiratory secretions or aerosols (including but not limited to cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, sputum induction)? ☐ Yes ☐ No
9. *FOR INTERVIEWER:* Check all that apply and determine risk status based on answers to questions above.

A. Exposure to COVID-19 Positive-Resident

LOW RISK INCLUDES ANY OF THE FOLLOWING:

- ☐ HCP wearing all recommended PPE and adhering to all recommended infection control practices.
- ☐ HCP not using all recommended PPE only had brief interactions with a resident regardless of whether resident was wearing a facemask.
Examples of brief interactions include: brief conversations at triage desk; briefly entering a resident room but not having direct contact with the resident or the resident's secretions/excretions; or entering the resident room immediately after the resident was discharged.

If resident **was** wearing mask (medical-grade facemask or cloth/alternative mask):

- ☐ HCP wearing all recommended PPE (except a facemask instead of respirator).
- ☐ HCP wearing all recommended PPE except for gown or gloves **AND** HCP **did not** have extensive body contact with the resident (e.g., turning the resident).
- ☐ HCP wearing all recommended PPE except for eye protection.

If resident **was not** wearing a mask (medical-grade facemask or cloth/alternative mask):

- ☐ HCP wearing all recommended PPE (except wearing a facemask instead of a respirator) **AND** aerosol-generating procedures (see description above) **were not** performed while HCP was present.
- ☐ HCP wearing all recommended PPE except for gown or gloves **AND** HCP **did not** have extensive body contact with the resident (e.g., rolling the resident) **AND** aerosol-generating procedures (see description above) **were not** performed while HCP was present.

MEDIUM RISK INCLUDES ANY OF THE FOLLOWING:

If resident **was** wearing a mask (medical-grade facemask or cloth/alternative mask):

- ☐ HCP wearing all recommended PPE except for gown or gloves **AND** HCP **had** extensive body contact with the resident (e.g., turning the resident).
- ☐ HCP not wearing facemask or respirator.
- ☐ HCP not wearing any PPE.

If resident **was not** wearing a mask (medical-grade facemask or cloth/alternative mask):

- ☐ HCP wearing all recommended PPE (except wearing a facemask instead of a respirator) **AND** an aerosol-generating procedure (see description above) **was** performed while HCP was present.

- ☐ HCP wearing all recommended PPE except for gown or gloves **AND** HCP **had** extensive body contact with the resident (e.g., rolling the resident) **OR** an aerosol-generating procedure (see description above) **was** performed while HCP was present.
- ☐ HCP wearing all recommended PPE except for eye protection **AND** aerosol-generating procedures (see description above) **were not** performed while HCP was present.

HIGH RISK INCLUDES ANY OF THE FOLLOWING:

If resident **was not** wearing a mask (medical-grade facemask or cloth/alternative mask):

- ☐ HCP wearing all recommended PPE except for eye protection **AND** an aerosol-generating procedure (see description above) **was** performed while HCP was present.
- ☐ HCP wearing all recommended PPE except for a facemask or respirator.
- ☐ HCP not wearing any PPE.

B. Exposure to COVID-19 Positive-Coworker

NO IDENTIFIABLE RISK:

- ☐ Interactions with COVID-19-positive HCW that don't meet high-, medium-, or low-risk conditions, such as walking by the COVID-19-positive HCW or staying briefly (<10 minutes) in the same room.

LOW RISK INCLUDES ANY OF THE FOLLOWING:

- ☐ Present in the same indoor environment but not within 6 feet for ≥ 10 minutes.
- ☐ Close contact (<6 feet) with the COVID-19-positive HCW for prolonged period (≥ 10 minutes) while both HCW are wearing facemasks **OR** while only the positive HCW is wearing a medical-grade facemask.
- ☐ Close contact (<6 feet) with the COVID-19 positive-HCW for prolonged period (≥ 10 minutes) while both HCW are wearing alternative/cloth masks.

MEDIUM RISK INCLUDES ANY OF THE FOLLOWING:

- ☐ Close contact (<6 feet) with the COVID-19-positive HCW for prolonged period (≥ 10 minutes) while neither HCW is wearing facemask or cloth/alternative mask.
- ☐ Close contact (<6 feet) with the COVID-19-positive HCW for prolonged period (≥ 10 minutes) while positive HCW is not wearing facemask or alternative/cloth mask.
- ☐ Direct contact with infectious secretions of a COVID-19-positive person (e.g., being coughed on).

HIGH RISK INCLUDES ANY OF THE FOLLOWING:

- ☐ There are no HCW-HCW exposures considered to be high risk.

Appendix I: Response Checklist for Long-term Care Facilities

Long-term Care Facility COVID Planning Checklist

Purpose: To prepare the facility for crisis-level staffing and effectively be able to care in place if large numbers of key staff were ill or on quarantine.

Administration actions and incident command (before first COVID-positive case)

- ☐ Review your facility's incident command structure. If you do not have an incident command structure, consider developing formal teams to guide efforts such as staff support, communication, and infection control.
- ☐ Develop a quick and efficient process to communicate any changes in acceptable resident care practices to all staff.
- ☐ Assign someone to monitor regulation changes and recommend changes regarding internal facility policies and procedures.
- ☐ If not already in place, implement a nonclinical rotation of leadership on-site during off hours to address issues and audit practices.
- ☐ Develop back-up plans if the Administrator and DON were ill or quarantined at the same time. Are there in-house supports that could immediately assume the role (other licensed administrators, clinical leadership, etc.)?
- ☐ If you are part of a parent company or organization, determine who could step in as on-site leadership in case of key leadership quarantine.
- ☐ Ensure that key leadership are addressing personal risk factors such as caregiving responsibilities or childcare at home.

Administration actions and incident command (after first COVID-positive case)

- ☐ Consider on-call rotations for leadership to prevent burnout.

Infection prevention and control measures (before first COVID-positive case)

- ☐ Restrict visitation of all visitor and nonessential healthcare personnel, except for compassionate care.
- ☐ Post signs at the entrances indicating visitor restrictions are in place.
- ☐ Cancel all group activities, including external outings.
- ☐ Adjust dining service to avoid communal dining.
- ☐ Actively screen all employees and visitors before they enter the building. Actively screen means that a person should physically monitor the temperature of those entering the building and ask questions regarding other COVID-related symptoms.
- ☐ Distribute fabric masks to employees as source masking.
- ☐ Develop a process for collecting and washing fabric masks on-site.
- ☐ Actively screen residents for symptoms of COVID at least once per shift. Best practice is to use a line list to monitor trending closely.

Infection prevention and control measures (after you have informed MDH of COVID-19 case in facility)

- ☐ When a case is detected, put into place your response plan, including infection prevention and control actions.

- ☐ If you do not hear back from MDH within 24-48 hours, after informing MDH of a positive case, call MDH at 651-201-5414.
- ☐ Begin communication with MDH when they contact you.
 - ☐ For a case(s) of confirmed COVID-19 in a resident(s), first contact will be made by the MDH COVID Surveillance Team.
 - ☐ For a confirmed case in a staff member, you will first hear from the MDH Health Care Worker Monitoring Team.
- ☐ Provide MDH with needed information about the case(s) and contact(s).
 - ☐ MDH will request information about the infected resident(s) (e.g., symptom onset date, demographics) and the facility (e.g., facility type, number of beds, other symptomatic residents). This MDH team will describe the way that MDH will work with the facility over the following weeks.
 - ☐ Facility management will be asked conduct staff risk assessment and provide contact information about exposed staff members.
- ☐ Collaborate with MDH to respond and to support staff health monitoring and quarantine recommendations.
 - ☐ Participate in calls with the COVID Case Management Team, and use this as a venue to ask questions and request support for the response.
 - ☐ Work with MDH to communicate recommended voluntary quarantine, including work exclusion, for staff that experienced a medium- or high-risk exposure through 14 days after their last unprotected exposure. Use all other staffing options to fill shortages before asking these staff members to work during the voluntary quarantine.
 - ☐ MDH will provide email-based daily symptom monitoring for exposed staff members with medium- or high-risk exposures.
 - ☐ Participate in a tele-ICAR (Infection Control Assessment and Response) assessment to get tailored infection prevention and control support.

Clinical care support planning (before first COVID-positive case)

- ☐ Engage with primary care providers for all residents and ensure POLST and advanced directives are consistent with resident wishes. Ask providers to address COVID-specific risk factors and care decisions to ensure the residents wishes are followed in case of infection.
- ☐ Create a resource document for on-site staff with specific steps on what to do if a resident presents with symptoms.
- ☐ Create a resource document for clinical leadership to provide and verify direction to on-site staff if a resident develops COVID symptoms after hours.
- ☐ Plan for how to cohort residents that are returning or admitting from the hospital and for residents that develop symptoms of COVID and require precautions.
 - ☐ Confine symptomatic residents and exposed roommates to their rooms.
 - ☐ Place symptomatic residents together in one area of the facility.
 - ☐ Close units where symptomatic and asymptomatic residents reside.
 - ☐ Assign staff on either affected or nonaffected units to prevent transmission between units.
 - ☐ Clean and disinfect frequently touched surfaces with EPA-registered disinfectant with a label indicating effectiveness against human coronavirus or emerging viral pathogens.

- ☐ Review the layout for residents in shared rooms. Consider options for limiting exposure in shared spaces such as transferring roommates to private rooms when available.
- ☐ Determine pharmacies' ability to quickly deliver palliative care medication. If concerns exist about speed of delivery, coordinate with a back-up pharmacy.
- ☐ Review [MDH: Crisis Standards of Care](https://www.health.state.mn.us/communities/ep/surge/crisis/index.html) (<https://www.health.state.mn.us/communities/ep/surge/crisis/index.html>)

Clinical care support planning (after first COVID-positive case)

- ☐ Partner with hospice and home care organizations to ensure essential visits continue.
- ☐ Whenever possible, combine visits to the resident room to limit exposure and conserve PPE. For example, deliver a meal tray and administer medication in one visit to the room.
- ☐ When appropriate, adjust aerosol-generating procedures (consider inhalers rather than nebulizers).
 - ☐ Review [CDC: FAQ on Infection Control](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html>) for information on which procedures are considered aerosol-generating in healthcare settings.
 - ☐ Review [CDC: Infection Control Guidance #4](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#take_precautions) (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#take_precautions) for information on precautions to take when performing aerosol-generating procedures.
- ☐ Dedicate equipment to the COVID-positive unit, including mechanical lifts, vital signs machines, med carts, etc.

Staffing contingencies (before first COVID-positive case)

- ☐ Develop an accommodating sick leave policy for employees.
- ☐ Implement a clinical MOD rotation to cover shifts if necessary by leadership.
- ☐ Create a list of staff with prior direct care experience currently serving in other roles in the facility who would be willing to provide direct care during staffing crises. Create a competency checklist in accordance with temporarily relaxed guidelines that will prepare these staff for immediate scheduling if needed.
- ☐ Proactively consider staff that have high-risk situations that are likely to be unavailable for COVID care. Identify weaknesses in the existing staffing plan such as multiple high-risk staff working on the same unit.
- ☐ Proactively survey staff about their ability and interest in serving COVID-presumed or COVID-positive residents.
- ☐ Create a team of COVID-assigned staff of all applicable departments that would be available to work with residents that develop symptoms. Consider adding hazard pay for these individuals.
- ☐ Track return to work (RTW) dates for employees under quarantine to understand approaching staffing crisis levels.
- ☐ Call staffing agencies before you have a need and determine their availability to meet a short-notice need in the future (12 hours, 24 hours, etc.).

Staffing contingencies (after first COVID-positive case)

- ☐ Consider scheduling additional clinical staff for shifts, anticipating potential call-ins.
- ☐ Contact staffing agencies to verify their availability to assist with staffing in an urgent crisis.
- ☐ Determine plan for providing access to med carts/med rooms for contract staff.
- ☐ Determine process for documentation and med pass for contract staff (EHR, paper MAR, etc.)

Family/media communications (before first COVID-positive case)

- ☐ Assign a person to be the primary communicator to various stakeholders (residents, families, and staff). This may be the same person for all groups.
- ☐ Determine the methods of communication to families, staff, (email, calling tree, technology, text message, etc.). Multiple methods should occur. Ensure someone has the ability to communicate during off-hours.
- ☐ Ensure contact information for families is current.
- ☐ Assign a person to update contact information of families based on discharges, deaths, and admissions regularly.
- ☐ Educate staff on what they should do if they are contacted by the media.

Family/media communications (after first COVID-positive case)

- ☐ Transparent communication is encouraged to both reduce fear and foster trust.
- ☐ Without revealing personal information, share with families, residents, and staff when there is a COVID-positive case. (Note that disclosing the specific number of cases is not required but may be disclosed if the facility believes it would benefit their community.)

Support services (before first COVID-positive case)

Nutrition & Culinary

- ☐ Assign designated staff to serve specific areas of the campus whenever possible.
- ☐ Train 1-2 back-up staff (beyond normal operations) for ordering food. Consider talking to sister facilities of similar size or corporate support staff that could assist with this process.
- ☐ Train 1-2 back-up staff (beyond normal operations) for cooking. Consider staff that do not have overlapping shifts and have different exposure outside of work (e.g., avoid training family members or roommates for the same role as they may be excluded at the same time).
- ☐ Create a back-up plan for serving food. Consider creating a team of staff that could step in if significant numbers of the culinary department were out sick.
- ☐ Prepare a training manual to quickly and effectively orient cross-trained staff to procedures such as special diets, fluid restrictions, thickened liquids, etc.

Environmental Services

- ☐ Limit vendors entering the building to only essential services.
- ☐ Assign designated staff to serve specific areas of the campus whenever possible.
- ☐ Prioritize frequent cleaning of high-touch areas such as doorknobs, light switches, etc.

Funeral Directors

- ☐ Contact frequently used funeral directors to discuss altered practices during the pandemic.
 - ☐ Address whether mortuary staff should enter the building and determine if they have appropriate PPE.
 - ☐ Develop procedures for transporting bodies with dignity if mortuary staff will not be entering the building.
 - ☐ Discuss capacity at local funeral homes to determine whether alternatives may be needed in the case of mass fatalities.

Support services (after first COVID-positive case)

Nutrition & Culinary

- ☐ Designate assigned staff to serve residents in COVID-positive units or partner with clinical staff on alternative meal delivery models.
- ☐ Consider disposable products for COVID-positive units or limit dishwashing of product to designated areas with designated staff.

Environmental Services

- ☐ Designate assigned staff to clean in COVID positive units.

Supplies

- ☐ Assess existing supply of essential clinical items such as oxygen cannulas, thermometer probes, etc.
- ☐ Contact vendors and request additional supplies as needed.

PPE

- ☐ Create PPE carts or stations that can be immediately implemented if a resident requires precautions.
- ☐ Ensure PPE is secure and that conservation strategies are being utilized.
- ☐ Educate staff about appropriate PPE conservation strategies.
- ☐ Document and educate staff about appropriate donning and doffing of PPE.

Assisted Living specific considerations

- ☐ If you have residents on EW or CA, contact the case manager for review of care needs.
- ☐ Consider hiring and/or staffing additional nurses to allow effective models for care in place.

Memory Care specific considerations

- ☐ Plan to care in place whenever possible.

The CDC also has a Long-Term Care Checklist. [CDC: COVID-19 Preparedness Checklist \(https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care-checklist.html).