STATE OF GEORGIA
DEPARTMENT OF PUBLIC HEALTH
ADMINISTRATIVE ORDER
LONG-TERM CARE FACILITIES REOPENING GUIDANCE

WHEREAS, on March 14, 2020, Governor Brian P. Kemp issued Executive Order 03.14.20.01, declaring a Public Health State of Emergency in Georgia due to the impact of Novel Coronavirus Disease 2019 (COVID-19); and

WHEREAS, on March 16, 2020, the Georgia General Assembly concurred with Executive Order 03.14.20.01 by joint resolution; and

WHEREAS, the Public Health State of Emergency has been extended as provided by law; and

WHEREAS, the Centers for Disease Control and Prevention ("CDC") recommends that all states and territories implement aggressive measures to slow and contain transmission of COVID-19 in the United States; and

WHEREAS, the number of cases of COVID-19 in the state of Georgia continues to grow; and

WHEREAS, COVID-19 presents a severe threat to public health in Georgia; and

WHEREAS, COVID-19 is a severe respiratory disease that is transmitted primarily through respiratory droplets produced when an infected person coughs or sneezes; and

WHEREAS, beginning March 13, 2020, Georgia long-term care facilities began implementing guidance from the Centers for Medicare and Medicaid Services ("CMS") that outlined recommended restrictions to normal operations in an attempt to mitigate the entry and spread of COVID-19; and

WHEREAS, public health mitigation efforts remain critically important, especially in long-term care settings where residents may be more vulnerable to virus exposure, and the state acknowledges that it is equally important to consider the quality of life and dignity of the residents who reside in these settings; and

WHEREAS, using recent guidance from CMS, the state has collaborated with appropriate agencies, long-term care associations, and other stakeholders on how to responsibly ease restrictions in long-term care facilities while COVID-19 remains in communities across the state; and

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WHEREAS, I have determined that it is necessary and appropriate to adopt guidance for long-term care facilities, which for the purposes of this Order includes intermediate care facilities, personal care homes, and skilled nursing facilities as defined by O.C.G.A. §31-6-2; nursing homes as defined by Ga. Comp. R. & Regs. r. 111-8-56-.01(a); inpatient hospice as defined by Code Section 31-7-172 and licensed pursuant to O.C.G.A. §31-7-173; and assisted living communities and all facilities providing assisted living care pursuant to O.C.G.A. §31-7-12.2.

NOW, THEREFORE, in accordance with O.C.G.A. §§ 31-2A-4, 31-12-4, and Governor Kemp's Executive Orders,

IT IS HEREBY ORDERED as follows:

Section 1.0 Recommendations for Progression Through Phases

1. 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 CMS in QSO-20-30-NH:

   > **Commented [A1]:** Should be QSO 20-39-NH as it supersedes the prior guidance

   a. *Case status in local community*: Facilities in communities with high incidence of COVID-19 are at increased risk for introduction of COVID-19 into the facility. Recommendations based on surveillance data are listed for each phase. These are subject to change as knowledge evolves.

   b. *Case status in the facility*: Absence of any new facility-onset resident COVID-19 cases, or any staff cases.

   c. *Other outbreaks in the facility*: Absence of facility outbreak of other etiology (e.g., norovirus, C. difficile, influenza).

   > **Commented [A2]:** We do not see this in the CMS guidance

   d. *Written plans to support reopening*: In accordance with Code section 31-7-12.5, the long-term care facility will maintain and publish for its residents and their representatives or legal surrogates policies and procedures pertaining to infection control and mitigation within their facilities and update such policies and procedures annually; and as part of the facility's disaster preparedness plan required pursuant to subsection (c) of Code Section 31-7-3 and Department of Community Health rules and regulations, include an epidemic and pandemic plan for influenza and other infectious diseases which conforms to department and federal CDC standards that contains the following minimum elements:

      i. Protocols for surveillance and detection of epidemic and pandemic diseases in residents and staff;
      ii. A communication plan for sharing information with public health authorities, residents, residents' representatives or their legal surrogates, and staff;
      iii. An education and training plan for residents and staff regarding infection control protocols;

iv. An infection control plan that addresses visitation, cohorting measures, sick leave and return-to-work policies, and testing and immunization policies; and

v. A surge capacity plan that addresses protocols for contingency staffing and supply shortages.

e. *A testing plan*: Based on recommendations listed in Section 4.0. At minimum, the plan should consider the following components:

i. Testing of all symptomatic residents and staff, outbreak response testing, and testing of asymptomatic staff;

ii. Arrangements with commercial laboratories to test residents using tests able to detect SARS-CoV-2 virus (e.g., polymerase chain reaction (PCR)). Antibody test results should not be used to diagnose active SARS-CoV-2 infection; and

iii. 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).

f. *Adequate staffing*: Facility is not under a contingency staffing plan and/or is not receiving supplemental staffing from the State.

g. *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.

h. *Local hospital capacity*: Ability for the local hospital to accept transfers from nursing homes.

Section 2.0 Critical Components of Infection Prevention and Control

1. The following practices are recommended throughout the pandemic. Section 3.0 provides considerations for identifying the reopening phases and infection control recommendations for each phase. Infection control questions can be directed to the district health department (https://dph.georgia.gov/document/document/directory-district-epidemiologists/download) or hai@dph.ga.gov.

a. *Implement Universal source control.* Implementation and compliance evaluation of universal source control: Residents and visitors should 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 and frequently during their visit at the facility.

b. *Designate a COVID-19 unit.*

i. Create a plan for management of COVID-19 positive residents.

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    ii. Designate a COVID-19 unit or cluster of rooms with dedicated staff for cohorting and managing care for residents who test positive with COVID-19. This unit also houses admitted residents with a history of COVID-19 that have not met criteria for discontinuation for transmission-based precautions. Assign dedicated staff to work on the COVID-19 care unit and provide separate facilities and entrance/exit for these staff. These staff should have separate breakrooms and bathrooms.

    iii. If the predetermined COVID-19 unit may not be feasible based upon the number of positive residents and the types of rooms available, matching resident gender for room assignments, or a high census, consider the following:

        1. Install temporary physical barriers/screens/curtains that separate residents by at least 6 feet.
        2. Transport COVID-19 residents to a dedicated facility in consultation with your local health department.

c. *Designate an observation unit for admissions/re-admissions.* Designate an observation unit or cluster of rooms to manage new admissions and readmissions with an unknown COVID-19 status. The observation unit needs to be separate from the COVID-19 unit. In the observation unit, residents are monitored for 14 days.

d. *Manage new resident admission and re-admission placement.*

    i. Residents with confirmed COVID-19 who have not met criteria for discontinuation of transmission-based precautions should be placed in the designated COVID-19 care unit.

    ii. Residents who have met criteria for discontinuation of transmission-based precautions can go to a regular unit unless the resident has persistent COVID-19 symptoms (e.g., persistent cough). Those with persistent symptoms should be placed in a single room, be restricted to their rooms, and wear a facemask during care activities until all symptoms are resolved and they meet criteria for discontinuation of transmission-based precautions.

    iii. New admissions and readmissions whose COVID-19 status is unknown should be placed in the observation unit.

e. *Create a plan to respond to widespread testing results.*

    i. If widespread testing is being conducted in the facility, the facility should not move residents until test results are available and should be prepared to assess relocation once results are received.

    ii. If a facility decides to relocate residents who have been exposed but test negative, the following should occur:

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1. Residents should be quarantined for 14 days in a private room on transmission-based precautions. If a private room is not available, leave the resident in place until a single room is available.
2. Close daily monitoring for COVID-19 signs and symptoms (i.e., screen 3 times a day)
3. If a resident becomes symptomatic, they should be retested.

 f. *Manage exposed and symptomatic residents.*

  i. When a resident develops COVID-19 symptoms, test the resident in their room and wait for results before moving the resident. If the symptomatic resident has a roommate, ensure that the roommate is tested and leave the roommate in place unless the facility has an available single room to which to move them.

  ii. If testing indicates a positive resident with a negative roommate, move the positive resident to the COVID-19 care unit and leave the roommate in the room by themselves. For the negative resident, quarantine in place for 14 days.

Section 3.0 Considerations to Identify Pandemic Phase and Recommended Mitigation Steps

1. Facilities may use discretion to be more restrictive in certain areas, where deemed appropriate through internal policies, as long as the restrictions are consistent with any applicable federal requirements. Additional guidance for assisted living communities is provided in Section 6.0 and for long-term care facilities with memory care units in Section 7.0.

> **Commented [A3]:** To address CMS mandates

 a. Phase III guidance will serve as the least restricted phase a facility may operate in until further guidance is issued.

 b. Many senior care communities that include assisted living programs attached to skilled nursing facilities or are a part of a continuing care retirement community or senior living campus have commonly shared kitchen facilities. In the current public health mitigation environment, facilities should not routinely share direct care, dietary, or environmental services staff who may have contact with residents or tenants in other segments of the senior living operations. If there are identified cases of COVID-19 in other service delivery areas of the campus, there should be no sharing of staff between those care systems unless the same criteria and guidance are being followed.

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	Phase I	Phase II	Phase III
Phase Identification	Phase I is designed for vigilant infection control during periods of heighted virus spread in the local community and potential for healthcare system limitations. 14-day COVID-19 county positivity rate >10%	Facility may decide to initiate Phase II upon alignment with all of the following: • Baseline testing of residents and direct care staff has been conducted (see Section 4.0) • 14 days since last confirmed or suspected case resolved. • 14-day COVID-19 county positivity rate 5-10%	Facilities may decide to initiate Phase III upon alignment with all of the following: • Baseline testing of residents and direct care staff has been conducted (see Section 4.0) • 14 days since last COVID-19 confirmed or suspected case identified • 14-day COVID-19 county positivity rate <5%
Data Sources to Identify Pandemic Phases	The DPH COVID-19 Status Report web site (https://dph.georgia.gov/covid-19-daily-status-report) includes a weekly report with the 14-day PCR positivity rates by county under the Laboratory Tests tab (https://...). See also CMS county report: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg.		
Visitation - Outdoor	Outdoor visitation is preferred when possible given the lower risk of transmission due to increased space and airflow. See Section 5.0 for details on outside visitation. If the facility is undergoing outbreak testing, outside visits may occur if the facility has staffing to support outbreak containment and observation of outside visits. Outdoor visits are only for non-symptomatic and non-COVID positive residents. Each facility must determine their capacity to manage limited visits, based on considerations such as, staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits. Facilities should develop a limited visitation policy which addresses the following, at minimum: • Visitation schedule, hours, and location. • Number of visitors and visits. • Infection control practices including proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors and social distancing. • Use of PPE. • By appointment only, or as coordinated by the nursing facility, based on their ability to manage infection control practices and proper social distancing.		

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	Phase I	Phase II	Phase III
	• Designated areas to ensure safe distancing, proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors.		

Visitation	Visitation generally prohibited except for:
	• Indoor visitation for end or life and compassionate care situations, which include psychosocial or medical issues associated with isolation (as further specified below).
	
	• Window visitation as detailed in Section 5.0.
	
	• Virtual visitation, whenever possible, include:
	  o Access to communication with friends, family and their spiritual community
	  o Access to the Long-Term Care Ombudsman
		In addition to visitation permitted in Phase I, outdoor visitation (see Section 5) and limited indoor visits are allowable for non-symptomatic and non-COVID positive residents. To provide limited indoor visitation, the facility must have completed baseline testing (see Section 4.0) and be without any new facility onset COVID-19 cases for 14 days.
		
		Each facility must determine their capacity to manage limited visits, based on considerations, such as, staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits.
		
		Facilities should develop a limited visitation policy which addresses the following, at minimum:
		• Visitation schedule, hours, and location.
		• Number of visitors and visits. Facilities should limit the number of visitors per resident and the total number of visits in the facility to support social distancing.
		• Infection control practices including proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors and social distancing. Visitors need to agree to adhere to infection control practices and staff need to monitor adherence, particularly for those that may have difficulty, such as children.
		• Use of PPE.
		• By appointment only, or as coordinated by the nursing facility, based on their ability to manage infection control practices and proper social distancing.
		• Screening of visitors upon entry. Visitors unable to pass the screening or comply with infection control practices like masks should refrain from visiting
		• Rapid testing of visitors if feasible (see Section 4.0).
		• Designated areas to ensure safe distancing overall facility supervision of safe practices related to visitors. Unless the resident cannot leave their room, visits for residents in shared room should not be conducted in the resident's room.	

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Screen visitors upon arrival¶
Assist visitors with PPE donning/doffing¶
Escort to and from the resident's location¶
Limit visitor access to other areas within the facility¶
Conduct ongoing assessment of resident need for compassionate visits including but not limited to, end of life care ¶
Continuously monitor residents for social distancing, placement of mask (correct usage) and placement of furniture to support social distancing. ¶
Instruct residents and visitors to avoid touching the outside of their masks (it is contaminated); if an adjustment is needed to perform hand hygiene before and after. ¶
Instruct visitors to conduct hand hygiene frequently during visit; at a minimum upon entrance to the facility, exit from the resident's room, and exit from the facility.¶
Instruct residents to perform hand hygiene prior to leaving their room and don a mask (if tolerated). Upon re-entry to the facility or re-entry to their room, perform hand hygiene.¶
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	Phase I	Phase II	Phase III
		• Visitor movement within the facility; visitors should enter the facility and go to directly to the resident room or designated visiting area.	
Visitation – Indoors for Observation Unit, Symptomatic and COVID Positive Residents	• End of life and compassionate care visits are allowed for residents that are COVID positive, are symptomatic and awaiting test results, and for residents on quarantine in the Observation Unit. Compassionate care situations include residents recently admitted struggling to adapt to a new home, recent grief from loss, experiencing weight loss and dehydration, and those exhibiting signs of emotional distress. • Residents that are COVID positive, are symptomatic and awaiting test results, and residents on quarantine in the Observation Unit must remain in their rooms. Required protocol for end of life and compassionate care visits: • Screen visitors upon arrival • Assist visitors with PPE donning/doffing • Escort to and from the resident's location • Limit visitor access to other areas within the facility • Conduct ongoing assessment of resident need for compassionate visits including but not limited to, end of life care • Continuously monitor residents for social distancing, placement of mask (correct usage) and placement of furniture to support social distancing. • Instruct residents and visitors to avoid touching the outside of their masks (it is contaminated) and if an adjustment is needed to perform hand hygiene before and after. • Instruct visitors to conduct hand hygiene frequently during visit; at a minimum upon entrance to the facility, exit from the resident's room, and exit from the facility. • Instruct residents to perform hand hygiene prior to leaving their room and don a mask (if tolerated). Upon re-entry to the facility or re-entry to their room, perform hand hygiene.		
Window Visitation – Window in Resident Room	Window visits in the residents' room may be feasible during outbreaks. See Section 5.0 for detailed recommendations.		
Widow Visitation – Window not in Resident Room	Window visits at a window not in the resident's room (i.e., resident needs to be transported to a common area with a window) can be conducted for non-symptomatic and non-COVID-19 positive residents unless the facility is undergoing an outbreak. See Section 5.0 for detailed recommendations.		
Non-essential healthcare personnel	Restricted entry of non-essential healthcare personnel.	Entry of limited non-essential healthcare personnel/contractors as determined necessary by the facility, with screening and additional precautions,	Allow entry of non-essential healthcare personnel/contactors as determined necessary by the facility, with screening and additional

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	Phase I	Phase II	Phase III	Formatted Table
		including social distancing, hand hygiene, and cloth face covering or facemask.	precautions, including social distancing, hand hygiene, and cloth face covering or facemask.	
Resident trips outside the facility for non-medically necessary reasons	Non-medically necessary trips should be avoided. Telemedicine should be used whenever possible.	Non-medically necessary trips outside the building should be limited. Trips might be allowed for COVID-19 negative residents or residents that meet discontinuation of transmission-based precautions and are asymptomatic. Residents with multiple co-morbidities and immunodeficiencies (i.e., at increased risks for severe illness) are not recommended to participate in non-medically necessary resident trips. For limited non-medically necessary trips away from the facility: • The resident must wear a cloth face covering or facemask; and • Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. • Transportation staff should use alcohol-based hand sanitizer (ABHR) upon entry and exit to the facility. Residents should use ABHR prior to leaving facility and upon re-entry. • Transportation equipment shall be sanitized between transports • Resident screening for signs and symptoms three times a day for 14 days.		
Resident trips outside the facility for medically necessary reasons	For medically necessary trips away from of the facility: • 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 entity with whom the resident has the appointment. • Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. • Transportation staff should use alcohol-based hand sanitizer (ABHR) upon entry and exit to the facility. Residents should use ABHR prior to leaving facility and upon re-entry. • Transportation equipment shall be sanitized between transports. • Resident screening for signs and symptoms three times a day for 14 days.			

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	Phase I	Phase II	Phase III	Formatted Table
Communal dining	Communal dining limited to residents not exhibiting any signs or symptoms and only if the facility has completed baseline testing (see Section 4.0) and is without any new facility onset COVID-19 cases for 14 days. • Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). • A limited number of individuals in a dining area at one time, not to exceed 50 percent of capacity unless that would be less than 10 people. • If staff assistance is required, appropriate hand hygiene (ABHR preferred) must occur between residents as well as use of appropriate PPE. • All tables, chairs, and dining area to be cleaned and disinfected after each use.			
Screening of Residents and Staff	• Resident screening each shift for a minimum of 3 times a day. It should be clearly documented in the facility policies when shift screenings should occur and how it is tracked. • Staff screening and documentation at the beginning of each shift.		• Daily resident screening. Screening process should be documented in the facility guidelines. • Staff screening and documentation at the beginning of each shift.	
Universal Source Control & Personal Protective Equipment (PPE)	• 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. • In communities with moderate to substantial transmission of COVID-19, CDC recommends universal eye protection (face shield or googles) for staff (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html). • 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. (Note: we do not recommend quarantine for residents undergoing hemodialysis at outpatient clinics or for resident day outpatient visits.)			
Group Activities	Restrict group activities but some outdoor/doorway small group activities may be conducted (for COVID-19 negative or asymptomatic residents only) with social distancing, hand hygiene,	Limit group activities • Small group activities may occur with social distancing, hand hygiene, and use of a cloth face covering or facemask and no more than 10 people	Limit large group activities • Expanded group activities may occur with hand hygiene and use of a cloth face covering or facemask, and no more than the	

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	Phase I	Phase II	Phase III	
	and use of a cloth face covering or facemask (e.g., sit in doorway for group activity). • 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 (e.g. church service, art classes, book clubs). • Consider surveying residents for interest in activities and including recreation that supports social distancing, such as broadcasting music and worship services.	or such that social distancing is maintained. • Facilities must restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss).	number of people where social distancing among residents can be maintained. • Facilities should restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss).	Formatted Table
Salons	Entry of beautician or barber prohibited.	Entry of beautician or barber generally prohibited, but facility may conduct a risk assessment to determine if it can safely include these staff at its facility for COVID-19 negative and asymptomatic residents. To allow entry of beautician or barber, see Phase III requirements.	All applicable rules for operation of salon facilities set forth in the Governor's Executive Orders shall be followed. Additionally, the following requirements shall be followed: • The beautician or barber must remain in the salon area and avoid common areas of the facility. • Hood dryers are preferred. • Residents must wear a face mask during their salon visit. • The same guidelines need to be followed for trimming beard with two exceptions: (1) facemask removal only for the time to trim facial hair and (2)	

	Phase I	Phase II	Phase III
			no other residents in the salon.
On site gym or fitness center	No gym access. Physical therapy is addressed under medically necessary visits (see: Resident trips outside the facility for medically necessary reasons).	Gym access is limited to COVID-19 negative or asymptomatic residents or residents who meet criteria for discontinuation for transmission-based precautions. All applicable rules for operation of gyms and fitness facilities set forth in the Governor's Executive Orders shall be followed. Physical therapy is addressed under medically necessary visits (see Resident trips outside the facility for medically necessary reasons).	
Testing	• Facility shall report progress towards completion of baseline testing for staff and residents, as described in Section 4.0. • See additional testing guidance in Section 4.0.	• See guidance for testing in Section 4.0.	• See guidance for testing in Section 4.0.
Testing and Resident Management	See Section 2.0 for further details on setting up a COVID Unit, an Observation Unit, and Management of Positive and symptomatic residents and their roommates.		
Phase regression	• Not Applicable.	• A facility will continue to monitor for the presence of COVID-19 in their buildings. This will occur through resident screenings and staff screening before each shift and through the review of the facility COVID-19 data, which includes COVID-19 cases, availability of PPE, laboratory testing, and alcohol-based hand sanitizer. • If one or more staff or resident is confirmed positive for COVID-19 the facility will return to Phase I. • Once 14 days have passed with no additional	• A facility will continue to monitor for the presence of COVID-19 in their buildings. This will occur through daily resident screening and staff screening before each shift and through the review of the facility COVID-19 data, which includes COVID-19 cases, availability of PPE, laboratory testing, and alcohol-based hand sanitizer. • If one or more staff or resident is confirmed positive for COVID-19 the facility will return to Phase I. Once 14 days have passed with no additional residents or staff testing positive for

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	Phase I	Phase II	Phase III	Formatted Table
		residents or staff testing positive for COVID-19, the facility has demonstrated the ability to mitigate the spread of COVID-19 and may return to Phase II of the reopening process. • The facility also returns to Phase I when the county meets Phase I high transmission criteria.	COVID-19, the facility has demonstrated the ability to mitigate the spread of COVID-19 and may return to Phase III of the reopening process. • The facility also returns to Phase I or Phase II when the data criteria for Phase III are no longer met.	

References: Facilities should consult these authorities on a regular basis to ensure current understanding of guidance and recommendations:
- CMS website: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
- CDC website: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- GA Department of Public Health Website: https://dph.georgia.gov/
- District health department; see district health department (https://dph.georgia.gov/document/document/directory-district-epidemiologists/download).
- Georgia Department of Public Health: email hai@dph.ga.gov.

Section 4.0 Testing Requirements and Guidance

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1. On May 18, 2020, 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 previously imposed to mitigate the spread of COVID-19. CMS indicates in the above referenced QSO memorandum that testing will be a critical part of a facility lifting restrictions on operations.

2. On August 25, 2020, CMS has issued interim final rules requirement for testing of residents and staff (https://www.cms.gov/files/document/covid-ifc-3-8-25-20.pdf), and on August 26, 2020, CMS issued QSO-20-38-NH (https://www.cms.gov/files/document/qso-20-38-nh.pdf), which provides some details on requirements for resident and staff testing. This section will be updated as more information becomes available.

    a. *Antigen, PCR and Serology Tests.*

        i. All nursing homes need to arrange with a commercial laboratory to conduct nucleic acid (i.e., PCR) testing for SARS-CoV-2. As part of this arrangement, nursing homes need to have a procedure in place to retain supplies at their facility or to receive them via overnight shipping. Although antigen testing may be conducted in many circumstances, nursing homes need to maintain access to PCR testing for confirmatory testing.

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ii. On July 22, 2020, the U.S. Department of Health and Human Services (HHS) announced the distribution of rapid, antigen point-of-care (POC) testing devices to some nursing homes, and that nursing homes have the option to purchase additional instruments and supplies. On August 26, 2020, CMS issued QSO-20-38-NH (https://www.cms.gov/files/document/qso-20-38-nh.pdf), which specifies nursing homes with a CLIA waiver (https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/HowObtainCertificateofWaiver.pdf) can meet testing requirements using the POC devices.

iii. While having the benefit of rapid turnaround times, antigen tests generally have lower sensitivity compared to PCR, and the FDA Emergency Use Authorization recommends negative antigen tests be considered presumptive.

iv. If antigen testing is available, it can be used for rapid testing of symptomatic residents and staff, and all negative antigen tests for these individuals must be followed by collection and shipment of a specimen for PCR testing within 48 hours. Clinicians should use their judgment to determine if a patient has signs or symptoms compatible with COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html) and whether the patient should be tested. Most patients with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough) but some infected patients may present with other symptoms (e.g., altered smell or taste) as well. Clinicians are encouraged to consider testing for other causes of respiratory illness, for example influenza, in addition to testing for SARS-CoV-2 depending on patient age, season, or clinical setting; detection of one respiratory pathogen (e.g., influenza) does not exclude the potential for co-infection with SARS-CoV-2.

v. Antigen tests may be used to test asymptomatic staff to meet CMS staff serial testing requirements based on local incidence of COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html). Facilities should follow CDC test considerations (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-antigen-testing.html) and interpretation guidance (https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/nursing-home-testing-algorithm-508.pdf).

vi. Antigen tests may be used to test asymptomatic residents and staff as part of a COVID-19 outbreak response. Facilities should follow CDC test considerations and interpretation guidance. COVID-19 outbreaks must be reported to the district health department, including the use of PCR or antigen testing as part of the response.

vii. Nursing homes must report all positive and negative results for PCR and antigen testing of residents and staff to the health department. Procedures to report these data are under development and will be published at a later date.

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viii. As of August 2020, CDC is evaluating the performance of commercial antibody (serology) tests for SARS-CoV-2. At this time, DPH does not recommend serology testing as the sole basis for diagnosis of COVID-19 in residents or staff. In certain situations, serologic assays may be used in conjunction with viral detection tests to support clinical assessment of persons who present late in their illness.

b. *Mandatory Baseline Testing.*

i. O.C.G.A. 31-7-12.2 requires all long-term care facilities to complete baseline testing for all residents and direct care staff no later than September 28, 2020. Direct care staff includes any employee, facility volunteer, or contract staff who provide to residents any personal services, including but not limited to, medication administration or assistance, assistance with ambulation and transfer, and essential activities of daily living, such as eating, bathing, grooming, dressing, toileting, or any other limited nursing services.

ii. All long-term care facilities must conduct baseline testing for all residents and direct-care staff before progressing to Phase II. Baseline testing can identify asymptomatic and pre-symptomatic residents and healthcare workers so that informed decisions can guide appropriate steps for containment. Baseline testing should include testing all staff and residents except individuals previously testing positive in the past 3 months. As an additional recommendation, if a staff or nursing home-onset case is identified, testing should be repeated for all previously negative or untested residents and staff until no new positives are identified as discussed under Outbreak Response Testing below.

c. *Additional Testing Guidance for Residents and Staff.*

i. Immediately test any resident or staff with symptoms.

ii. Asymptomatic residents or staff who have previously tested positive for SARS-CoV-2 (by PCR or antigen detection methods) and recovered (i.e., have met criteria for removal from isolation or return to work) do not need retesting for 3 months. Residents and staff who develop new symptoms of COVID-19 should be retested regardless of previous infection.

iii. Consider testing any staff who had close contact with an individual and exposure is considered high risk (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html), either at work or in the local community that has tested positive for COVID-19. For certain exposures believed to pose a high risk, CDC recommends that exposed staff be excluded from work for 10 days following the exposure. When testing is readily available, performing testing during the 14-day post-exposure period can be considered to more quickly identify pre-symptomatic staff who could contribute to SARS-CoV transmission. Facilities that elect to perform post-exposure testing of staff should be aware that testing only identifies the presence of virus at the

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time of the test. It is possible that staff can tested negative because they are in the early stages in their infection when the sample is collected. In such situations, repeat testing can be considered.

iv. Staff that decline testing should be treated as having a positive or unknown COVID-19 status. The facility should make recommendations based on whether they are in conventional, contingency, or crisis capacity status (https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html).

v. Facilities need to follow their respective policies regarding staff testing as a condition of employment.

d. Testing for Indoor Visitors
   i. Recommend testing of indoor visitors if feasible, particularly those that visit more than once per week. Visitors may be tested weekly using an on-site rapid test or they may provide test results representing the testing conducted in the past 48-72 hours.

e. *Outbreak Response Testing.*

   i. In a long-term care facility, an outbreak is defined as a confirmed COVID-19 facility-onset case in one or more residents or one or more confirmed cases in staff members. When one staff person tests positive, consult with the health department to evaluate the risk of exposure to facility residents and staff.

   ii. In the event of an outbreak, facilities should conduct testing every week of all staff and residents except those previously testing positive in the past 90 days. Testing should be conducted every week until there are no new cases among staff or nursing-home onset cases among residents for the previous 14 days (at a minimum testing should be conducted twice). Testing in response to an outbreak is required by CMS for nursing homes as of August 25, 2020 (see https://www.cms.gov/files/document/covid-ifc-3-8-25-20.pdf).

   iii. Once a facility is no longer conducting weekly outbreak response testing, it should immediately return to testing any residents or staff with symptoms.

   iv. The trigger to resume weekly outbreak response testing is the identification of a facility-onset case in a resident or a case in a staff member.

   v. Direct care staff and staff directly exposed to residents through job responsibilities (e.g., environmental services) declining testing should be treated as having a positive or unknown COVID-19 status. The facility should make recommendations based on their current status: conventional, contingency, and crisis capacity (https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html).

f. *Serial Testing of Asymptomatic Nursing Home Staff.*

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i. On August 26, 2020, CMS issued QSO-20-38-NH (https://www.cms.gov/files/document/qso-20-38-nh.pdf), Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care Facility Testing Requirements. The County Positivity Rate is posted at this CMS web site: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg. The following information is excerpted from QSO-20-38-NH:

Community COVID-19 Activity	County Positivity Rate in past week	Minimum Testing Frequency
Low	<5%	Once a month
Medium	5%-10%	Once a week*
High	>10%	Twice a week*

*This frequency presumes availability of Point of Care Testing on-site at the nursing home or testing by a laboratory where turnaround is <48 hours. If the 48-hour turnaround time cannot be met due to community testing shortages, limited access or inability of laboratories to process tests within 48 hours, the facility should document its efforts to obtain quick turnaround test results with the identified laboratories and contact with local or state health departments.

ii. The nursing home should begin testing all staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported in the past week. Nursing homes should monitor their county positivity rate every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above.

iii. If the county positivity rate increases to a higher level of activity, the nursing home should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity are met.

iv. If the county positivity rate decreases to a lower level of activity, the nursing home should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency. See QSO-20-38-NH (https://www.cms.gov/files/document/qso-20-38-nh.pdf) for more details.

g. *Test Result Reporting.*

i. All long-term care facilities should report resident and staff cases (including baseline testing) to their district health department and all data required to the State COVID Long-Term Care Facility Database. Nursing homes also need to report all mandated data required to NHSN; see Section 8.0 for conferring rights to the State of Georgia.

ii. Pursuant to O.C.G.A. 31-7-12.5, long-term care facilities must also notify residents and their representatives or legal surrogates by 5:00 P.M. the next calendar day following the occurrence of either a single confirmed infection of

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COVID-19 or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other.

iii. All on-site antigen testing conducted by long-term care facilities must be reported to DPH within 24 hours of test completion for all testing completed for each individual tested. CMS reporting requirements can be found here (https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf). DPH will issue state reporting requirements in the future.

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Section 5.0 Guidance for Time Outdoors, Window Visits, and Outdoor Visits

1. This section provides guidelines for allowing residents to have time outdoors, outdoor visits, and window visits. This guidance also includes recommendations for safe transport of residents to participate in these activities. Georgia long-term care facilities should follow these guidelines if the facility chooses to offer outdoor and visitation guidance for its residents.

2. *Safely Transporting Residents to Have Time Outdoors, Window Visits, and for Outdoor Visits.*

   a. Staff should wear face mask and eye covering (face shield or googles) and any other appropriate PPE
   b. Resident should wear a face covering (cloth is acceptable) or face mask if tolerated.
   c. Resident treatments should be performed in the resident's room (except in emergency situations).
   d. Prior to departing room, the resident should void/have incontinence care provided and put on clean clothes/gown. The resident should use soap/water for hand hygiene after using the bathroom.
   e. If resident utilizes a dedicated wheelchair/assistive devices, staff should use multiple appropriate disinfectant wipes to wipe down all parts of the chair/device (e.g., handles, arm rest, seat back, seat, and wheels—clean areas from cleanest to dirtiest) following the disinfectants instructions for use (dwell/contact/kill time) and prior to resident being placed in wheelchair and/or prior to exiting their room, and again upon exiting the common areas, dining room, therapy gym, etc.
   f. Prior to departing room, ensure that the resident has performed hand hygiene with alcohol-based hand rub or washed hands with soap and water (if hands are visibly soiled) and donned clean clothes. Teach the resident how to properly perform hand hygiene with alcohol-based hand rub and soap/water. Validate comprehension by return demonstration by staff.
   g. Staff should perform hand hygiene before and after resident contact (after leaving resident in visitation area and prior to retrieving resident) as well as other hand hygiene indications.
   h. Upon re-entry to the facility, staff and residents should perform hand hygiene.

3. *Allowing Residents to Have Time Outdoors.*

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a. Resident time outdoors is not recommended during widespread outbreaks. During more contained outbreaks, the facility needs to assess staff ability to safely provide this service.

b. Current COVID-19 positive residents, residents with COVID-19 signs or symptoms, and residents in quarantine in the Observation Unit are not eligible for time outdoors.

   i. Assess the size of the outside space. Determine how many residents/staff can safely go out at once while adhering to social distancing. Assess the necessity for social distancing of residents (i.e., roommates, spouses, siblings).
   ii. Consider marking areas to support maintaining social distancing in designated outdoor space.
   iii. Staff must accompany residents outside. While residents are outside, at least one staff member should be present.
   iv. Residents who are suspected or confirmed of having COVID-19 should not go outside.
   v. Determine the route to travel to get outside. The route should not go through the COVID-19 Unit or Observation Unit.
   vi. Prior to leaving their room, the resident should don a mask and perform hand hygiene. If the resident cannot tolerate wearing a mask, they must adhere to social distancing.
   vii. Follow the safe transport procedures to allow residents to have time outdoors, socially distanced.
   viii. When erecting open tents or other structures outdoors to support outdoor visitation, ensure that such structures allow for natural ventilation and do not require mechanical ventilation, such as an air conditioner or fan.

4. *Window Visits.*

   a. Window visits in the residents' room may be feasible during outbreaks. Window visits requiring moving the resident from their room should not occur during outbreaks.

   b. Current COVID-19 positive residents, residents with COVID-19 signs or symptoms, and residents in quarantine in the Observation Unit are not eligible for window visits that require moving the resident from their room. These residents can participate in window visits in their room.

      i. <u>Determine if it is appropriate for your facility have window visits</u>:

         1. Consider if your residents have access to ground-floor windows and staffing to support window visits.
         2. If not all residents have access to ground-floor windows, evaluate if the facility has an area with windows to which it can safety transport residents.

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ii.   Issue a communication to your families regarding your plans for window visits.

    1.   Explain that with residents with dementia may not understand the rules of this type of visit and may become confused or frustrated. Residents may also become confused or scared if someone walks up to their window.

    2.   Families need to plan for a window visit and notify the facility to make sure the resident is prepared to greet them and has access to a phone.

    3.   For residents without window access, families will need to make appointments.

iii.   For residents with windows in their rooms:

    1.   If the resident's window will be open, the resident should stay three feet from the window and wear a face mask. Family members at the window outside the building, should sit 3 feet away from the window and wear a cloth facemask.

    2.   Visitors need to practice social distancing during the visit and stay in family group or sit 6 feet apart from other family group/visitors.

    3.   Staff should monitor window visits and provide support, such as providing a telephone for communication if needed.

iv.   For residents without windows in their rooms:

    1.   Evaluate if your facility has a ground-floor common area with windows that can accommodate socially distanced residents inside and distanced visitors outside.

    2.   Request that families make appointments in advance for window visits in common areas and have at least one staff monitor window visits.

    3.   Limit the number of residents and visitors to ensure residents and visitors are socially distanced and visits are not to extend beyond 1 hour.

    4.   Disinfect all surfaces in the visitation area, including chairs and tables.

5.   *Outdoor Visits.*

    a.   Outdoor visitation is only recommended for facilities that meet all criteria for Phase 2 or Phase 3 (see Section 3.0).

    b.   Facility-related recommendations

        i.   Establish a schedule for visitation hours, and should work with prospective visitors individually.

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    ii. Ensure adequate staff must be present to allow for helping transport residents and to assist with cleaning and disinfecting any visitation areas as necessary.

   iii. Ensure that staff maintain visual observation but provide as much distance as necessary to allow for privacy of the visit conversation.

   iv. Have a system to ensure visitors are screened for signs and symptoms of COVID-19 at a screening location designated outside the building.

    v. Have a system to ensure residents and visitors always wear a mask or other face covering , as described below.

   vi. Designate outdoor visitation spaces to be accessible to visitors without walking through the facility.

   vii. Ensure outdoor visitation spaces support social distancing of at least 6 feet between the visitor and resident.

  viii. Provide alcohol-based hand rub to persons visiting residents and provide signage or verbal reminders of correct use.

   ix. Establish additional guidelines as needed to ensure the safety of visitations and their facility operations. These guidelines must be reasonable and must consider the individual needs of residents.

    x. Consider weather conditions when permitting outdoor visitation. Visits may be prohibited or cancelled if weather conditions pose a potential safety risk.

   xi. Ensure that open tents or other structures outdoors to support outdoor visitation allow for natural ventilation and do not require mechanical ventilation, such as an air conditioner or fan.

c. <u>Resident-related recommendations</u>

    i. Residents who have had COVID-19 must no longer require transmission-based precautions as outlined by the CDC and DPH guidelines in order to participate in outdoor visitation.

   ii. Residents must wear a mask, or other face covering, as tolerated.

d. <u>Visitor-related recommendations</u>

    i. Wear a mask, or other face covering, during the entire visit unless medically contraindicated.

   ii. Use alcohol-based hand sanitizer upon entering and exiting the visitation area.

   iii. Participate in active screening for signs and symptoms of COVID-19 and attest to COVID19 status if known. This should be done at a designated location outside the building.

   iv. Walk around rather than through the facility to get to the outdoor visitation area.

    v. Sign in and provide contact information.

   vi. Not engage in holding hands, hugging, kissing, or other physical contact during family visits to reduce risk of exposure

    vii.   Control visitors under age 12 years who accompany them and ensure they comply with social distancing requirements.

   viii.   Control pets who accompany them

    ix.   Maintain 6 feet social distance.

    x.   Stay in designated visitation locations.

Section 6.0 Considerations for Assisted Living Communities

1. In contrast to nursing homes, assisted living communities may have small units or apartments that residents may occupy by themselves. Residents may function more independently and may need some assistance with activities of daily living, like dressing and bathing. Family members and friends may come to visit residents and to also take them on visits outside the facility. Most of the guidelines provided in this document apply to assisted living communities, and the following modifications are provided.

2. The visitation guidelines listed above apply to assisted living community residents. During Phases 1 and 2, assisted living community residents should also not leave the facility. The facility may designate leave policies for its residents under Phase III and will educate its residents on appropriate infection control measures, such as social distancing, hand hygiene, and wearing a cloth face covering or facemask.

3. Because residents may be in single rooms, cohorting of roommates may not apply. Residents that are symptomatic or confirmed with COVID-19 can be isolated in their rooms. Place contact precaution and CDC COVID-19 PPE signs (https://www.cdc.gov/coronavirus/2019-ncov/downloads/COVID-19_PPE_illustrations-p.pdf) on the resident's door and provide PPE for staff use before entering the residents room.

4. Moving confirmed positive COVID-19 residents in an assisted living community takes planning and consideration. Assisted living residents have a full apartment of furniture and personal affects. We do not recommend moving residents, except as a last resort. Staff moving items for either positive or suspect COVID-19 residents must wear full PPE for a COVID-19 patient while in the resident's room.

5. The facility must ensure that a suspect or confirmed COVID-19 resident has appropriate access to medical care.

6. The facility must ensure that residents in the assisted living community have COVID-19 screenings as outlined in this document.

7. Before progressing beyond Phase I, ensure facility is not under a contingency staffing plan.

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8. Any cluster of illness should be reported immediately to your district health department and COVID-19 is included on the DPH Notifiable Disease List (https://dph.georgia.gov/epidemiology/disease-reporting).

9. A resident with COVID-19 might be able to remain in the facility if the resident:

    a. Is able to perform their own activities of daily living or a consultant personnel (e.g., home health agency) can provide the level of care needed with access to all recommended PPE and training on proper selection and use
    b. Can isolate in their room for the duration of their illness;
    c. Can have meals delivered;
    d. Can be regularly checked on by staff (e.g., checking in by phone during each shift (if resident has a phone) or visits by home health agency and assisted living community staff who wear all recommended PPE); and
    e. Is able to request assistance if needed.

10. All long-term care facilities should report their baseline and ongoing testing numbers for residents and staff to their district health department and to the State COVID Long-Term Care Facility Database. Assisted living communities also have the option to report data to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 module (https://www.cdc.gov/nhsn/ltc/covid19/index.html) weekly.

11. Additional recommendations for assisted living can be found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html.

Section 7.0 Considerations for Memory Care Units

1. Memory care units are dedicated wings or units that provide specialized care for individuals with cognitive impairment, such as Alzheimer's disease or other dementia. In Georgia, these units are found in nursing homes, assisted living communities, and personal care homes. Implementing infection prevention strategies in memory care units is especially challenging, as residents can be mobile and may not be able to follow recommended infection prevention practices, such as social distancing, washing their hands, avoiding touching their face, and wearing a cloth face covering or surgical mask for source control.

2. In addition to the guidance provided in this document, the following is provided:
    a. Dedicate personnel to work only on memory care units when possible and try to keep staffing consistent. Limit personnel on the unit to only those essential for care.
    b. Continue to provide structured activities, which may need to occur in the resident's room or be scheduled at staggered times throughout the day to maintain social distancing.

    c. Provide safe ways for residents to continue to be active, such as personnel walking with individual residents around the unit or outside.

    d. Frequently clean often-touched surfaces in the memory care unit, especially in hallways and common areas where residents and staff spend a lot of time.

    e. Continue to ensure access to necessary medical care, and to emergency services if needed and if in alignment with resident goals of care.

    f. Increase the frequency of hand hygiene for staff and residents.

3. When a resident on a memory care unit is suspected or confirmed to have COVID-19, consider the following:

    a. Given that memory care residents may be ambulatory and often cannot follow infection prevention recommendations, consider that all residents and unit staff may have been exposed.

    b. Interactions with memory care residents can be unpredictable, so include eye protection (face shield or googles) for all staff on the memory care unit. Eye protection is in addition to other PPE recommendations.

    c. Before moving a positive resident to a COVID-19 unit, consider if the COVID-19 unit staff can manage a memory care resident.

4. Additional guidance can be found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html

Section 8.0 Reporting to the National Healthcare Safety Network (NHSN)

1. The CMS requirement for nursing homes to report data to the NHSN LTCF COVID-19 module became effective on May 8, 2020 when CMS published their interim final rule with comment (https://www.govinfo.gov/content/pkg/FR-2020-05-08/pdf/2020-09608.pdf). CMS memo QSO-20-29-NH (https://www.cms.gov/files/document/qso-20-29-nh.pdf) provides additional information for nursing homes to meet COVID-19 reporting requirements including details about a grace period prior to enforcement.

2. CMS is only collecting nursing home (i.e., skilled nursing facility and/or nursing facility) data. Nursing homes are to confer rights (share data) in NHSN to the Georgia Department of Public Health group prior to entering Phase I. Instructions for conferring rights can be found here.

3. Assisted living communities and personal care homes larger than 25 beds may submit data to NHSN and confer rights to the State of Georgia if they wish, but they are not required to do so.

4. More details regarding the NHSN LTC Module are found at https://www.cdc.gov/nhsn/ltc/covid19/index.html.

This Administrative Order shall take effect at __:__ a.m./p.m. on September ___, 2020, and unless amended, terminated, or otherwise superseded, shall remain in effect until the conclusion of the Public Health State of Emergency initially declared by Executive Order 03.14.20..

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SO ORDERED, this _____ day of September 2020.

_____
Kathleen E. Toomey, M.D., M.P.H.
Commissioner
State Health Officer

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