

STAY SAFE **MN**

COVID-19 Toolkit

INFORMATION FOR LONG-TERM CARE FACILITIES



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Contents

Minnesota Department of Health: What we do.....	4
When and how to report cases of COVID-19.....	4
How to use this toolkit.....	4
Part I: Preparing for COVID-19 in long-term care facilities.....	5
Administration concepts.....	5
Keep COVID-19 from entering your facility	6
Make a plan for action	9
Train and empower staff members	11
Plan to group (“cohort”) residents based on COVID-19 status	13
Identify infections early	13
Notify MDH early and rapidly	15
Prevent unseen spread of COVID-19 in your facility	15
Reimbursement for emergency expenses	18
Part II: Responding to COVID-19 cases in long-term care facilities.....	21
Use a line list to track residents with COVID-19	21
Assess current and anticipated supply of PPE	21
Assess staffing availability.....	22
Prevent spread of COVID-19 in your facility	22
Review and audit IPC practices, including hand hygiene	23
Care for COVID-19 residents, and implement the cohort plan	24
Discontinue transmission-based precautions when appropriate	25
Conduct staff risk assessment and monitoring	26
Facilitate post-mortem testing	28
Use a checklist.....	29
Part III: Ideas to inspire	29
Hold a COVID-19 preparedness exercise	29
Empowering staff with knowledge and training.....	30
Leaders: Consider these five things that you can do right now	30
Help residents and families remain connected	31
Resources	31

Appendix A: Staff Health Screening Log	34
Appendix B: PPE Posters	35
Appendix C: Long-term Care Emergency Staffing.....	37
Appendix D: Hand Hygiene and PPE Compliance Observations.....	39
Appendix E: Active Resident Monitoring for COVID-19 Symptoms.....	40
Appendix F: Template Line List for Residents with Signs and Symptoms of COVID-19	42
Appendix G: PPE Breach Log	43
Appendix H: Sample Risk Assessment for Health Care Workers Potentially Exposed to COVID-19 in Minnesota	44
Exposure to COVID-19-positive patient or resident	45
Exposure to COVID-19 Positive Co-worker	46

Summary of recent changes as of August 14, 2020

- Compassionate care visit guidance updated per CMS
- Guidance for dining and activities updated per CDC and CMS
- Discontinuation of Transmission-Based Precautions guidance updated per CDC
- Contingency Staffing Plan updated per the State Emergency Operations Center

Summary of recent changes as of February 26, 2021:

- How to report cases of COVID-19
- Visitation guidance
- Screening of health care workers and visitors updated per CDC
- PPE allocation and use per CDC and State Emergency Operations Center updates
- Cohorting guidance per MDH guidance
- Resident dining during quarantine per MDH guidance
- DHS reimbursement updates
- Appendix A updates per CDC guidance
- Removed Appendix I

Minnesota Department of Health: What we do

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

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

When and how to report cases of COVID-19

[Minnesota Rule 4604.7050 \(https://www.revisor.mn.gov/rules/4605.7050/\)](https://www.revisor.mn.gov/rules/4605.7050/) includes:

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

- Individual residents or staff identified with confirmed COVID-19.
- Death in a resident with suspected or confirmed COVID-19.

COVID-19 cases in residents and staff and COVID-19-associated deaths in residents may be reported using the online form [REDCap: Submitting Clinical Information on Long Term Care COVID-19 Cases \(https://redcap-c19.web.health.state.mn.us/redcap/surveys/?s=H8MT9TTNCD\)](https://redcap-c19.web.health.state.mn.us/redcap/surveys/?s=H8MT9TTNCD).

We will notify your local public health department as needed.

How to use this toolkit

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

Additional resources for facilities without cases, including guidance for visitation and outside services, is available at [Long-term Care: COVID-19 \(https://www.health.state.mn.us/diseases/coronavirus/hcp/ltc.html\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/ltc.html).

Part I: Preparing for COVID-19 in long-term care facilities

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

Administration concepts

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

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

Leadership should review the facility's incident command structure and emergency plans and decide what aspects fit for COVID-19 and what may need modification. If you do not have an incident command structure, consider developing formal teams to guide efforts such as staff support, communication, and infection control. Having a process and clear line of communication and authority are vital to a successful plan and response. [Long-Term Care Emergency Preparedness - Minnesota Dept. of Health](https://www.health.state.mn.us/communities/ep/ltc/index.html) (<https://www.health.state.mn.us/communities/ep/ltc/index.html>)

Command planning should account for the following areas:

- **Command** – Who is in charge and has authority to make decisions? What is the back-up plan if they become ill? If you are part of a parent company or organization, determine who could step in as on-site leadership in case key leadership has a prolonged absence due to COVID-19. Implement a nonclinical rotation of leadership on-site during off hours. These leaders can address issues, audit practices, and be a resource for staff questions and concerns.
- **Communications** – How can leadership be reached including off-hours? What is the communication plan/process to communicate with staff, residents, and families?
- **Coordination** – Who is the facility working with in the community and region to take advantage of assets, training, and other resources? This should include MDH regional personnel as well as your local emergency manager, local public health department, and your health care coalition (including your Regional Health Care Preparedness Coordinator)

[Regional Health Care Preparedness Coordinators \(RHPCs\) - Minnesota Dept. of Health \(https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html\).](https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html)

- Space – How will the facility most effectively utilize its space to provide care for one or multiple residents with COVID-19? How can space be used for staff to assure appropriate areas for doffing and donning PPE and to assure that break rooms and other areas remain “clean.” [Principles for COVID-19 Cohorting \(https://www.health.state.mn.us/diseases/coronavirus/hcp/lcipchohort.pdf\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/lcipchohort.pdf)
- Staff – Facility must have staffing redundancies so that if staff become ill on shift or receive a positive test result (particularly when multiple staff are tested and could be pulled off shift on short notice) contingencies are in place. Staff training and appropriate fit-testing for N95 respirators should be included in the staff planning. What support can be provided for staff that have child care or other issues? What will be the plan for getting staff connected with testing if required, and to make determinations about return to work?
- Supplies – What supplies are needed, including PPE, training supplies, additional resident linens or care supplies if duplicate carts/resources will be needed in the COVID-19 resident care areas?
- Special considerations – What are the policies and processes for COVID-19 resident care? What special training may be needed or changes to usual operations to accommodate safely the care of COVID-19 residents? Memory care residents may also require specific plans and policy.

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

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

Keep COVID-19 from entering your facility

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

Visitation

- **Screen and restrict visitors who have symptoms of COVID-19 from entry into the facility.** [CMS: Frequently Asked Questions \(FAQs\) on Nursing Home Visitation \(https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf\).](https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf)
- [COVID-19 Guidance: Nursing Home Visitation and Activity Restriction Modifications \(https://www.health.state.mn.us/diseases/coronavirus/hcp/nhvisit.pdf\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/nhvisit.pdf)

- QSO-20-39-NH [Nursing Home Visitation-COVID-19](https://www.cms.gov/files/document/qso-20-39-nh.pdf) (<https://www.cms.gov/files/document/qso-20-39-nh.pdf>)
- When a resident spends time with a visitor for a compassionate visit, even if outdoors on facility grounds, they must remain at least six feet apart.
- Restrict all volunteers and nonessential health care personnel, including consultant services (e.g., barber).
- Develop processes to help residents and family members remain connected, including facilitating resident access to virtual visits by phone and other electronic devices.
- Assist families with placement of electronic monitoring devices if requested.
- Make a plan to ensure regular communication with families and residents.

Screen staff

Screen all staff for fever and symptoms of illness before starting each shift. In addition to facility staff, conduct health screening for other essential health care personnel including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyors, chaplain at end of life, mortician, etc.

- Conduct assessment for fever (measured temperature higher than 100.0°F) or subjective fever (chill, feeling feverish).
- Ask about new symptoms of illness (e.g., measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell).
- Consider further evaluation for fever lower than 100.0°F, or other symptoms not attributable to another diagnosis, including, nausea, vomiting, diarrhea, abdominal pain, runny nose, and fatigue.
- Facility staff are a priority group for COVID-19 testing in Minnesota and symptomatic staff should be tested as soon as possible.
- A sample paper form for documenting staff screening is provided in Appendix A.
- An electronic Employee Illness Tracking Tool and instructions are available at [Long-term Care: COVID-19](https://www.health.state.mn.us/diseases/coronavirus/hcp/ltc.html) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/ltc.html>). This Microsoft Excel-based tool can be used by facilities to meet the Centers for Medicaid and Medicare Services requirements for employee monitoring.

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

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

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

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

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

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

Limit and monitor resident transport out of facility

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

- Residents should wear well-fitting face mask when they leave their room and when traveling via resident transport services. If the resident has or is suspected to have COVID-19, wear a well-fitting face mask if tolerated when leaving the room or when within 6 feet of others if able.
- Develop a process to ensure communication about inter-facility transfer (including EMS) of residents with confirmed or suspected COVID-19. Communicate with any transport services ahead of time if a resident with suspected or confirmed COVID-19 needs transport.
- Screen residents for fever and new respiratory symptoms (cough, shortness of breath) when going offsite for dialysis or other medical appointments.
- Alert the receiving facility ahead of time if there is COVID-19 in the facility. Dialysis centers may adjust the resident's schedule due to possible exposure to COVID-19.
- If a resident with respiratory symptoms, or who is COVID-19 positive, needs dialysis, work with the dialysis center to develop a plan. The goal is to put in place infection control measures, and to adjust the resident's dialysis schedule to accommodate the dialysis center's protocol of treating residents with respiratory symptoms or COVID-19-positive status.

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

- Because of the quarantine implications, we recommend that residents do not leave the facility campus during this time of COVID-19 community transmission (e.g., when the source of COVID-19 infection cannot be traced). This does not mean residents cannot go outside for fresh air. Residents should wear a well-fitting face mask as tolerated when they go outside and should maintain social distancing.
- [Long-term Care Guidance for Non-medically Necessary Outings](https://www.health.state.mn.us/diseases/coronavirus/hcp/lcceoguide.pdf)
(<https://www.health.state.mn.us/diseases/coronavirus/hcp/lcceoguide.pdf>)

Appendix A: Staff Health Screening Log

Make a plan for action

Utilize your All Hazard Plan/Emergency Operations Plan

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

Complete the COVID-19 Action Plan for health care facilities

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

- The tool will also lead to recognition of actions where you have not yet defined steps or a responsible person.
- Everyone in the organization, including organizational leadership, needs to be involved in creating, supporting, and disseminating the COVID-19 Action Plan.
- If you need infection prevention and control assistance in your preparation, email Health.icar@state.mn.us.
- Engage in conversations with residents, their families, and their primary care providers to ensure all residents have opportunity to develop POLST (Physician Orders for Life Sustaining Treatment) and advanced directives. Providers should address COVID-19-specific risk factors and care decisions to ensure the resident's wishes are followed in case of infection.

Know what PPE you need and how much you have available

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

CDC recommendations regarding PPE to implement for universal source control measures and for care of a resident with suspected or confirmed SARS-CoV-2 infection can be found at: [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic \(https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#definitions\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#definitions)

Cloth/alternative masks are not PPE and should not be worn by health care personnel when PPE is indicated. [MDH: Contingency Standards of Care for COVID-19 Personal Protective Equipment For Congregate Care Settings \(https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf\)](https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf).

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

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

Initiate measures to optimize current supply.

- Consider extended use and reuse of face masks and eye protection, and prioritization of gowns for certain resident-care activities [Optimizing Personal Protective Equipment \(PPE\) Supplies \(https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html)
- **If supplies become low (4-7 days left), complete a PPE Request Form.** [COVID-19 Supply Chain \(https://redcap.health.state.mn.us/redcap/surveys/?s=LXR9JMRYEJ\)](https://redcap.health.state.mn.us/redcap/surveys/?s=LXR9JMRYEJ). In completing this form, there is no guarantee your request will be filled. Requests will go through a needs prioritization process. A facility can request PPE again if needed.
- Facilities should continue to work with their PPE vendors to obtain PPE.

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

- For residents on Transmission-Based Precautions (e.g., those with confirmed or suspected COVID-19), focus staff education on what to wear and when (gown, respirator, eye protection, and gloves). Reinforce hand hygiene prior to donning PPE and after removal of PPE.
- Post visual references like CDC's donning and doffing instruction sheets where they can be seen by staff. [CDC: Using Personal Protective Equipment \(PPE\) \(https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html), Appendix B.
- Use signs for resident doors to remind staff when COVID-19 precautions are needed. [MDH: Enhanced Respiratory Precautions Essential Personnel Only - Keep Door Closed \(https://www.health.state.mn.us/diseases/coronavirus/hcp/ppepresign.pdf\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/ppepresign.pdf).

Plan for staff illness and shortages

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

Staffing needs might arise before a positive case is detected. Use the resources in Appendix C to make local staffing contacts.

Broad approaches to sustain strong staffing include:

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

Appendix B: PPE Posters

Appendix C: Long-term Care Emergency Staffing

Train and empower staff members

Emphasize infection prevention and control (IPC) protocols

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

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

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

- Practice strict hand hygiene
- Maintain social distancing (e.g. during breaks, when in common areas).

- Appropriately put on (don), take off (doff), and care for respirator, well-fitting face mask, eye protection, and other PPE.
- Implement Transmission-Based Precautions, including training, demonstration, and observation of donning and doffing.

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

Provide situational awareness and empower employees to make good choices

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

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

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

Empower employees to make decisions that will keep them, residents, and co-workers safe.

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

Safeguard your staff's mental well-being

- Create a peer-to-peer buddy system for residents and one for staff so that everyone can have someone to check in with daily.
- Assess residents for depression and anxiety or other behavioral issues. Make connections to mental health services for those who need additional support.
- Facilitate access to mental health care and mental health crisis resources for residents and staff as needed.

MDH resource: [MDH: Disaster Mental and Behavioral Health and COVID-19](https://www.health.state.mn.us/communities/ep/behavioral/covid19.html)
(<https://www.health.state.mn.us/communities/ep/behavioral/covid19.html>)

Appendix D: Hand Hygiene & PPE Compliance Observations

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

Make a plan for COVID-19-positive residents

Grouping of residents, or cohorting, should be done when possible to separate COVID-19-positive residents from residents who are not affected. Plans to cohort should be carefully established in advance and should be centered on implementation of robust IPC practices. The better you plan and include the resident, the better this temporary move will be. Provide residents being transferred with the contact information for the Office of Ombudsman for Long-Term Care. [Principles for COVID-19 Cohorting in Long-term Care](https://www.health.state.mn.us/diseases/coronavirus/hcp/lcipcchort.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/lcipcchort.pdf>)

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

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

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

Identify infections early

Conduct active health screening and surveillance of residents

Actively screen all residents for fever and respiratory symptoms of illness at least daily.

Increase monitoring of ill residents to at least three times daily. Consider increasing monitoring of asymptomatic residents from daily to every shift to rapidly detect any residents with new symptoms.

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever (temperature of 100.0°F or higher) and symptoms consistent with COVID-19. If residents have fever or symptoms consistent with COVID-19, implement Transmission-Based Precautions as described below.
- Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than

two temperatures higher than 99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.

- Routine use of pulse oximetry to screen for new or worsening hypoxia may identify infected residents. If a pulse oximeter is available, daily screening is recommended.
- Chart all clinical measurements and symptoms for each resident. An active surveillance sheet is available in Appendix E.
- Use cumulative data to conduct active surveillance. Record daily the number of residents that have been transferred to acute care, even for nonrespiratory disease, by using a sheet like the one in Appendix E. In some facilities, an increasing number of transferred residents has preceded confirmation of COVID-19 in the facility.
- All residents positive for fever or symptoms should be isolated, placed under Transmission-Based Precautions, and tested for COVID-19. Clinicians are encouraged to test for other causes of respiratory illness in addition to COVID-19.

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

- Assess newly admitted residents with respiratory symptoms that include cough, fever, or shortness of breath for known exposure to a person with COVID-19 in the 14 days prior to illness onset, or recent admission to facilities with COVID-19 cases. Ask discharging facility whether diagnostic testing has been conducted for COVID-19.
- If the resident was SARS-CoV-2-positive within the last 90 days and has met criteria to discontinue Transmission-Based Precautions, and is currently asymptomatic, the resident may return or be admitted to the facility with standard care. [Principles for COVID-19 Cohorting \(https://www.health.state.mn.us/diseases/coronavirus/hcp/ltpchhort.pdf\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/ltpchhort.pdf)

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

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

- Contact local provider group or health system to arrange for testing of residents and staff. Arrange for possible facility-wide testing in the case of high number of residents or staff becoming ill in a short timeframe.
- If you do not have access to laboratory services through a local provider group, work with MDH to facilitate testing. MDH can provide swabs and process specimens. The facility must use staff or other services (e.g., local public health) to collect nasal swabs from residents and staff.
- Before you conduct broad testing (e.g., point prevalence survey) in your facility, please complete the form at [COVID-19 Testing Requests and Allocations for Long Term Care](#)

(<https://redcap.health.state.mn.us/redcap/surveys/?s=FXNEEE7PXX>). This form should be filled out regardless of whether you are using a local provider group to test or need support from the State. MDH will use this information to ensure that Minnesota laboratory testing capacity is not overwhelmed, and to provide specimen collection materials and support to your facility, if needed.

Find out more about laboratory testing:

- [MDH: COVID-19 Testing Recommendations for Long-term Care Facilities](https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctestrec.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctestrec.pdf>)
- [MDH: Long-term Care Testing: COVID-19](https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html>)
- [MDH: Evaluating and Testing: COVID-19](https://www.health.state.mn.us/diseases/coronavirus/hcp/eval.html) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/eval.html>)
- [CDC: Testing Guidelines for Nursing Homes](https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>)

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

Notify MDH early and rapidly

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

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

COVID-19 may be reported using the [MDH: COVID-19 Case Report Form](https://www.health.state.mn.us/diseases/coronavirus/hcp/covidreportform.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/covidreportform.pdf>), reporting online at [REDCap: Submitting Clinical Information on Long Term Care COVID-19 Cases](https://redcap-c19.web.health.state.mn.us/redcap/surveys/?s=H8MT9TTNCD) (<https://redcap-c19.web.health.state.mn.us/redcap/surveys/?s=H8MT9TTNCD>).

Prevent unseen spread of COVID-19 in your facility

Educate residents and families

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

Group activities may be facilitated (for residents who have fully recovered from COVID-19, and for residents not in quarantine, or not suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a well-fitting face

mask. Facilities may be able to offer a variety of activities while also taking the necessary precautions. Group activities may be conducted with appropriate precautions, either indoors or outdoors.

When a resident leaves their room, they should wear a well-fitting face mask if tolerated and should maintain social distancing of at least six feet from other residents at all times.

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

No residents with signs or symptoms of a respiratory infection, or with confirmed diagnosis of COVID-19 (regardless of symptoms) may eat in dining rooms. For dining, long-term care facilities should apply social distancing methods, such as ensuring residents sit at separate tables at least six feet apart. Residents who are in quarantine and require staff supervision during a meal, can eat in the dining room with other residents on quarantine following all other applicable infection control practices. This should be separate from other residents and no resident with active covid should eat in the dining room.

Staff actions

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

Institute use of eye protection (e.g., face shield, goggles) during all resident care encounters as a way to reduce COVID-19 exposure risk to staff. Eye protection is recommended when staff are in a resident care areas . Use of appropriate PPE can reduce staff exposures that might lead to exclusion from work.

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

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

Ancillary services and disinfection guidelines

Management of laundry, food service utensils, and medical waste should be performed in accordance with routine procedures.

Clean and disinfect frequently touched surfaces. Surfaces frequently touched by multiple people, such as door handles, bathroom surfaces, and handrails, should be cleaned with soap and water or another detergent at least daily. More frequent cleaning and disinfection may be required based on area and level of use. Cleaning removes dirt and impurities, including germs,

from surfaces. Cleaning alone does not kill germs, but it reduces the number of germs on a surface.

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

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

Implement CDC recommendations

- [CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic \(https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)
- [Clinical Questions about COVID-19: Questions and Answers | CDC \(https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html)

Note section on Environmental Cleaning and Disinfection [CDC: Cleaning and Disinfection for Community Facilities \(https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html\)](https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html)

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

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

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

For additional food safety guidance, see [MDH: Food Safety during the COVID-19 Pandemic \(https://www.health.state.mn.us/people/foodsafety/emergency/covid.html\)](https://www.health.state.mn.us/people/foodsafety/emergency/covid.html).

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

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

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

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

Reimbursement for emergency expenses

Department of Human Services

- Expedited reimbursement for costs related to COVID-19 may be available to licensed Medicaid nursing facility providers for incremental increases in costs for staffing, PPE, and other necessary supplies.
- Information was sent to all Minnesota Medicaid-enrolled nursing facility providers on March 25, March 31, November 24, and Dec. 29, 2020 via email.
- [DHS: Nursing Facility Provider Portal](https://nfportal.dhs.state.mn.us/PortalLogin.aspx?ReturnUrl=%2f) (<https://nfportal.dhs.state.mn.us/PortalLogin.aspx?ReturnUrl=%2f>) COVID FAQs and click on the COVID Form to request reimbursement.
- Facilities are generally limited to one reimbursement application form submission per month; invoices must be included with the provider's reimbursement request to DHS.
- If you have questions after reviewing the emails from the NFRP Division, and the COVID-19-related documents on the NFRP Portal login page, email DHS.NFRP.CostReport@state.mn.us or the NFRP staff member who conducted the most recent audit of a cost report for your facility.

Minnesota Department of Health COVID-19 Health Care Response Grant

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

FEMA Public Assistance

- Stafford Act Funds – 75% federal and 25% state cost-share.
- Must be eligible nonprofit (including health care entity) or public entity.
- Homeland Security and Emergency Management (HSEM) will hold information sessions in early May.
- Emergency expenses could be related to staffing, also pays for state-level actions such as National Guard activation, resource purchases, etc.
- More information on COVID-19 at [FEMA: Coronavirus \(COVID-19\) Response \(https://www.fema.gov/disasters/coronavirus\)](https://www.fema.gov/disasters/coronavirus).

CARES Act Provider Relief Fund

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

Federal Provider Relief Fund Program

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

Economic Injury Disaster Loan

- Low-interest loan with portions that may not need to be repaid.
- [MSN: PPP Loans vs. EIDL: Which is right for your small business? \(https://www.msn.com/en-us/money/smallbusiness/ppp-loans-vs-eidl-which-is-right-for-your-small-business/ar-BB12ljg8\)](https://www.msn.com/en-us/money/smallbusiness/ppp-loans-vs-eidl-which-is-right-for-your-small-business/ar-BB12ljg8)

Paycheck Protection Program

- [Treasury: Paycheck Protection Program \(PPP\) Information Sheet: Borrowers \(https://home.treasury.gov/system/files/136/PPP--Fact-Sheet.pdf\)](https://home.treasury.gov/system/files/136/PPP--Fact-Sheet.pdf)

The Accelerated and Advance Payment Program

- Financial hardship relief for Medicare providers during the COVID-19 pandemic.
- [CMS Fact Sheet: Expansion of the Accelerated and Advance Payments Program for Providers and Suppliers during COVID-19 Emergency](https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf) (<https://www.cms.gov/files/document/Accelerated-and-Advanced-Payments-Fact-Sheet.pdf>)
- Nursing facility providers must apply via their Medicare Administrative Contractor (MAC). For most Minnesota nursing facility providers, the MAC is National Government Services: [Accelerated or Advanced Payments](https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/job-aids-manuals/advance%20payments%20to%20providers%20of%20part%20b%20services/) (<https://www.ngsmedicare.com/ngs/portal/ngsmedicare/newngs/home-lob/pages/job-aids-manuals/advance%20payments%20to%20providers%20of%20part%20b%20services/>).

Employee Retention Credit

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

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

- Medicaid-certified nursing facilities are eligible to receive up to \$3,000 in Civil Money Penalty (CMP) funds to purchase communication technology. This technology is intended to enable residents to conduct “virtual” visits with family and friends and to participate in telehealth visits. This program was initiated in response to the restrictions placed on visitors to nursing homes, in order to prevent the spread of COVID-19.
- These funds may be used by nursing facilities to purchase tablets, iPads, and similar devices, as well as some types of accessories.
- Additional information about the grant is available in the [CMP Application for Communicative Technology Requests FAQ for State Medicaid Agencies](https://leadingage.org/sites/default/files/COVID-19_APPLICATION_FAQ_FINAL_508_202004161101154368.PDF) (https://leadingage.org/sites/default/files/COVID-19_APPLICATION_FAQ_FINAL_508_202004161101154368.PDF) prepared by CMS and the [Minnesota-Specific Instructions for COVID-19 CMP Technology Grant Applications](https://mn.gov/dhs/assets/COVID-19-CMP-technology-application-template_tcm1053-469960.pdf) (https://mn.gov/dhs/assets/COVID-19-CMP-technology-application-template_tcm1053-469960.pdf).
- Qualified Minnesota nursing facilities that are interested in participating in this grant opportunity are asked to read the [Minnesota-specific instructions and submit a completed CMP Reinvestment Application Template COVID-19 Communicative Technology Request](https://mn.gov/dhs/assets/UPDATED-COVID-19-Application-template-final-508_20200428_tcm1053-430719.pdf) (https://mn.gov/dhs/assets/UPDATED-COVID-19-Application-template-final-508_20200428_tcm1053-430719.pdf) via email to DHS at DHS.NFRP.CostReport@state.mn.us.

- Applications will be reviewed to verify that they are complete and requests fall within the parameters established by CMS. Successful applicants will receive an approval letter from DHS with further instructions.
- Information on this funding opportunity and how to apply is online at [DHS: Nursing homes: news, initiatives, reports, work groups \(https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/nursing-homes/\)](https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/nursing-homes/).

On the page, go to “Initiatives,” then click to expand the link entitled “Civil Monetary Penalty (CMP) Initiatives” to view the posting. The listing is mid-page, once you expand the link.

- For technical assistance with your application, or questions regarding this funding opportunity or the Minnesota CMP Program, please email the DHS staff liaison (munna.yasiri@state.mn.us).

Part II: Responding to COVID-19 cases in long-term care facilities

Use a line list to track residents with COVID-19

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

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

Assess current and anticipated supply of PPE

If supplies are low (4-7 days left), complete a PPE Request Form. [COVID-19 Supply Chain \(https://redcap.health.state.mn.us/redcap/surveys/?s=LXR9JMRYEJ\)](https://redcap.health.state.mn.us/redcap/surveys/?s=LXR9JMRYEJ).

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

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

Assess staffing availability

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

- Exclusion of ill staff members, with suspected COVID-19 or other clinical illnesses. No staff should work while sick.
- Exclusion of staff with confirmed COVID-19, regardless of whether they have signs or symptoms of illness. If all staff are tested, some may test positive. Even if they are not sick, they must stay out of work for a minimum of 10 days.
- Some staff might be asked by MDH to stay out of work after experiencing unprotected exposure to a resident or co-worker with confirmed COVID-19 disease. This work exclusion might last as long as 14 days after the staff member's last contact with the positive person.
- Staff with a household contact or intimate partner who is COVID-19 positive will be asked by MDH to stay out of work.
- Staff that work at multiple facilities may be asked by MDH to stay out of work because of an unprotected exposure at another work location.
- A cycle of fear and miscommunication can occur among people working in LTC. This may contribute to staff absenteeism among staff not exposed to COVID-19, and those who should continue to work after experiencing low-risk exposures to residents or co-workers with COVID-19.

Use the resources in Appendix C to make local staffing contacts.

Appendix C: Long-term Care Emergency Staffing

Prevent spread of COVID-19 in your facility

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

If a resident needs to leave their room, a well-fitting face mask should be used if tolerated.

Group activities may be facilitated (for residents who have fully recovered from COVID-19, and for residents not in quarantine, suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a cloth face covering or well-fitting face mask. Facilities may be able to offer a variety of activities while also taking the necessary precautions. Group activities may be conducted with appropriate precautions, either indoors or outdoors.

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

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

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

CDC Recommendations regarding PPE to implement for universal source control measures and for care of a resident with suspected or confirmed SARS-CoV-2 infection can be found at: [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic \(https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#definitions\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#definitions)

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

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

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

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

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

Appendix B: PPE Posters

Appendix G: PPE Breach Log

Review and audit IPC practices, including hand hygiene

Review COVID-19-specific IPC training for staff, including PPE. Audit hand hygiene, PPE use and environmental cleaning and disinfection practices. Note sample tool in Appendix D.

Contact MDH with questions and for assistance with IPC measures.

If you need infection prevention and control assistance, email Health.icar@state.mn.us.

Appendix B: PPE Posters

Appendix D: Hand Hygiene & PPE Compliance Observations

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

Because long-term care facilities are not just a place to receive health care, but also a home, moving residents to a new room is neither easy nor trivial. Plans to cohort, or group, residents should be carefully established in advance (see above), before testing results are received, and they should be centered on implementation of robust IPC practices. [Principles for COVID-19 Cohorting in Long-term Care](#)

[Cohorting in Long-term Care](https://www.health.state.mn.us/diseases/coronavirus/hcp/lcipcchohort.pdf)

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

Confirmed COVID-19 residents

Residents with COVID-19 should be placed in a single-person room with private bathroom, with the door closed if able. If applicable, implement your cohorting plan to use a dedicated space, with dedicated staff, for COVID-19-positive residents. All residents positive for COVID-19 (symptomatic and asymptomatic) should be restricted to their room in long-term care facilities, except for medically necessary purposes. If it is essential to leave their room, residents should:

- Wear a well-fitting face mask (if tolerated).
- Perform hand hygiene.
- Practice social distancing (at least 6 feet from others).

Staff who enter the room of a resident with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator, gown, gloves, and eye protection. Approaches to optimize PPE should be put into place. 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.

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

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

Observation unit

If able, close off an observation unit to care for residents who are new admissions, readmissions or for residents who may have been exposed to COVID-19. It is recommended to

actively screen residents every shift for fever and respiratory symptoms (i.e., cough, sore throat, shortness of breath), and have a low threshold for testing. More information about observation units can be found [Principles for COVID-19 Cohorting in Long-term Care](https://www.health.state.mn.us/diseases/coronavirus/hcp/lcpcpchohort.pdf) (<https://www.health.state.mn.us/diseases/coronavirus/hcp/lcpcpchohort.pdf>)

Discontinue transmission-based precautions when appropriate

Except for rare situations, a test-based strategy is no longer recommended to determine when to discontinue Transmission-Based Precautions because, in a majority of cases, it results in prolonged isolation of residents who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious. The decision to discontinue Transmission-Based Precautions for residents with confirmed SARS-CoV-2 infection should be made using a symptom-based strategy.

Symptom- and time-based strategies

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

- At least 10 days have passed since symptoms first appeared, AND
- At least 24 hours have passed since last fever without the use of fever-reducing medications, AND
- Symptoms (e.g., cough, shortness of breath) have improved.

For residents who are not severely immunocompromised and who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test.

Residents with severe to critical illness or who are severely immunocompromised:

- At least 20 days have passed since symptoms first appeared, AND
- At least 24 hours have passed since last fever without the use of fever-reducing medications, AND
- Symptoms (e.g., cough, shortness of breath) have improved.

For severely immunocompromised residents who were asymptomatic throughout their infection, Transmission-Based Precautions may be discontinued when at least 20 days have passed since the date of their first positive viral diagnostic test.

Test-based strategy

In some instances, a test-based strategy could be considered for discontinuing Transmission-Based Precautions earlier than if the symptom-based strategy were used. However, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some residents (e.g., those who are severely immunocompromised) in consultation with local infectious disease experts if concerns exist for the residents being infectious for more than 20 days.

The criteria for the test-based strategy are:

Residents who are symptomatic:

- Resolution of fever without the use of fever-reducing medications, AND
- Symptoms (e.g., cough, shortness of breath) have improved, AND
- Results are negative from at least two consecutive respiratory specimens collected 24 hours apart or more (total of two negative specimens), tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

Residents who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected 24 hours apart or more (total of two negative specimens), tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA.

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

Conduct staff risk assessment and monitoring

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

Identify at-risk staff

Make a list of staff that had an exposure with a person (resident or co-worker) that tested positive for COVID-19. This should include people involved in direct care, food service, house cleaning, and other activities.

- The list should include all staff that interacted with the positive person from 48 hours before symptoms started until one of the following conditions is met:

Positive resident: All necessary PPE (i.e., Transmission-Based Precautions) is put in place for the positive resident, OR the resident was transferred out of the facility

Positive co-worker: The last day that the COVID-19 positive staff member came to work

- In other words, the exposure risk period starts 48 hours before the resident or staff member developed symptoms and ends on the date that risk of COVID-19 transmission was eliminated.
- For persons tested when asymptomatic, the exposure risk period starts 48 hours before the resident or staff member was tested and ends on the date that risk of COVID-19 transmission was eliminated.

Conduct staff risk assessment

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

- Conduct an initial risk assessment for everyone on the list of staff members who interacted with the positive resident or co-worker. A sample risk assessment sheet is provided in Appendix H.
- Send to MDH (by encrypted email) the names and phone numbers of employees (health care workers and other staff members) identified to have had low- or higher-level risk. Include the name of the person (staff or resident) with confirmed COVID-19 and the facility name on the employee list.
- Tell staff that MDH will contact those with higher-risk exposures with recommendations to stay out of work and for health monitoring.
- If unable to perform the initial risk assessment for each employee within 24 hours of identification, notify MDH as soon as possible and provide MDH a list of the remaining employees and their contact information. MDH will complete the unfinished risk assessments and provide the employees' risk level.

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

Alert staff about work-related recommendations

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

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

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

but the State of Minnesota provides worker protections for this group of people during the voluntary quarantine period (Minnesota Statutes section 144.4196).

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

More detailed information regarding quarantine and return to work guidance for employees can be found on the MDH website: [MDH: COVID-19 Recommendations for Health Care Workers \(https://www.health.state.mn.us/diseases/coronavirus/hcp/hcwrecs.pdf\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/hcwrecs.pdf)

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

Appendix I: Response Checklist for Long-term Care Facilities

Facilitate post-mortem testing

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

Facilities with cases of COVID-19

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

Facilities with no known cases of COVID-19

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

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

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

[\(https://www.health.state.mn.us/diseases/coronavirus/hcp/eval.html\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/eval.html) for appropriate forms and submission guidance, and call MDH (1-877-676-5414) to report the death and suspicion of COVID-19.

Use a checklist

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

Additionally, CDC has a checklist available: [CDC: Coronavirus Disease 2019 \(COVID-19\) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings](https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf) (https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf).

Part III: Ideas to inspire

Hold a COVID-19 preparedness exercise

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

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

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

contact with COVID-19-positive residents and the amount of PPE that is used. In general, only essential staff should enter the room of residents with COVID-19. Work together to ensure that essential tasks are completed with the least risk to staff. For example, consider how meals will be delivered, waste removed, and high-touch surface cleaning be done while exposing the fewest staff possible.

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

Empowering staff with knowledge and training

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

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

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

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

- **Set up a Town Hall with your staff.** Be clear and honest, and listen to concerns. Downplaying COVID-19 cases and deaths would be disingenuous, could undermine your credibility, and could be perceived as your “not hearing” or being out of touch with staff concerns. There is undeniable risk when staff are in direct contact with a resident that has COVID-19. Focus on ways to best protect the staff during this interaction. Also use this time to highlight areas (e.g., social distancing, hand hygiene, wearing a face mask) that need work. Remind staff of situations where they have had successes in the past. For example, discuss a considerably difficult influenza season or a situation where you needed to prevent transmission of a multidrug-resistant organism in the facility. Highlighting successes might help to empower staff and reduce anxieties.
- **Walk the floors regularly to boost morale and show support.** Leaders, including the CEO and Medical Director, can be present, walk the floors, recognize challenges, and acknowledge the hard work of the staff. If staff are expected to work on-site when residents are ill with COVID-19, leadership can show solidarity by doing the same.

- **Model desired behaviors from the top down.** Have a nurse leader demonstrate how to safely and effectively don and doff PPE, answer questions, and provide hands-on training. That same leader should provide weekly supportive oversight to ensure PPE are being used correctly.
- **Establish a buddy system.** The buddy system can be used to ensure PPE and hand hygiene are used correctly and to lend an ear during these difficult times. Physical safety as well as mental health and well-being are essential at this time.
- **Show your staff appreciation and regard for their well-being.** Send regular email updates, highlighting both challenges and successes. Treat staff with food, snacks, or care packages (e.g., hand lotion, laundry pods, dryer sheets). Provide access to telehealth sessions with licensed therapists.

Help residents and families remain connected

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

Resources

COVID-19 Case Report Form

(www.health.state.mn.us/diseases/coronavirus/hcp/covidreportform.pdf)

Evaluating and Testing: COVID-19

(www.health.state.mn.us/diseases/coronavirus/hcp/eval.html)

CDC: Testing Guidelines for Nursing Homes (www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html)

CMS: Frequently Asked Questions (FAQs) on Nursing Home Visitation

(www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf)

CMS: Appendix Z—Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Downloads/Appendix-Z-EP-SOM-February-2019.pdf)

COVID-19 Action Plan for Congregate Settings

(www.health.state.mn.us/diseases/coronavirus/hcp/icpaction.pdf)

Infection Control Assessment and Response Program (ICAR)

(www.health.state.mn.us/facilities/patientsafety/infectioncontrol/icar/index.html)

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

Enhanced Respiratory Precautions Essential Personnel Only - Keep Door Closed

(www.health.state.mn.us/diseases/coronavirus/hcp/ppepresign.pdf)

Health Care Coalitions (www.health.state.mn.us/communities/ep/coalitions/index.html)

Interim Guidance for Discharge to Home or New/Re-Admission to Congregate Living Settings and Discontinuing Transmission-Based Precautions

(www.health.state.mn.us/diseases/coronavirus/hcp/hospdischarge.pdf)

Potential Exposure to Residents with COVID-19 in Long-term Care, Nursing Home, and Assisted Living Settings (www.health.state.mn.us/diseases/coronavirus/hcp/ltcassess.pdf)

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

CMS: 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios

(www.cms.gov/files/document/qso-20-25-nh.pdf)

CDC: Preparing for COVID-19 in Nursing Homes (www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html)

Health Care Response Grant

(www.health.state.mn.us/facilities/ruralhealth/funding/grants/covidlong.html)

FEMA: Coronavirus (COVID-19) Response (www.fema.gov/disasters/coronavirus)

HHS: Provider Relief Fund (www.hhs.gov/provider-relief/index.html)

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

MSN: PPP Loans vs. EIDL: Which is right for your small business? (www.msn.com/en-us/money/smallbusiness/ppp-loans-vs-eidl-which-is-right-for-your-small-business/ar-BB12ljg8)

Treasury: Paycheck Protection Program (PPP) Information Sheet: Borrowers

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

CMS: Reevaluates Accelerated Payment Program and Suspends Advance Payment Program (www.cms.gov/newsroom/press-releases/cms-reevaluates-accelerated-payment-program-and-suspends-advance-payment-program)

Disaster Mental and Behavioral Health and COVID-19

(www.health.state.mn.us/communities/ep/behavioral/covid19.html)

[CDC: Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic \(www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)

[Food Safety during the COVID-19 Pandemic \(www.health.state.mn.us/people/foodsafety/emergency/covid.html\)](https://www.health.state.mn.us/people/foodsafety/emergency/covid.html)

[World Health Organization: Oxygen sources and distribution for COVID-19 treatment centres \(www.who.int/publications-detail/oxygen-sources-and-distribution-for-covid-19-treatment-centres\)](https://www.who.int/publications-detail/oxygen-sources-and-distribution-for-covid-19-treatment-centres)

[Resources to Find Low-Cost Health Care or Get Health Insurance \(www.health.state.mn.us/diseases/coronavirus/materials/lowcost.html\)](https://www.health.state.mn.us/diseases/coronavirus/materials/lowcost.html)

[CMS: Long-term Care Nursing Homes Telehealth and Telemedicine Tool Kit \(www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf\)](https://www.cms.gov/files/document/covid-19-nursing-home-telehealth-toolkit.pdf)

[CDC: Coronavirus Disease 2019 \(COVID-19\) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings \(www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf\)](https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf)

[Contingency Standards of Care for COVID-19 Personal Protective Equipment For Congregate Care Settings \(www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf\)](https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf)

[CDC: Clinical Questions about COVID-19: Infection Control \(www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control)

[CDC: Cleaning and Disinfection for Community Facilities \(www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html\)](https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html)

[Crisis Standards of Care \(www.health.state.mn.us/communities/ep/surge/crisis/index.html\)](https://www.health.state.mn.us/communities/ep/surge/crisis/index.html)

[CMS: Coronavirus \(COVID-19\) Partner Toolkit \(www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit\)](https://www.cms.gov/outreach-education/partner-resources/coronavirus-covid-19-partner-toolkit)

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

[DHS webinar: Expedited reimbursement for COVID-19 related costs in nursing facilities \(www.youtube.com/watch?v=OO_fHyNUTJk\)](https://www.youtube.com/watch?v=OO_fHyNUTJk)

[DHS: Nursing Facility Provider Portal \(https://nfportal.dhs.state.mn.us/PortalLogin.aspx?ReturnUrl=%2f\)](https://nfportal.dhs.state.mn.us/PortalLogin.aspx?ReturnUrl=%2f)

COVID FAQs and click on COVID Form A.EZ to request reimbursement.

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

Appendix A: Staff Health Screening Log

This log should be completed every day. An educated staff member, with leadership oversight, should be identified to ensure the facility has an effective screening system. Considerations of recent vaccination may need to be considered. See [Post Vaccine Considerations for Healthcare Personnel](https://www.cdc.gov/coronavirus/2019-ncov/hcp/post-vaccine-considerations-healthcare-personnel.html) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/post-vaccine-considerations-healthcare-personnel.html>), since employees could have post vaccination symptoms arise.

Date	Staff Name	Respiratory symptoms including cough or shortness of breath. Fever (temp $\geq 100^{\circ}\text{F}$ or feeling feverish), sore throat, muscle pain, headache, chills, new loss of taste or smell or other CDC-identified symptoms. Confirmation that staff has NO:	Initials of Screener
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	
		<input type="checkbox"/> No fever, respiratory or other COVID symptoms	

Appendix B: PPE Posters

CDC: Using Person Protective Equipment (PPE)

(<https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html>)

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

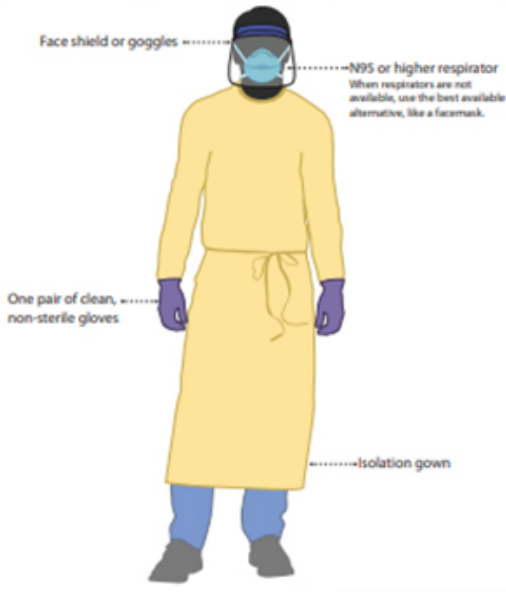
Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

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

Remember:

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

Preferred PPE – Use N95 or Higher Respirator




Face shield or goggles

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

One pair of clean, non-sterile gloves

Isolation gown

Acceptable Alternative PPE – Use Facemask




Face shield or goggles

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

One pair of clean, non-sterile gloves

Isolation gown



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www.cdc.gov/coronavirus

Donning (putting on the gear):

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

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

Doffing (taking off the gear):

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

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

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

www.cdc.gov/coronavirus

Appendix C: Long-term Care Emergency Staffing

The Minnesota State Emergency Operations Center (SEOC) LTC staffing team, in collaboration with Health Care Coalitions, have developed a Long-term Care Contingency Staffing Plan template. The template can be found at [Defining Crisis Staffing Shortage in Congregate Care Facilities \(https://www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html\)](https://www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html).

As a reminder, all response begins locally. Therefore, the plan outlines the steps and progression that occurs from local to state response.

If additional state assistance is needed, please reference the SEOC LTC Staffing Line Flyer on the next page. The staffing line is made available for facilities who are in contingency and crisis level staffing shortages.

Minnesota State Emergency Operations Center Long-term Care Staffing Line

651-201-3970
or
1-833-454-0149

When calling the Minnesota SEOC LTC Staffing Line for supplemental staffing needs, please have the following information:

- Caller name, phone number, and email address
- Secondary contact name and phone number
- Facility name and address
- County where the facility is located
- Type of facility (SNF or AL)
- Type and number of staff needed by date and shift
- Wage range for each type of staff needed.

The Minnesota State Emergency Operations Center (SEOC) Long-term Care (LTC) Staffing Line exists to support LTC facilities* experiencing staffing shortages due to COVID-19. The hours of the LTC Staffing Line are Monday through Friday from 8 AM-7 PM. Calls placed over the weekend will be triaged and addressed accordingly based on need.

One function of the LTC Staffing Line is management of an electronic staffing alert system to notify interested healthcare workers about temporary paid positions in Long-term Care facilities.

The LTC Staffing Line is not a staffing agency, but a resource to connect healthcare workers to facilities. After the staffing line connects a facility with an interested healthcare worker, the facility is then responsible to complete all necessary human resources and regulatory requirements at the beginning of the shift, **prior to** the healthcare worker caring for residents.

If a Long-term Care facility has staffing needs related to COVID-19, the facility may call the LTC Staffing Line for assistance. The LTC Staffing Line will also provide contact with a Crisis Staff Manager for additional assistance.

*Long-term Care facilities include: Skilled Nursing and Assisted Living facilities

Appendix D: Hand Hygiene and PPE Compliance Observations

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

Unit: _____

Date: ____/____/____

Time: _____

Observer Name: _____

HH = Hand Hygiene Compliance

PPE = Personal Protective Equipment Compliance

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

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

Adapted from Hand Hygiene Program Johns Hopkins

_____ % of Hand Hygiene Compliance

_____ % of PPE Compliance

Appendix E: Active Resident Monitoring for COVID-19 Symptoms

MONITORING FOR RESIDENT COVID-19 SYMPTOMS

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

Measures: Temp (Fever $\geq 100.0^{\circ}\text{F}$), SpO_2 (%), look for decreasing trends).

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

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

WEEKLY MONITORING FOR RESIDENT COVID-19 SYMPTOMS

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

Reporting Illness to MDH

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

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

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

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

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

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

Symptom key: O=low SpO₂, F=fever, C=cough, S=short of breath, D=diarrhea, T=sore throat, M=mental status change, TBP=Transmission-Based Precautions.

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

Appendix G: PPE Breach Log

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

Date	Staff Name	Confirmation that staff has NO PPE Breach:	Staff Signature	Initials of Screener
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		
		<input type="checkbox"/> I wore all required PPE with no breach during my shift		

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

Staff member name: _____

Interview conducted by: _____

Date of interview: ____ / ____ / ____

1. Have you been within 6 feet of a person diagnosed with confirmed COVID-19 infection?

☐ Yes ☐ No

How long (cumulative during shift)? ☐ <15 minutes ☐ ≥15 minutes

Describe contact: _____

2. Have you had unprotected direct contact with secretions or excretions of a person diagnosed with confirmed COVID-19 infection?

☐ Yes ☐ No

*** If "No" or "<15 minutes" to Question 1 AND "No" to Question 2 then exposure is LOW RISK, skip to Question 9 ***

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

4. Did you wear the following personal protective equipment?

a. Eye protection ☐ Yes ☐ No

i. Goggles/safety glasses with side protection ☐ Yes ☐ No

ii. Face shield ☐ Yes ☐ No

iii. PAPR ☐ Yes ☐ No

b. Respiratory protection ☐ Yes ☐ No

i. N95 respirator ☐ Yes ☐ No

ii. Surgical face mask ☐ Yes ☐ No

iii. PAPR ☐ Yes ☐ No

c. Gown ☐ Yes ☐ No

d. Gloves ☐ Yes ☐ No

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

Describe breach in PPE: _____

-
-
6. Was the person diagnosed with confirmed COVID-19 infection wearing a face mask (cloth masks are acceptable)?
- ☐ Yes ☐ No
- a. If yes, at any point, was their face mask removed for ≥ 15 minutes? ☐ Yes ☐ No
7. Did you perform or were you in the room for any procedures that were likely to generate higher concentrations or respiratory secretions or aerosols (including but not limited to noninvasive positive pressure ventilation (e.g., BiPAP and CPAP), CPR, manual ventilation, endotracheal intubation, bronchoscopy, open suctioning of airway secretions, and sputum induction)?
- ☐ Yes ☐ No
8. Did you have extensive body contact with the resident (e.g., rolling/positioning) when you **were not** wearing a gown and gloves?
- ☐ Yes ☐ No

*** If "Yes" to Question 8 and "Yes" to Question 4a. and 4b. then exposure is LOW RISK; however, this interaction may have some risk for infection particularly if hand hygiene is not performed prior to the HCW touching their eyes, nose or mouth. Gown and gloves are recommended when caring for a known or suspected COVID-19 resident. An individual facility has the discretion to deem this type of exposure as HIGH RISK. ***

9. **FOR INTERVIEWER:** Check all that apply and determine risk status based on answers to questions above.

Exposure to COVID-19-positive patient or resident

Low risk includes any of the following:

- ☐ HCW not using all recommended PPE but did not have prolonged close contact* with patient/resident.

HCW had prolonged close contact* with patient/resident:

- ☐ HCW wearing all recommended PPE and adhering to all recommended infection control practices.
- ☐ HCW is wearing surgical face mask but no eye protection while positive patient or resident is wearing surgical face mask or alternative/cloth mask.
- ☐ HCW wearing a surgical face mask and eye protection, regardless of gown and gloves, **AND** aerosol-generating procedures (see description above) **were not** performed while HCW was present.
- ☐ HCW wearing a respirator, eye protection, gown and gloves **AND** an aerosol-generating procedure (see description above) **was** performed while HCW was present.

High risk includes any of the following:

HCW had prolonged close contact* with patient/resident:

- ☐ HCW not wearing surgical face mask or respirator.
- ☐ HCW not wearing eye protection and positive patient or resident is not wearing a surgical face mask or alternative/cloth mask.
- ☐ HCW not wearing all recommended PPE (respirator, eye protection, gown and gloves) **AND** an aerosol-generating procedures (see description above) **was** performed while HCW was present.
- ☐ HCW has sustained breach in PPE for 15 minutes or more or has direct contact with excretion or secretions from positive patient or resident without wearing recommended PPE (eye protection, surgical mask, gown and gloves).

Exposure to COVID-19 Positive Co-worker

Low risk includes any of the following:

- ☐ Present in the same indoor environment but did not have prolonged close contact* with positive co-worker

HCW had prolonged close contact* with positive co-worker:

- ☐ HCW wearing surgical face mask and eye protection, regardless of PPE worn by positive co-worker
- ☐ HCW wearing surgical face mask but no eye protection while positive co-worker is wearing surgical face mask or alternative/cloth mask

High risk includes any of the following:

- ☐ Direct contact with infectious secretions or excretions of positive HCW (e.g., being coughed on) without wearing recommended PPE (eye protection, surgical face mask, gown and gloves)

HCW had prolonged close contact* with positive co-worker:

- ☐ HCW not wearing surgical face mask, regardless of PPE worn by positive co-worker
- ☐ HCW wearing surgical face mask but no eye protection and positive co-worker is not wearing surgical face mask or alternative/cloth mask

**Prolonged close contact is defined as being within 6 feet for 15 minutes or more cumulatively during a shift OR having unprotected direct contact with secretions or excretions of a person with confirmed COVID-19 infection.*

The CDC also has a long-term care checklist. [CDC: Coronavirus Disease 2019 \(COVID-19\) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings](https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf) (https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf).