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**Infection Control COVID-19**

**Policy Statement**

[facility name’s] Infection Control Program (ICP), includes policies and procedures to assist in preventing transmission of COVID-19 into the [facility name] campus. In the event a transmission occurs, prompt detection and effective triage and isolation of potentially infectious residents are essential to prevent unnecessary exposures among additional residents, employees, and visitors. [facility name] recognizes its high-risk population and, as such, the actions listed below will be implemented, and [facility name] will further coordinate the ICP and Emergency Preparedness (EP) plans to address COVID-19. These policies and practices are based on Infection Prevention and Control recommendations from the Centers for Disease Control (CDC) and the Iowa Department of Public Health (IDPH) and requirements implemented by the Centers for Medicare and Medicaid Services (CMS). This information is based on the information available about coronavirus disease 2019 (COVID-19) related to disease severity, transmission efficiency, and shedding duration. According to the CDC, their guidance is applicable to all U.S. healthcare settings and subject to change as more information becomes available. [facility name] will monitor the CDC, IDPH and CMS websites routinely and update this policy as needed.

This policy incorporates all guidelines related to the prevention and detection of COVID-19, except vaccination. The vaccination policy and procedures will remain a stand-alone policy due to requirements included in the CMS Requirements of Participation or Conditions of Participation as applicable to covered entities.

**Definitions:**

**Close Contact:** Being within 6 feet for a cumulative total of 15 or more minutes or more over a 24-hour period with someone with SARS-CoV-2 infection.

**Cohorting** is the practice of grouping residents infected with the same infectious agent together to confine their care to one area and prevent contact with susceptible residents. During outbreaks, healthcare staff may be assigned to a specific cohort of residents to further limit opportunities for transmission.

**Core Infection Prevention and Control Principles:**

* Providing guidance about recommended actions for visitors who have a positive COVID-19 test, symptoms of COVID-19, or had close contact with someone with COVID-19. Visitors should defer non-urgent, in-person visitation until they meet CDC criteria for healthcare settings to end isolation.
* Hand Hygiene (use of alcohol-based hand rub is preferred).
* Face coverings or masks as defined in this policy.
* Instructional signage throughout the building educating visitors on COVID-19 signs and symptoms and applicable practices to reduce transmission of COVID-19.
* Cleaning and disinfection of high-frequency touched surfaces in the building.
* Appropriate use of PPE by staff.
* Effective cohorting of residents as outlined.
* Testing of staff and residents as outlined.

**Facemask:** OSHA defines facemasks as “a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as ‘medical procedure masks’”. Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

**Fully Vaccinated:** a person has received their primary series of COVID-19 vaccines.

**Healthcare Personnel (HCP)***:* For the purposes of this document HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to residents or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, dental healthcare personnel, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in resident care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting.

**Higher-Risk Exposure:** HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection, if the HCP was not wearing a respirator, or if wearing a facemask the infected person was not wearing a cloth mask or facemask, not wearing eye protection if the infected person was not wearing a cloth mask or facemask, or the HCP was not wearing all recommended PPE while performing an aerosol-generating procedure.

**Immunocompromised: For the purposes of this document, moderate to severely immunocompromising conditions include, but might not be limited to, those defined in the** [**Interim Clinical Considerations for Use of COVID-19 Vaccines**](https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html)**.**

* **Other factors, such as end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about need for work restriction if the HCP had close contact with someone with SARS-CoV-2 infection. However, people in this category should still consider continuing to practice physical distancing and use of source control while in healthcare facility, even if they have received all COVID-19 vaccine doses, including booster dose, as recommended by the CDC.**
* **Ultimately, the degree of immunocompromise for the HCP is determined by the treating provider, and preventative actions are tailored to each individual and situation.**

**Illness Severity Criteria (Adapted from the NIH COVID-19 Treatment Guidelines):**

* **Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 without shortness of breath, dyspnea, or abnormal chest imaging.**
* **Moderate Illness: Individuals who have evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen (SpO2) at or less than 94% on room air at sea level.**
* **Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fracture of inspired oxygen (PaO2/Fi02) <300 mmHg, or lung infiltrates >50%.**
* **Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.**

**Isolation**means the separation of a person or group of people known or reasonably believed to be infected with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease.

**Level of Community Transmission:** is the metric currently recommended to guide select practices in healthcare settings to allow for earlier intervention, before there is a strain on the healthcare system and to better protect the individuals seeking care in these settings. The community transmission metric is different from the COVID-19 Community Level metric used for non-healthcare settings. Community transmission refers to measures of the presence and spread of COVID-19. COVID-19 community levels place an emphasis on the measures of the impact of COVID-19 in terms of hospitalizations and healthcare system strain, while accounting for transmission in the community. The COVID-19 community transmission can be found on the [Centers for Disease Control and Prevention (CDC) COVID-19 Integrated County View](https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk&null=Risk) website.

**Nursing Home-Onset SARS-CoV-2 Infections:** refers to SARS-CoV-2 infections that originated in the nursing home. It does not refer to the following:

* When a resident with known COVID-19 is admitted directly into transmission-based precautions, or
* When a resident known to have close contact with someone with COVID-19 is admitted directly into transmission-based precautions and develops COVID-19 before transmission-based precautions are discontinued.

**Outbreak:** A newly identified COVID-19 infection in any staff or any nursing home-onset COVID-19 infection in a resident.

**Personal protective equipment (PPE**) are protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission. This includes but is not limited to gloves, gowns, goggles, facemasks, or respirators.

**Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

**Standard precautions** are infection prevention practices that apply to all residents, regardless of suspected or confirmed diagnosis or presumed infection status. Standard precautions are based on the principle that all blood, body fluids, secretions, excretions except sweat, regardless of whether they contain visible blood, non-intact skin, and mucous membranes may contain transmissible infections agents.

**Source Control:** Use of respirators, well-fitting facemasks, or well-fitting cloth masks to cover a person’s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Source control devices should not be placed on children under the age of 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing one safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their source control device without assistance. Face shields alone are not recommended for source control.

**Transmission based precautions** are the second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission.

**Unvaccinated** refers to a person who does not fit the definition of “fully vaccinated”, including people whose vaccination status is not known, for the purposes of this guidance.

**Up to Date with COVID-19 Vaccines**: completion of a COVID-19 vaccine primary series and receipt of the most recent booster dose recommended for each individual by the CDC.

**Routine Infection Prevention and Control Practices During the COVID-19 Pandemic:**

**[Enter facility name]** will encourage all healthcare providers, residents/tenants and visitors to remain up to date with COVID-19 vaccines, including education on the importance of vaccination and offering or assisting with coordinating vaccine administration as appropriate.

**Visual alerts will be posted strategically throughout the building with instructions on the current infection prevention and control recommendations such as when to utilize source control and performing hand hygiene.**

**A visual alert will be posted at each entrance informing all healthcare providers as defined earlier in this policy and visitors of recommended actions to prevent COVID-19 transmission. This visual alert will instruct everyone to:**

* **Report the following to the [enter title/name]:**
  + A positive test result for COVID-19 within the last 10-days.
  + [Symptoms](https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html) consistent with COVID-19, or
    - Fever or chills
    - Cough
    - Shortness of breath or difficulty breathing
    - Fatigue
    - Muscle or body aches
    - Headache
    - New loss of taste or smell
    - Sore throat
    - Congestion or runny nose
    - Nausea or vomiting
    - Diarrhea
  + Close contact with someone with COVID-19 infection (resident/tenants and visitors or higher-risk exposures (healthcare providers).
* **[enter title/name]** will provide guidance to the individual reporting any of the above criteria to minimize COVID-19 transmission including:
  + Following guidance described in the close contact/higher-risk exposure section of this policy.
  + Those with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they have met the healthcare criteria to end isolation; this time period is longer than what is recommended in the community.
  + Individuals who had close contact or were in a higher-risk situation (such as large event). It is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria in the above section.

**Source Control:**

The use of universal source control including well-fitting facemasks or respirators covering a person’s mouth and nose will be based on several factors outlined below.

* When community transmission levels according to **[enter specific website – CDC or IDPH] are high** universal source control will be utilized by all staff and visitors except for:
  + When visitors are in a private area during visitation and the resident/tenant is agreeable to not wearing source control.
* When community transmission levels according to **[enter specific website – CDC or IDPH] are high**, residents that are new admissions are recommended to utilize source control for 10 days following admission.
* When community transmission levels according to **[enter specific website- CDC or IDPH]** **are not high**, source control will be utilized on a case-by-case basis including for those individuals who:
  + Have suspected or confirmed respiratory symptoms or infection **other than** COVID-19.
  + Had close contact (residents/tenants and visitors) or a higher-risk exposure (healthcare providers) with someone with COVID-19 infection for 10 days after their exposure.
  + Reside or work on a unit or area of the building that is experiencing a COVID-19 outbreak until no new cases are identified for 14 days.
  + Have otherwise been recommended to wear source control by public health authorities.
* Individuals may choose to wear source control at any point based on their individual preference. Acceptable forms of source control based on individual preference include a well-fitting face mask or a respirator with higher-level protection that is not visibly soiled.

**PPE Use for Healthcare Providers:**

All healthcare providers will utilize standard precautions for all resident-care encounters according to policies and procedures.

If a resident is suspected or confirmed to have COVID-19 healthcare providers will utilize transmission-based precautions including an N95 or higher level respirator, gloves, isolation gown, and eye protection, under conventional strategies which include removal or disinfection of all PPE following each resident encounter, or as otherwise directed in infection control policies and procedures.

**When community transmission levels are high, the potential increases for healthcare providers encountering individuals who are asymptomatic or pre-symptomatic with COVID-19. When [enter facility name] is in high community transmission all healthcare providers will utilize additional PPE as follows:**

* **A NIOSH-approved particulate respirator with N95 filters or higher for:**
  + **All aerosol-generating procedures according to CDC’s** [Which procedures are considered aerosol-generating procedures in healthcare settings](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control) **document.**
  + **Healthcare providers may wear N95 or higher-level respirators may be used where additional risk factors for transmission are present, such as poorly ventilated areas or as directed by [enter IP or other designated person]**.
* **Eye protection for all resident/tenant encounters.**

**Optimizing the Use of Engineering Controls and Indoor Air Quality:**

**To further protect healthcare providers, residents/tenants, and visitors [enter facility name] implemented the use of additional measures including:**

* **[enter specific controls that have been implemented such as air purifiers, HEPA filtration systems, etc.]**

**Testing:**

Testing for COVID-19 will be completed according to CDC recommendations and CMS requirements. Tests will be performed according to the FDA Emergency Use Authorization for the COVID-19 testing device or kit and the manufacturer’s recommendations.

Admission:

* When community transmission is high, residents will be tested upon admission, regardless of their vaccination status, with a series of 3 tests.
  + The initial test will be conducted on the day of admission.
  + If the initial test is negative, a 2nd test is completed 48 hours following the first.
  + If the second test is negative, a 3rd test is completed 48 hours following the second.
* Residents/tenants who leave the building for 24 hours or longer will be tested in accordance with admission testing as appropriate.

Symptomatic:

* Testing will be conducted as soon as possible, regardless of their vaccination status, on any healthcare provider or resident that has symptoms consistent with COVID-19.
* Healthcare providers and residents/tenants will be isolated as indicated in the isolation section later in this policy and isolation/return to work criteria will be followed.

Close Contact (resident/tenant) or High-Risk Exposure (healthcare provider):

* Residents/Tenants or Healthcare providers that have been exposed to an individual with COVID-19 as defined in close contact or high-risk exposure in this policy must be tested with a series of 3 tests.
  + The initial test should be conducted immediately, but not earlier than 24 hours following the exposure.
  + If the initial test is negative, a 2nd test is completed 48 hours following the first.
  + If the second test is negative, a 3rd test is completed 48 hours following the second.

Outbreak:

A single case of COVID-19 identified in a resident or healthcare provider will trigger an outbreak investigation. If **[enter facility name]** is able to identify close-contacts (resident/tenant) or higher-risk exposures (healthcare provider) to the newly identified case of COVID-19, testing should be conducted according to the previous section (close contact or high-risk exposure).

If nursing home transmission is identified or **[enter facility name]** is unable to contact trace, broad based testing strategies should be implemented. Broad based testing includes conducting tests on either specific units, shifts, or departments or the entire building based on the circumstances. Broad based testing occurs every 3-7 days for all residents and healthcare providers until no further new cases are identified for a 14 day period. If antigen testing is used for broad-based testing, consideration will be given to testing every 3 days.

If additional cases are identified during contact tracing, consideration will be given to shifting to broad-based testing strategies if not already implemented.

Testing on Individuals with Previous COVID-19 Infection:

Testing is generally not recommended on individuals who have recovered from COVID-19 infection within the last 30 days.

Testing should be considered for individuals who have recovered from COVID-19 infection within the last 31-90 days, however, it is recommended to test these individuals with an antigen test instead of a nucleic acid amplification test (NAAT) due to individuals testing positive on a NAAT test but not being infectious during this period.

Residents Who Refuse Testing:

**[enter facility name]** will educate residents who refuse to be tested for COVID-19 on the importance of being tested based on the circumstances. If the resident continues to refuse to be tested the resident will **[input procedures for residents that refuse testing.].**

**Recommended Infection Prevention and Control Practices for Residents with Suspected or Confirmed COVID-19**

Close Contact:

In general, residents/tenants who are asymptomatic that have been in close contact with an individual with COVID-19 do not require isolation with transmission-based precautions. However, **[enter facility name]** may determine that isolation with transmission-based precautions are necessary on a case-by-case basis which will be documented in the resident’s medical record. Circumstances that may warrant isolation include but are not limited to:

* The resident/tenant is unable to wear source control as recommended for 10 days following close contact.
* The resident/tenant refuses to be tested for COVID-19 as recommended.
* The resident/tenant is moderately to severely immunocompromised.
* The resident/tenant resides on a unit with other residents/tenants who are immunocompromised.
* The resident/tenant is residing on a unit experiencing ongoing COVID-19 transmission that is not controlled with initial interventions.

If a resident/tenant is placed in empiric transmission-based precautions because of close contact, the resident/tenant can be removed from transmission-based precautions:

* After day 7 following close contact (the day of close contact is day 0), if the resident/tenant remains asymptomatic and all testing is negative.
* After day 10 following close contact (the day of close contact is day 0), if the resident/tenant remains asymptomatic.

Symptomatic/Confirmed COVID-19:

Residents/tenants with symptoms consistent with COVID-19 or have tested positive for COVID-19 should ideally be placed in a single-person room, including a dedicated bathroom, with the room door closed (if safe to do so). Transmission-based precautions must be implemented, including additional use of PPE as identified in this policy.

Nursing home providers could consider designating entire units within the building or cohorting, with dedicated healthcare providers, to care for residents/tenants. If implemented, cohorting should consist of:

* An area for residents who are COVID-19 positive.
* An area for residents who are symptomatic consistent with symptoms of COVID-19, but testing results are pending.
* An area for residents who are in empiric transmission-based precautions for close contact exposures.
* An area for residents who have not been in close contact and are asymptomatic.

Nursing homes that are unable to cohort residents in single rooms are encouraged to cohort residents with similar communicable diseases, including consideration for MDROs.

In circumstances of either a really low or high number of COVID-19 cases are identified or staffing shortages are present, dedicated units may not be feasible, and COVID-19 positive residents may reside in their own room, ideally without a roommate.

Care for symptomatic or positive residents/tenants include:

* Limiting movement outside of their room and only for medically essential purposes.
* Communicating COVID-19 status to all other departments/healthcare entities that the resident/tenant may receive care from.
* Aerosol-generating procedures should be performed cautiously and avoided if appropriate alternatives exist. If necessary:
  + These procedures should be completed in an airborne infection isolation room (AIIR), if possible.
  + The number of healthcare providers present during the procedure should be limited to only those essential for the treatment and procedure support.
  + Visitors should not be present during the procedure.

Discontinuing Transmission-Based Precautions for Symptomatic Residents/Tenants:

Residents/tenants who have symptoms consistent with COVID-19 should remain in isolation with transmission-based precautions until the diagnosis of COVID-19 is excluded. In general, a negative result from one antigen test would be sufficient to discontinue isolation, however, if there is a higher level of clinical suspicion for COVID-19 infection, despite the negative result:

* Consideration for continuing transmission-based precautions and confirming the first test with a NAAT test or a second negative antigen test taken 48 hours after the first.
* If the first was a NAAT test, a second NAAT test could be collected confirming the results of the first.

If a symptomatic resident/tenant was not tested for COVID-19, **[enter facility name]** will have the resident/tenant remain in isolation until they meet criteria to discontinue isolation for a confirmed COVID-19 case.

Empiric Use of Transmission-Based Precautions in an Outbreak:

In the event of ongoing transmission that is not controlled with initial interventions, strong consideration will be given to the use of empiric use of transmission-based precautions for residents/tenants and work restriction of healthcare providers with high-risk exposures.

Discontinuing Transmission-Based Precautions for Confirmed COVID-19 Cases:

Residents/tenants who are asymptomatic and are not moderately to severely immunocompromised:

* At least 10 days has passed since the date of their first positive test.

Residents/tenants with mild to moderate illness who are not moderately to severely immunocompromised:

* At least 10 days has passed since symptoms first appeared.
* At least 24 hours have passed since their last fever without the use of fever-reducing medications, and
* Symptoms have improved.

Residents/tenants with severe to critical illness and who are not moderately to severely immunocompromised: (this includes individuals who were hospitalized)

* At least 10 days and up to 20 days have passed since symptoms first appeared, and
* At least 24 hours have passed since last fever without the use of fever-reducing medications, and
* Symptoms have improved.
* The test-based strategy as described below for moderately to severely immunocompromised residents/tenants can be used to inform the duration of isolation.

Residents/tenants who are moderately to severely immunocompromised:

* Use of test-based strategy:
  + Resolution of fever without the use of fever-reducing medications (if symptoms present), and
  + Symptoms have improved (if symptoms present), and
  + Results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) using an antigen or NAAT.
* Consultation (if available) with an infectious disease specialist.

**Environmental Infection Control**

Residents/tenants in isolation with transmission-based precautions will have their own dedicated medical equipment. If medical equipment is unable to be dedicated it will be cleaned and disinfected according to manufacturer’s instructions before use on another resident/tenant.

An EPA-registered disinfectant in accordance with [List N](https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2) on the EPA website will be used following a thorough cleaning of the item(s). The disinfectant will be applied as directed by the contact kill times located on the product’s label.

Management of laundry, food service utensils, and medical waste will be in accordance with the Isolation Precautions or Transmission-Based Precautions policy and procedure.

Once the transmission-based precautions have been discontinued or the resident/tenant has discharged, healthcare providers shall refrain from entering the room without appropriate PPE until sufficient time has elapsed for enough air changes to remove potentially infectious particles from the room. The room and all equipment shall be appropriately cleaned and disinfected before it is returned to reuse.

**Visitation**

Visitation for residents/tenants should generally occur at all times, regardless of COVID-19 activity in the building or the community. Visitors should defer non-urgent visitation if they have tested positive for COVID-19 in the last 10 days, have symptoms consistent with COVID-19, or have been in close contact with someone who has COVID-19 in the last 10 days.

Visitors will receive education about the core infection prevention and control principles. including:

Outdoor visitation generally poses a lower risk of transmission of COVID-19. Outdoor visitation may occur in established areas, weather permitting. Visitors should adhere to the core principles of infection prevention, despite outdoor visitation.

Indoor visitation:

Indoor visitation must be allowed at all times, for all residents, as permitted in the Federal Regulations for nursing homes and the State Rules for non-Medicare participating providers. Indoor visitation must be conducted in a manner that adheres to the core principles of infection prevention and does not pose an increased risk to other residents/tenants.

During peak times of visitation and during large gatherings, **[enter facility name]** encourages all residents/tenants and visitors to physically distance from other groups.

Source Control During Indoor Visitation:

* When **[enter facility name]** is in **high** community transmission, everyone is required to wear a face covering or mask.
* When **[enter facility name]** is **not in high** community transmission, the safest practice is for all residents/tenants and visitors to wear face coverings or masks, however, they are not required unless there are cases of COVID-19 identified among residents/tenants and/or staff.
* Regardless of the community transmission, residents and visitors may choose to remove face coverings or masks and have close contact (including touch) whenever alone in a designated visiting area.
* If a roommate is present in the resident’s room during the visit, the safest practice is to wear a face covering or mask during the visit.

While not recommended, residents in transmission-based precautions may still receive visitors. The resident and the visitor should be counseled prior to the visit on the increased risk for infection transmission and the visitor will be instructed on key principles of infection control including the use of PPE during the visit and instructions for the safety of staff and other residents following the visit.

When the building is completing an outbreak investigation, all visitors should be notified of COVID-19 being identified in the building and additional mitigation measures they can take to reduce the spread of COVID-19.

Visitors can be asked to test for COVID-19 prior to their visit, however, testing cannot be utilized as a condition of visitation. Visitors may also be asked about their vaccination status, however, vaccination status and/or proof of vaccination status also cannot be used as a condition of visitation.

Representatives from state and federal agencies including but not limited to the Department of Inspections and Appeals(DIA), Long-Term Care Ombudsman, Protection & Advocacy Agencies, and CMS will be allowed access to the building at all times. Resident’s may visit with these officials during their visits. If residents do not want these representatives to visit, they must indicate this at the time of the visit to the representative. If a resident is on transmission-based precautions, these representatives are still allowed to visit and will be notified that these residents are in transmission-based precautions with directions on how to visit the resident with the required PPE.

**Communal Dining, Activities and Resident Outings**

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. The safest approach is for everyone, particularly those at high risk for severe illness, is to wear a face covering or mask while in communal areas of the building.

Residents have the right to leave the building as they choose. Residents and the individual accompanying the resident should be educated to follow all recommended infection prevention practices such as wearing a face covering or mask especially for those at high risk for severe illness and when community transmission is high, performing hand hygiene and encouraging those around them to do the same.

Upon return to the building, the nursing home should take the following actions:

* Screen residents upon return for signs or symptoms of COVID-19.
  + If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, **[enter facility name]** will follow procedures for residents with close contact as outlined in this policy.
  + If the resident develops signs or symptoms of COVID-19 after the outing, **[enter facility name]** will follow procedures for symptomatic residents as outlined in this policy.

In most circumstances, quarantine is not recommended for residents who leave the building for less than 24 hours except in certain situations as described in the empiric transmission-based precautions section of this policy. Residents who leave the building for 24 hours or longer will be managed as a new admission.

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