

LONG-TERM CARE COVID-19 PHASING GUIDANCE

This Long-Term Care Phasing Guidance is intended to be used by nursing homes and assisted-living facilities, in conjunction with the Long-Term Care COVID-19 Response Planning Tool, as they plan for gradual return to standard practices of the facility. Mitigation efforts that have been put in place remain critically important, especially in long-term care settings where residents may be more vulnerable to virus exposure; however, the Department of Health and Human Services (DHHS) understands that it is equally important to consider the quality of life and dignity of the residents in long-term care facilities.

This document is based on recent guidance from the Centers for Medicare and Medicaid Services (CMS), and on best-practice recommendations and evidence. DHHS has developed this guidance for responsibly easing restrictions in long-term care facilities while COVID-19 remains in communities across Nebraska. A regional approach will be used in implementing the transition to each new phase. Facilities within a Local Health District will be allowed to enter each phase based upon the data for their respective District meeting the criteria for entering a phase as long as the facility also meets the basic requirements for relaxing restrictions outlined in this document. This phasing guidance will continue to be updated as additional information becomes available, and facilities should regularly monitor new information and adjust their plans accordingly.

Following are the three phases that have been developed, including considerations and mitigation steps for each phase. All facilities are currently in Phase I, and the phasing guidance includes criteria that must be met by each long-term care facility in a Local Health District in order for that facility to transition to the next phase that aligns with the current phase of their Local Health District. Each of the phases in this plan match similar directed health measures (DHM) relaxed restriction phases for each of the Local Health Districts (for example: Phase I of this plan matches the full restrictions and DHM phase 1 relaxed restrictions; Phase II of this plan matches the DHM phase 2 relaxed restrictions; Phase III of this plan matches the DHM phase 3 relaxed restrictions). The DHM phases may be used as a guide to know when to move through Phases in this plan. Prior to the DHM relaxation of restrictions or increasing of restrictions, the COVID-19 data of each Local Health District is reviewed before the decision is made. Please note that each facility will need to pay close attention to current county/local community trends (e.g., outbreaks) and determine if movement through Phases is appropriate for that facility or if additional precautions are warranted (e.g., additional testing or expanded PPE precautions).

PHASE I – Significant Mitigation and Highest Level of Vigilance

Consideration	Mitigation Steps
Visitation	<ul style="list-style-type: none"> • Visitation is generally prohibited, except for: <ul style="list-style-type: none"> ○ Compassionate care situations restricted to end-of-life and psycho-social needs as determined by the facility, but limit contact as much as possible; and ○ Under limited and controlled conditions, coordinated by the facility, in consideration of social distancing and universal source control, such as window visits or with appropriate barriers in place, such as plexiglass.

Consideration	Mitigation Steps
Visitation (continued)	<ul style="list-style-type: none"> • All visitors are screened upon entry and additional precautions are taken, including social distancing and hand hygiene. • Visitors unable to pass the screening or comply with infection control practices such as wearing a facemask should refrain from visiting. • All visitors must wear a cloth face covering or facemask for the duration of their visit. • The facility must provide a facemask to any visitor who does not have one to ensure universal source control. • The facility should have policies in place for virtual visitation, whenever possible, which include: <ul style="list-style-type: none"> ○ Access to communication with friends, family, and their spiritual community; and ○ Access to the Long-Term Care Ombudsman.
Communal Dining	<ul style="list-style-type: none"> • Communal dining must be limited to only COVID-19 negative or asymptomatic residents. • Residents may eat in the same room with appropriate social distancing, spaced at least 6 feet apart or with appropriate barriers in place, such as plexiglass, with no more than 2 people at a table. • No more than 50% of capacity in a dining area at one time. • If staff assistance is required, appropriate hand hygiene must occur between assisting residents, as well as use of appropriate PPE.
Group Activities	<ul style="list-style-type: none"> • Restrict group activities. • Some activities may be conducted only for COVID-19 negative or asymptomatic residents with appropriate social distancing, hand hygiene, and use of a cloth face covering or facemask. • Engagement through technology is preferred to minimize opportunity for exposure. • Facilities should have policies in place to engage virtually, where possible, in activities that improve quality of life such as church service, art classes, concerts, etc. • Facilities must restrict activities that involve multiple residents to handle the same object(s) such as ball toss.
Screening	<ul style="list-style-type: none"> • 100% screening for all residents at least daily: <ul style="list-style-type: none"> ○ Temperature checks. ○ Questions and observation for other signs or symptoms of COVID-19. ○ Facility policy should clearly identify when daily screenings should occur and how they are tracked. • 100% screening for all persons entering the facility and all staff at the beginning of each shift: <ul style="list-style-type: none"> ○ Temperature checks. ○ Questionnaire about symptoms and potential exposure. ○ Observation of any signs or symptoms. ○ Ensure all outside persons and staff entering the facility have cloth face covering or facemask. ○ If a staff member becomes symptomatic, he/she must notify their supervisor immediately.

Consideration	Mitigation Steps
Universal Source Control and PPE	<ul style="list-style-type: none"> • Universal source control for everyone in the facility. Residents and visitors wear cloth face covering or facemask, if able to tolerate and wear safely. • All facility staff and essential healthcare personnel, regardless of their position, who may interact with residents or enter resident rooms, should wear a surgical/procedural facemask. Those facility staff, regardless of their position, who do not provide any care to the residents and who have no interaction with residents should wear either a cloth face covering or facemask while in the facility. • All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, in accordance with CDC PPE optimization strategies. • Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel). • New admissions or readmissions from a hospital setting must quarantine for 14 days.
Cohorting	<ul style="list-style-type: none"> • Dedicated space in facility, to the extent possible, for cohorting or as a last resort for transferring residents who are symptomatic or who test positive for COVID-19. • Plan to manage new admissions and readmissions who have an unknown COVID-19 status. • Plan to manage residents who routinely attend outside medically necessary appointments (e.g., dialysis).
Essential and Non-Essential Healthcare Personnel	<ul style="list-style-type: none"> • Restricted entry of non-essential healthcare personnel. • Non-essential healthcare personnel may be allowed into the facility as determined by the facility. • All healthcare personnel are screened upon entry to the facility and additional precautions are taken, including social distancing, hand hygiene, donning and doffing of appropriate PPE as determined by the task; and at a minimum, wearing a facemask for the duration of their visit.
Medical Trips Outside the Facility	<ul style="list-style-type: none"> • Non-Medically Necessary Trips <ul style="list-style-type: none"> ○ Should be avoided. ○ Telemedicine should be utilized whenever possible. • Medically Necessary Trips <ul style="list-style-type: none"> ○ The resident must wear a cloth face covering or facemask. ○ The facility must share the resident's COVID-19 status with the transportation service and with the entity with whom the resident has the appointment. ○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. ○ Transportation equipment must be sanitized between transports. ○ Observe and monitor for 14 days upon return if asymptomatic and not in a positive COVID-19 status.
Testing	<ul style="list-style-type: none"> • See attached Testing Guidance. • Facility must report ongoing testing efforts to DHHS as requested.

PHASE II – Initial Relaxing of Restrictions

A facility may decide to initiate Phase II when its respective Local Health District has moved into DHM phase 2 of relaxed restrictions and meets the following criteria:

- Adequate staffing levels
- Adequate supply of PPE to adhere fully to CDC guidance for proper PPE use for infection control as described at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>
- Ability of local hospital to accept referrals/transfers
- Capable of cohorting, or as a last resort, transferring residents in the case of suspected or positive cases
- No one in the facility is currently in isolation (red zone) or quarantine (yellow zone) due to COVID-19
- Facilities may use discretion to be more restrictive in areas, where deemed appropriate through internal policies, even if the facility has moved to Phase II

Consideration	Mitigation Steps
Visitation	<ul style="list-style-type: none"> • Visitation is allowed for compassionate care situations, including end-of-life and residents with significant changes in condition including psycho-social or medical issues as determined by the facility, but limit contact as much as possible. • Visits must be limited as follows: <ul style="list-style-type: none"> ○ By appointment only, as coordinated by the nursing home, based on their ability to manage infection control practices and proper social distancing. ○ Only in designated areas to ensure safe distancing, proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors. Each facility must determine its capacity to manage limited visits, based on considerations that include, but are not limited to: <ul style="list-style-type: none"> ▪ Staff availability to screen visitors; ▪ Availability of supplies to support universal source control, such as facemasks; ▪ Monitoring for visitor compliance with safe visitation practices; and ▪ Disinfection of area between visits. ○ Facilities may limit the number of visitors for each resident per week and per occurrence. ○ Preference should be given to outdoor visitation opportunities such as parking lot or patio visits with social distancing. • All visitors are screened upon entry and additional precautions are taken, including social distancing and hand hygiene. • Visitors unable to pass the screening or comply with infection control practices such as wearing a facemask should refrain from visiting. • All visitors must wear a cloth face covering or facemask for the duration of their visit. • The facility must provide a facemask to any visitor who does not have one to ensure universal source control. • Types of visitation from Phase 1 may continue under limited and controlled conditions, coordinated by the facility, in consideration of social distancing and universal source control, such as window visits or with appropriate barriers in place, such as plexiglass; • The facility should have policies in place for virtual visitation, whenever possible, which include: <ul style="list-style-type: none"> ○ Access to communication with friends, family, and their spiritual community; and ○ Access to the Long-Term Care Ombudsman.

Consideration	Mitigation Steps
Communal Dining	<ul style="list-style-type: none"> • Communal dining limited. • Residents may eat in the same room with appropriate social distancing, spaced at least 6 feet apart or with appropriate barriers in place, such as plexiglass, with no more than 2 people at a table. • No more than 50% of capacity in a dining area at one time. • If staff assistance is required, appropriate hand hygiene must occur between assisting residents, as well as use of appropriate PPE.
Group Activities	<ul style="list-style-type: none"> • Limit group activities. • Small group activities with no more than 10 people may occur only for COVID-19 negative or asymptomatic residents with appropriate social distancing, hand hygiene, and use of a cloth face covering or facemask. • Facilities must restrict activities that involve multiple residents to handle the same object(s) such as ball toss.
Salons	<ul style="list-style-type: none"> • Salon services may be provided if barbers and cosmetologists are determined by the facility to be a low risk for entry. The following mitigation steps must be followed: <ul style="list-style-type: none"> ○ Salons may open, provided that the barber or cosmetologist is properly screened when entering the facility and must wear a facemask for the duration of time in the facility. ○ The barber or cosmetologist must remain in the salon area and avoid common areas of the facility. ○ Salons must limit the number of residents in the salon at one time to accommodate ongoing appropriate social distancing. ○ Staged appointments should be utilized to maintain appropriate social distancing and allow for infection control. ○ Salons must properly sanitize equipment and salon chairs between each resident; and the barber or cosmetologist must perform proper hand hygiene. ○ Limit use of hand held dryers, when possible. ○ Salons must routinely sanitize high-touch areas. ○ Residents must wear a facemask during their salon visit.
Screening	<ul style="list-style-type: none"> • 100% screening for all residents at least daily: <ul style="list-style-type: none"> ○ Temperature checks. ○ Questions and observation for other signs or symptoms of COVID-19. ○ Facility policy should clearly identify when daily screenings should occur and how they are tracked. • 100% screening for all persons entering the facility and all staff at the beginning of each shift: <ul style="list-style-type: none"> ○ Temperature checks. ○ Questionnaire about symptoms and potential exposure; ○ Observation of any signs or symptoms. ○ Ensure all outside persons and staff entering the facility have cloth face covering or facemask. ○ If a staff member becomes symptomatic, he/she must notify their supervisor immediately.

Consideration	Mitigation Steps
Universal Source Control and PPE	<ul style="list-style-type: none"> • Universal source control for everyone in the facility. Residents and visitors wear cloth face covering or facemask, if able to tolerate and wear safely. • All facility staff and essential healthcare personnel, regardless of their position, who may interact with residents or enter resident rooms, should wear a surgical/procedural facemask. Those facility staff, regardless of their position, who do not provide any care to the residents and who have no interaction with residents should wear either a cloth face covering or facemask while in the facility. • All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, in accordance with CDC PPE optimization strategies. • Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel), and remain in effect until further notice. • New admissions must quarantine for 14 days.
Cohorting	<ul style="list-style-type: none"> • Dedicated space in facility, to the extent possible, for cohorting or as a last resort for transferring residents who are symptomatic or who test positive for COVID-19. • Plan to manage new admissions and readmissions who have an unknown COVID-19 status. • Plan to manage residents who routinely attend outside medically necessary appointments (e.g., dialysis).
Essential and Non-Essential Healthcare Personnel	<ul style="list-style-type: none"> • Limited entry of non-essential healthcare personnel. • Non-essential healthcare personnel may be allowed into the facility, as determined by the facility, including the entry of barbers and cosmetologists (see Salon guidance). • All healthcare personnel are screened upon entry to the facility and additional precautions are taken, including social distancing, hand hygiene, donning and doffing of appropriate PPE as determined by the task; and at a minimum, wearing a facemask for the duration of their visit.
Medical Trips Outside the Facility	<ul style="list-style-type: none"> • Non-Medically Necessary Trips <ul style="list-style-type: none"> ○ Should be avoided. ○ Telemedicine should be utilized whenever possible. • Medically Necessary Trips <ul style="list-style-type: none"> ○ The resident must wear a cloth face covering or facemask. ○ The facility must share the resident’s COVID-19 status with the transportation service and with the entity with whom the resident has the appointment. ○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. ○ Transportation equipment must be sanitized between transports. ○ Observe and monitor for 14 days upon return if asymptomatic.
Testing	<ul style="list-style-type: none"> • See attached Testing Guidance. • Facility must report ongoing testing efforts to DHHS as requested.

Consideration	Mitigation Steps
Phase II Regression	<ul style="list-style-type: none"> • The facility will continue to monitor for the presence of COVID-19 in the facility. This will occur through resident screening each shift and staff screening before each shift, and leveraging the data points requested by the CDC as reported through the NHSN system. • The facility will continue to progress through the different phases of adjusting restrictions until a case of COVID-19 (either resident or staff) is identified at the facility, at which time, the facility must work with the Local Health District to determine whether the facility must return to Phase I. • If the facility must return to Phase I, and if 14 days have passed with no additional residents or staff testing positive for COVID-19, the facility may return to Phase II and may subsequently return to Phase III after an additional 7 days have passed since the facility has returned to Phase II as long as there is no one currently in isolation (red zone) or quarantine (yellow zone) at the facility.

PHASE III – Additional Relaxing of Restrictions

A facility may decide to initiate Phase III when its respective Local Health District has moved into DHM phase 3 of relaxed restrictions and meets the following criteria:

- Baseline testing for staff has been completed. It is recommended, but not required, that baseline testing for residents has been completed.
- Adequate staffing levels
- Adequate supply of PPE to adhere fully to CDC guidance for proper PPE use for infection control as described at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>
- Ability of local hospital to accept referrals/transfers
- Capable of cohorting residents with dedicated staff in the case of suspected or positive cases
- No one in the facility is currently in isolation (red zone) or quarantine (yellow zone) due to COVID-19
- Facilities may use discretion to be more restrictive in areas, where deemed appropriate through internal policies, even if the facility has moved to Phase III

Consideration	Mitigation Steps
Visitation	<ul style="list-style-type: none"> • All residents should have the ability to have limited visitation. • Each facility should develop a limited visitation policy which addresses the following, at minimum: <ul style="list-style-type: none"> ○ Visitation schedule, hours, and location. ○ Number of visitors and visits. ○ Infection control practices including proper hand hygiene, universal source control, and general supervision of safe practices related to visitors and social distancing. ○ Use of PPE. ○ By appointment only, as coordinated by the nursing home, based on their ability to manage infection control practices and proper social distancing. ○ Only in designated areas to ensure safe distancing, proper hand hygiene, universal source control, and general supervision of safe practices related to visitors. Each facility must determine its capacity to manage limited visits, based on considerations that include, but are not limited to: <ul style="list-style-type: none"> ▪ Staff availability to screen visitors; ▪ Availability of supplies to support universal source control, such as facemasks; ▪ Monitoring for visitor compliance with safe visitation practices; and ▪ Disinfection of area between visits.

Consideration	Mitigation Steps
Visitation (continued)	<ul style="list-style-type: none"> ○ Facilities may limit the number of visitors for each resident per week and per occurrence. ○ Preference should be given to outdoor visitation opportunities such as parking lot or patio visits with social distancing. ● All visitors are screened upon entry and additional precautions are taken, including social distancing and hand hygiene. ● Visitors unable to pass the screening or comply with infection control practices such as wearing a facemask should refrain from visiting. ● All visitors must wear a cloth face covering or facemask for the duration of their visit. ● The facility must provide a facemask to any visitor who does not have one to ensure universal source control. ● Types of visitation from Phase 1 may continue under limited and controlled conditions, coordinated by the facility, in consideration of social distancing and universal source control, such as window visits. ● The facility should have policies in place for virtual visitation, whenever possible, which include: <ul style="list-style-type: none"> ○ Access to communication with friends, family, and their spiritual community; and ○ Access to the Long-Term Care Ombudsman.
Communal Dining	<ul style="list-style-type: none"> ● Modified communal dining. ● Residents may eat in the same room with appropriate social distancing, spaced at least 6 feet apart or with appropriate barriers in place, such as plexiglass, with no more than 2 people at a table. ● A limited number of individuals in a dining area at one time. ● If staff assistance is required, appropriate hand hygiene must occur between assisting residents, as well as use of appropriate PPE.
Group Activities	<ul style="list-style-type: none"> ● Limit group activities. ● Expanded group activities may occur only for COVID-19 negative or asymptomatic residents with appropriate social distancing, hand hygiene, and use of a cloth face covering or facemask. ● Facilities must restrict activities that involve multiple residents to handle the same object(s) such as ball toss.
Salons	<ul style="list-style-type: none"> ● Salons may open, provided that the barber or cosmetologist is properly screened when entering the facility and must wear a facemask for the duration of time in the facility. ● The barber or cosmetologist must remain in the salon area and avoid common areas of the facility. ● Salons must limit the number of residents in the salon at one time to accommodate ongoing appropriate social distancing. ● Staged appointments should be utilized to maintain appropriate social distancing and allow for infection control. ● Salons must properly sanitize equipment and salon chairs between each resident; and the barber or cosmetologist must perform proper hand hygiene; ● Limit use of hand-held dryers, when possible. ● Salons must routinely sanitize high-touch areas. ● Residents must wear a facemask during their salon visit.

Consideration	Mitigation Steps
Screening	<ul style="list-style-type: none"> • 100% screening for all residents daily: <ul style="list-style-type: none"> ○ Temperature checks. ○ Questions and observation for other signs or symptoms of COVID-19. ○ Facility policy should clearly identify when daily screenings should occur and how they are tracked. • 100% screening for all persons entering the facility and all staff at the beginning of each shift: <ul style="list-style-type: none"> ○ Temperature checks. ○ Questionnaire about symptoms and potential exposure. ○ Observation of any signs or symptoms. ○ Ensure all outside persons and staff entering the facility have cloth face covering or facemask. ○ If a staff member becomes symptomatic, he/she must notify their supervisor immediately.
Universal Source Control and PPE	<ul style="list-style-type: none"> • Universal source control for everyone in the facility. Residents and visitors wear cloth face covering or facemask, if able to tolerate and wear safely. • All facility staff and essential healthcare personnel, regardless of their position, who may interact with residents or enter resident rooms, should wear a surgical/procedural facemask. Those facility staff, regardless of their position, who do not provide any care to the residents and who have no interaction with residents should wear either a cloth face covering or facemask while in the facility. • All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, in accordance with CDC PPE optimization strategies. • Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel), and remain in effect until further notice.
Cohorting	<ul style="list-style-type: none"> • Dedicated space in facility, to the extent possible, for cohorting or as a last resort for transferring residents who are symptomatic or who test positive for COVID-19. • Plan to manage new admissions and readmissions who have an unknown COVID-19 status. • Plan to manage residents who routinely attend outside medically necessary appointments (e.g., dialysis).
Essential and Non-Essential Healthcare Personnel	<ul style="list-style-type: none"> • Non-essential healthcare personnel may be allowed into the facility, as determined by the facility, including the entry of barbers and cosmetologists (see Salon guidance). • All healthcare personnel are screened upon entry to the facility and additional precautions are taken, including social distancing, hand hygiene, donning and doffing of appropriate PPE as determined by the task; and at a minimum, wearing a facemask for the duration of their visit.
Medical Trips Outside the Facility	<ul style="list-style-type: none"> • Non-Medically Necessary Trips <ul style="list-style-type: none"> ○ Should be limited. ○ Residents with high-risk co-morbidities should continue to avoid non-medically necessary trips outside the facility. ○ Decisions for residents to make non-medically necessary trips outside the facility must be made by the resident, and when appropriate, involve the resident's representative, a nursing home representative, and/or the resident's physician.

Consideration	Mitigation Steps
Medical Trips Outside the Facility (continued)	<ul style="list-style-type: none"> • Medically Necessary Trips and Non-Medically Necessary Trips <ul style="list-style-type: none"> ○ The resident must wear a cloth face covering or facemask. ○ The facility must share the resident's COVID-19 status with the transportation service and with the entity with whom the resident has the appointment. ○ Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. ○ Transportation equipment must be sanitized between transports. • Observe and monitor for 14 days upon return.
Volunteers	<ul style="list-style-type: none"> • Allow entry of volunteers, with screening and additional precautions including social distancing, hand hygiene, and cloth face covering or facemask.
Testing	<ul style="list-style-type: none"> • See attached Testing Guidance. • Facility must report ongoing testing efforts to DHHS as requested.
Phase III Regression	<ul style="list-style-type: none"> • The facility will continue to monitor for the presence of COVID-19 in the facility. This will occur through resident screening daily and staff screening before each shift, and leveraging the data points requested by the CDC as reported through the NHSN system. • The facility will remain in Phase III until a case of COVID-19 (either resident or staff) is identified at the facility, at which time, the facility must work with the Local Health District to determine whether the facility must return to Phase I. • If the facility must return to Phase I, and if 14 days have passed with no additional residents or staff testing positive for COVID-19, the facility may return to Phase II and may subsequently return to Phase III after an additional 7 days have passed since the facility has returned to Phase II as long as there is no one currently in isolation (red zone) or quarantine (yellow zone) at the facility.

Because staffing levels and access to supplies and testing may vary by facility and because the pandemic is affecting facilities and communities in different ways, decisions about relaxing restrictions in a facility should include the following considerations, as recommended by the Centers for Medicare and Medicaid Services (CMS) in QSO-20-30-NH:

- **Case status in community:** The level of community transmission. For example, a decline in the number of new cases, hospitalizations, or deaths (with exceptions for temporary outliers).
- **Case status in the nursing home(s):** Absence of any new nursing home onset COVID-19 cases (resident or staff), such as a resident acquiring COVID-19 in the nursing home.
- **Adequate staffing:** No staffing shortages and the facility is not under a contingency staffing plan.
- **Access to adequate testing:** A testing plan based on contingencies informed by the Centers for Disease Control and Prevention (CDC). At minimum, the plan should *consider* the following components:
 - The capacity for **all** nursing home **residents** to receive a single baseline COVID-19 test. Similarly, the capacity for all residents to be tested upon identification of an individual with symptoms consistent with COVID-19, or if a staff member tests positive for COVID-19.
 - The capacity for **all** nursing home **staff** (including volunteers and vendors who are in the facility on a weekly basis) to receive a single baseline COVID-19 test, with appropriate re-testing;
 - Written screening protocols for all staff (each shift), each resident (daily), and all persons entering the facility, such as vendors, volunteers, and visitors;

- An arrangement with laboratories to process tests able to detect SARS-CoV-2 virus (e.g., polymerase chain reaction (PCR)). Antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection;
- A procedure for addressing residents or staff that decline or are unable to be tested (e.g., symptomatic resident refusing testing in a facility with positive COVID-19 cases should be treated as positive); and
- Access to payment for appropriate testing.

Please note that for testing capacity assistance and details for utilizing Nebraska testing, refer to the attached Testing Guidance.

- **Universal source control:** Residents and visitors wear a cloth face covering or facemask. If a visitor is unable or unwilling to maintain these precautions (such as young children), consider restricting their ability to enter the facility. All visitors should maintain social distancing and perform hand washing or sanitizing upon entry to the facility.
- **Access to adequate Personal Protective Equipment (PPE) for staff:** Contingency capacity strategy is allowable, such as CDC's guidance on Strategies to Optimize the Supply of PPE and Equipment (facilities' crisis capacity PPE strategy would not constitute adequate access to PPE). All staff wear all appropriate PPE when indicated. Staff wear cloth face covering if facemask is not indicated, such as administrative staff.
- **Local hospital capacity:** Ability for the local hospital to accept transfers from nursing homes.

Appendix A: Testing Guidance

On May 18, 2020, The Centers for Medicare and Medicaid Services (CMS) issued QSO-20-30-NH, Nursing Home Reopening Recommendations for State and Local Officials. The document provides guidance for State Survey Agencies and other state officials to determine how nursing facilities may begin to lift restrictions placed to mitigate the spread of COVID-19. CMS indicates in this QSO that testing will be a critical part of a facility lifting restrictions on operations.

The Department of Health and Human Services (DHHS) agrees that it is important for all facilities to participate in baseline testing prior to consideration of lifting restrictions. Baseline testing of staff and residents is critical to understand how the virus may exist in facilities especially among those without symptoms, so that informed decisions can be made and appropriate steps are taken for containment. At minimum, facilities should meet the following testing metrics prior to moving to Phase III and may also follow this guidance any time a single positive case is identified in a facility:

- All staff (including administrative) in a facility (regardless of whether they had any previous COVID-19 cases or not) should be offered testing for COVID-19. Healthcare workers who are not on the staff, but frequently provide care to the residents in the facility, should also be offered testing for COVID-19.
- All residents of a facility, where a case of COVID-19 has ever been identified in either a resident or staff, should be offered testing for COVID-19. If the first case of COVID-19 was identified on baseline testing of staff, then the facility should also offer the baseline testing to all residents.
- Staff and residents declining testing should be treated as having a positive or unknown COVID-19 status. Facilities should have a plan to address declination of testing and ensuring safety of all residents and healthcare workers.
 - If a staff member refuses testing:
 - And is symptomatic, the staff member should be isolated in accordance with the following guidance: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>
 - But does NOT have symptoms and was exposed to COVID-19, the staff member should be quarantined in accordance with the following guidance: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assessment-hcp.html>
 - But does NOT have symptoms and was NOT exposed to COVID-19, the staff member should use PPE in accordance with the following guidance without reuse or extended use strategies: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>
 - If a resident refuses testing:
 - And is symptomatic (without alternate diagnosis), the facility should assume the resident to be infected and respond accordingly (this includes isolation of the resident)
 - But does NOT have symptoms and IS a close contact of a case, the resident should be quarantined for 14 days after their last exposure to the case (regardless of whether testing is needed)
 - But does NOT have symptoms and is NOT a close contact of a case, no additional measures are required of the resident.

In addition, DHHS encourages that at a minimum, facilities should offer COVID-19 testing (regardless of the phase they are in) to all residents who:

- Are currently symptomatic.
- Have had close contact with an individual who has tested positive for COVID-19.
- Residents who meet either of the above two bullets and decline testing should be treated as having a positive or unknown COVID-19 status. Facilities should have a plan to address declination of testing and ensuring safety of all residents and healthcare workers (see refusal guidance above).