Interim Guidance on the Management of COVID-19 for Employees and Residents of Licensed Group Homes

Guidance as of May 27, 2020

The Minnesota Department of Health (MDH) and Department of Human Services (DHS) are working together to monitor and respond to the developing COVID-19 situation. Together, the agencies provide guidance for DHS-licensed residential service providers who deliver 245-D licensed services in a licensed community residential setting and for MDH-licensed Intermediate Care Facilities (ICF/DD), referred to collectively in this document as “group homes.”

Guidance for group homes must balance workforce challenges and uphold individual rights while preventing spread of the virus that causes COVID-19 in these settings. Residential providers who deliver 245-D licensed services and ICFs are settings where rapid spread of COVID-19 can occur among employees and residents.

This document provides guidance for residents, staff, and administrators on how to best manage and reduce the spread of COVID-19 in a group home once a staff member or resident tests positive. For more information on the prevention of COVID-19 and mitigation of staffing shortages in group home settings, please visit the links to additional MDH resources at the end of this document. This guidance is intended to advise providers on best-practice recommendations in these settings and does not mandate specific actions.

1 In this document, the term “group home” refers to providers delivering 245-D licensed residential supports and services in adult foster care homes, community residential settings, supervised living facilities, and Intermediate Care Facilities (ICF-DD).
Recommendations for Residents

Staff should monitor all residents at least once a day for fever or symptoms of COVID-19\(^2\) and maintain a low threshold to test individuals with even slight changes in their health status. Older adults and individuals with disabilities may not display typical symptoms of illness. Other less common symptoms could include gastrointestinal symptoms like nausea, vomiting, diarrhea, or low pulse oxygenation.\(^3\) Any resident who tests positive for COVID-19 is considered to have a confirmed diagnosis while residents experiencing symptoms compatible with COVID-19 are considered to have a suspect diagnosis, even with no laboratory testing.

Staff who work with residents should use all appropriate PPE as resources allow:

- For prolonged\(^4\) close-contact\(^5\) encounters, staff should wear a surgical facemask or respirator\(^6\) and eye protection (e.g., face shield, goggles, or safety glasses with side shields).
  - Gowns and gloves should also be worn when contact with secretions or bodily fluids is anticipated or for any encounters that require extensive body contact (e.g., rolling, toileting).
  - Washable homemade masks are not considered PPE, so staff should wear a surgical facemask or respirator for any prolonged close-contact encounters with confirmed or suspected COVID-19 residents.
- If performing an aerosol-generating procedure\(^7\), staff should wear gown, gloves, eye protection, and respirator.

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\(^3\) More information can be found at \[Pulse Oximetry and COVID-19\](https://www.health.state.mn.us/diseases/coronavirus/hcp/pulseoximetry.pdf).

\(^4\) Prolonged exposures are any exposure of 15 minutes or more within a 24-hour period.

\(^5\) Close contact is defined as being within 6 feet of a person with confirmed COVID-19 or having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19.

\(^6\) Use of N95 or higher-level respirators are only recommended for staff who have been medically cleared, trained, and fit-tested, in the context of an employer’s respiratory protection program, as defined by the Occupational Safety and Health Administration (OSHA). Group home providers should document their good faith efforts to comply with OSHA standards for N95 use. During times of extreme supply constraints, when there may be limited availability of respirators or fit test kits, employers may face challenges in fit testing workers. For additional guidance in these circumstances, group home providers should refer to \[CDC’s NIOSH Science Blog: Proper N95 Respirator Use for Respiratory Protection Preparedness\](https://blogs.cdc.gov/niosh-science-blog/2020/03/16/n95-preparedness/).

\(^7\) \[MDH: Aerosol Generating Procedures and Patients with Suspected or Confirmed COVID-19\](https://www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf)
Diagnostic Testing of Symptomatic Residents

Testing of symptomatic residents in group homes is a high priority and strongly encouraged because of the severe potential for COVID-19 disease to spread in congregate settings. All residents with symptoms should be tested for COVID-19 and other causes of respiratory illness. While awaiting test results, residents should be advised to stay in their room or at least 6 feet away from others in the home.

Staff and administrators should assist residents to coordinate testing. The resident’s primary care physician may be able to provide COVID-19 testing or may need to refer the resident to an alternative testing site. Residents, staff, or administrators having difficulty identifying a testing site can contact their local public health department or MDH to identify testing resources in their area.

The type of test currently used for clinical decision-making is the RT-PCR test. This test is used to identify whether a person has detectable viral material present at the moment the specimen was collected. A person who tests negative on one day could still develop illness or eventually test positive. Testing of residents who do not have symptoms is recommended when the following criteria are met:

- There is a comprehensive strategy in place to physically separate COVID-19-positive residents together (cohorting) while also identifying and dedicating a subset of staff to work with them, AND
- The resident is informed of, and agrees to, COVID-19 testing and the potential consequences of positive test results (e.g., cohorting and the need to separate from others during the infectious period).

Testing of residents and staff throughout a home can be considered as a strategy to limit COVID-19 transmission when one or more infected individuals are identified. As part of this testing strategy, administrators and staff should have plans in place for additional staff (as some staff without symptoms may be found to be positive for COVID-19), implement enhanced infection prevention measures, increase appropriate use of PPE, and communicate with residents, families, and staff.

Care of Residents with Confirmed or Suspected COVID-19

Staff should monitor ill residents, including documentation of temperature and pulse oximetry results at least three times daily to quickly identify residents who require transfer to a higher level of care. For residents who require nebulizer treatments or open suctioning, providers should follow MDH guidance on [Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (PDF)](www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf). Staff who enter the room of a resident with confirmed or suspected COVID-19 should wear all appropriate PPE (i.e., surgical facemask or respirator, eye protection, gown, and gloves). [CDC: Strategies to Optimize the Supply of PPE and Equipment](www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html) should also be put into place.
Residents with confirmed or suspected COVID-19 should have a single-person room with a private bathroom and a door that closes. If a private bathroom is not possible, an alternative option would be to dedicate a separate bathroom in the home for positive residents. Staff should clean and disinfect the frequently used areas of the bathroom after each use by the COVID-19 positive resident and clean and disinfect the entire bathroom at least twice per day, or more frequently after times of heavy use.

If possible, a cohorting plan should be adopted to allow dedicated space, with dedicated staff, for COVID-19-positive residents. Residents with confirmed or suspected COVID-19 (symptomatic or asymptomatic) should remain in their room as much as possible. If it is essential to leave their room, residents should:

- Wear an alternative facemask or use another barrier, such as tissues, to cover their mouth and nose.
- Perform hand hygiene immediately before or after leaving their room.
- Practice social distancing to remain at least 6 feet from others.

**Discontinuing use of PPE for the Care of Residents with COVID-19**

Staff who provide direct care to residents with confirmed or suspected COVID-19 should use all appropriate PPE for a recommended period of time. It is important that staff should still continue to wear masks and eye protection for all resident encounters requiring close contact, whether or not they are confirmed or suspected to have COVID-19. Since the duration of viral shedding can vary from person to person due to differing circumstances, determining when to discontinue use of PPE is generally based on whether or not the resident displayed symptoms or is at high risk for complications, either due to advanced age (75 years of age or older) or immunocompromising conditions (e.g., medical treatment with immunosuppressive drugs, bone marrow or solid organ transplant recipients, inherited immunodeficiency, poorly controlled HIV).

- **For residents who displayed no symptoms,** follow CDC’s time-based or test-based strategy.
- **For residents who displayed symptoms,** follow CDC’s symptom-based or test-based strategy.


- **For residents with persistent symptoms or those who are 75 years of age or older (with or without symptoms),** MDH recommends that PPE be used for care of these individuals until:
  - At least 14 days have passed since symptom onset (or test date if asymptomatic), AND
  - 3 days have passed since recovery, defined as fever resolution without fever-reducing medication and improvement in respiratory symptoms (e.g., cough, shortness of breath).
For residents with immunocompromising conditions (with or without symptoms), MDH recommends that PPE be used for care of these individuals until:

- At least 21 days have passed since symptom onset (or test date if asymptomatic), AND
- 3 days have passed since recovery, defined as fever resolution without fever-reducing medication and clear improvement in respiratory symptoms (there may be lingering occasional cough). After release, residents with lingering cough should wear a facemask when around another person.

In some circumstances, depending on the nature of immunosuppression and concern about continued use of PPE, residents with immunocompromising conditions could undergo a test-based strategy to discontinue PPE use. In this case, consultation with an expert in infectious diseases may help interpret test results.

COVID-19 Positive Residents Returning from Hospitals

More information on hospitalized residents returning to a congregate setting, including group homes, can be found at [MDH: Interim Guidance for Hospital Discharge to Home or Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions (PDF)](https://www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf).

Recommends for Employees

Similar to residents, any staff member who tests positive for COVID-19 is considered to have a confirmed diagnosis, while those experiencing symptoms compatible with COVID-19 are considered to have a suspect diagnosis, even with no laboratory testing. Employees of a group home who become ill with measured or subjective fever, or other symptoms compatible with COVID-19, should notify their supervisor immediately and stay away from work.

Diagnostic Testing of Symptomatic Staff

Testing of symptomatic staff in group homes is a high priority and strongly encouraged because of the severe potential for COVID-19 disease to spread in congregate settings. Staff with symptoms compatible with COVID-19 should contact their primary care physician to be evaluated and appropriately tested for COVID-19 and other causes of respiratory illness. Employers may also develop their own plans to coordinate testing of their employees. Staff and administrators having

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8 “Transmission-Based Precautions” for COVID-19 are infection control practices to be used in addition to standard precautions like frequent hand hygiene and include use of all appropriate PPE (e.g., mask/respirator, eye protection, gown, and gloves), as resources allow. [CDC: Transmission-Based Precautions](https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html)
difficulty identifying a testing site can contact their local public health department or MDH to identify testing resources in their area.

As previously mentioned, the type of test currently used for clinical decision-making is the RT-PCR test. This test is used to identify whether a person has detectable viral material present at the time the specimen was collected. A person who tests negative on one day could still develop illness or eventually test positive. Testing of staff who do not have any symptoms is recommended if there is a comprehensive strategy in place to exclude positive staff for the recommended time period outlined below. Supplemental staff should be available to continue providing adequate care to residents.

**Return to Work Guidelines**

Staff who are symptomatic or have tested positive for COVID-19 may return to work when they meet certain established criteria.

**If employees were not tested for COVID-19 and have an alternate diagnosis:**
- Criteria for return to work should be based on that diagnosis (e.g., tested positive for influenza).
- If staff are hospitalized for an issue not related to COVID-19, return to work should be based on the discharge diagnosis from the hospital and the employer’s standard guidance for ill employees.

**If staff test negative for COVID-19:**
- If symptomatic, follow the employer’s standard guidance for ill employees, including at least 24 hours after fever resolution.
- If asymptomatic, staff are allowed to work but should continue to self-monitor for symptoms and consider retesting if fever or other symptoms compatible with COVID-19 occur.

**If staff test positive for COVID-19:**
- If symptomatic, follow the CDC’s symptom-based or test-based strategy to determine when they may return to work. After returning to work, staff should continue to wear a facemask (procedure or surgical mask, not a cloth face covering) for source control at all times until symptoms are completely resolved or 14 days after symptom onset, whichever is longer. Staff should self-monitor for symptoms and seek re-evaluation if respiratory symptoms recur or worsen.
- If asymptomatic, follow the CDC’s time-based strategy or test-based strategy to determine when they are able to return to work. Staff should wear a facemask (procedure or surgical mask, not a face covering) for source control at all times in the group home until 14 days after the test date.


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Recommendations for Owners, Administrators, and Program Directors

The following recommendations are intended for owners, administrators, or directors who manage licensed residential settings and who have residents or staff with confirmed or suspected COVID-19.

Perform Risk Assessments for Exposed Staff and Residents

Identification and classification of staff and resident exposures to a person with confirmed or suspected COVID-19 remains a useful tool for disease mitigation. MDH recommends that group home administrators perform individualized risk assessments as soon as possible after a confirmed case is recognized. The window of time for identifying exposures to COVID-19 positive individuals is 48 hours prior to the positive person’s symptom onset date (or test date if asymptomatic) until one of the following criteria is met:

- All appropriate measures were implemented to limit spread of disease (e.g., use of all appropriate PPE and social distancing greater than 6 feet).
- The person was no longer in the building or home.
- The person has been determined to be cleared of infection per the CDC’s symptom-based, test-based, or time-based strategies for discontinuation of PPE or return to work.

For classification of staff exposures with prolonged close contact with a resident, visitor, or other staff, follow CDC: Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html). MDH recommends these employees stay out of work for 14 days from the date of their last exposure. If staffing shortages occur (i.e., the employer has exhausted all other staffing options), employers may ask these staff to return to work if they do not have symptoms. MDH will request the names and contact information of these employees to enroll them in daily symptom monitoring and follow-up directly with them through email.

With the employee’s permission, symptom information can be shared with group home management who are responsible for overseeing employee health. Employees will also be provided with a phone number to reach MDH at all times.

For classification of resident exposures with prolonged close contact with a resident, visitor, or staff, MDH recommends following CDC: Public Health Recommendations for Community-Related Exposure (https://www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html) and maintaining a low threshold for testing if they have any change in health status.
MDH Assistance with Risk Assessment and Infection Control

MDH has a team dedicated to following up on staff exposures in congregate settings, including group homes. A representative of the MDH response team will attempt to contact the facility within 24 hours of being notified of group home resident or staff member testing positive for COVID-19. The response team will assist the group home in performing the risk assessment process; however, it is recommended that group home managers be familiar with the process and begin implementation of risk assessments and appropriate staff exclusion prior to being contacted by MDH. Following the initial call with the response team, a representative from MDH or DHS will contact the group home management to address any immediate issues in the home and link the management and staff to appropriate resources.

Continue to Implement Infection Control and Prevention Measures

Having strong infection control measures in place is paramount to reducing the spread of disease. In particular, perform the following:

- If available, licensed nurses play a critical role in the response to COVID-19 in group homes. Identify them as infection preventionists who educate, monitor, and audit all aspects of this guidance.
- As much as possible, limit the number of people allowed in recreational areas as well as the kitchen and dining area at one time, so that everyone can stay at least 6 feet apart from each other.
- Provide COVID-19 prevention supplies such as soap, alcohol-based hand sanitizers (containing at least 60% alcohol), tissues, trash baskets, and cloth face coverings that are washed or discarded after each use.
- Instruct staff to clean and disinfect shared areas (such as dining areas, laundry rooms, and elevators) and frequently touched surfaces using EPA-registered disinfectants more than once a day, if possible.
- Make sure that shared rooms have good air flow from an air conditioner or an opened window.
- Encourage residents to perform diligent hand hygiene and wear a cloth barrier for source control throughout the day, if tolerable.
- Ensure protocols requiring staff to wear appropriate PPE, as available, throughout their shift and that employees are trained and comfortable with these PPE protocols and hand hygiene measures.
- Instruct staff to perform hand hygiene on arrival to the group home, before and after resident encounters, before putting on PPE, after removing PPE, before and after eating, and prior to leaving the group home.
- Conduct end-of-shift assessments with staff to identify PPE breaches and potentially concerning exposures of staff to residents with COVID-19.
COVID-19 Management Recommendations for Group Homes

- Remain diligent for the potential re-introduction of COVID-19 into your facility. It is not yet known how long the immune response offers protection to those who have been infected.

Plan for Potential Staffing Shortages

Staffing shortages are likely to occur if residents or staff develop COVID-19. Facilities should plan for emergency staffing before a positive COVID-19 case occurs. Possible staffing options might include recruiting former or retired employees, using temporary staffing agencies, using furloughed staff from day program providers, establishing alternative care sites for residents needing use of emergency respite service, and working with local public health to identify any other local staffing resources.

Communicate to Residents, Families, and Staff

Group home providers should reassure residents, families, and staff how they will keep everyone safe:

- Identify communications such as email, websites, text messaging, and flyers to help convey information on ways to stay healthy, including how staff and residents can manage stress.
- Address potential language or cultural barriers, especially where to direct questions or concerns.
- Make sure that employees understand the organization’s sick leave policies and consider implementing flexible sick leave policies that encourage staff to stay home when sick, even without documentation from doctors, or to care for sick family or household members.

Resources