Laura Baker Services Association COVID-19 Preparedness Plan

Laura Baker Services Association (LBSA) is required to have a COVID-19 Preparedness Plan that protects staff, clients and the community we serve. According to Executive Order 20-48, critical businesses, including providers licensed or certified by the Department of Human Services to deliver residential services, are required to follow guidance from the Minnesota Department of Health (MDH) and the Centers for Disease Control and Prevention (CDC) to mitigate the spread of COVID-19. Because there is currently no vaccine for this virus, LBSA anticipates that we will need to operate our residential programs for many months with the possibility that COVID-19 could be confirmed in our staff and/or clients. The MDH/CDC guidance is designed to prevent, mitigate, or respond to the transmission of COVID-19.

LBSA's Preparedness Plan addresses the following locations: program offices at 211 Oak Street (referred to in this plan as Laura Baker Center), as well as the 5 intermediate care facility (ICF) residences located on its Oak Street campus and the 7 adult foster care residences served through the Community Services Program.

Notifying and Working with MDH

LBSA will notify MDH within 24 hours when there is a confirmed case of COVID-19 (staff or clients) in our programs by calling 651-297-1304 or 1-800-657-3504 (Mon.-Fri., 8AM-5PM). LBSA will work with MDH and comply with their directives when given, including conducting necessary assessments of exposure risk (*See Appendix 1*).

1. Hygiene and source controls

LBSA follows general Infection Prevention and Control protocols, as outlined in its Health Manuals for both Community Services and Oak Street Services.

With specific regard to COVID-19, we require staff provide direct support to don a surgical mask at the beginning of each shift and wear this mask for the duration of the shift, and specifically when in the presence with clients or co-workers. Eye protection must be worn when having prolonged close contact with clients during personal cares. Prolonged close contact is defined as contact within 6 feet for 15 minutes or longer and/or contact with bodily secretions. Staff working in non-direct support roles (i.e. administrative team, administrative support, dietary, health team when not providing direct care) must wear at least a cloth mask when working in LBSA Center and Millis Hall kitchen.

PPE has been provided for each direct support staff to wear 1 mask/shift for the duration of the shift, and each staff has been provided eye protection that can be re-used. Instruction in the care, cleaning and storage of the mask and eye protection has been provided to each staff (*see Appendix 2*). Additional PPE in the event of positive cases, such as gowns and gloves, is also located on each household and will be worn according to MDH and CDC guidance (*see Appendix 3*).

While visitation within a residence is prioritized for essential visitors, LBSA is permitting vitiation within the residences for family and others using certain visitation parameters (See Section 7 for additional information on visitors). Essential visitors include licensors, first responders, other required State staff, and those visiting for "compassionate care." All visitors are screened prior to entrance (Section 3 of this plan more fully addresses symptom screening of staff, clients and visitors), and are required to wear a mask when entering a residence and conduct hand hygiene. Alcohol based hand rub (ABHR) is situated close to the entry of each house for purposes of staff, clients and visitors conducting hand hygiene when entering the households.

With regard to LBSA Center, hours have been limited to reduce exposure risk; currently, the open hours at LBSA are M-F 11-3pm. ABHR is present at a hand hygiene station in the entrance lobby of Laura Baker Center. We expect that all visitors to LBSA Center will wear a mask for the duration of their visits; our receptionist has masks available should a visitor not have his/her own.

Signs are posted about hand hygiene and cough etiquette in all residences and in Laura Baker Center (*See Appendix 4*). Staff, clients and visitors are directed to wash their hands for at least 20 seconds with soap and water, and if unavailable, to use ABHR that contains at least 60% alcohol.

On March 25, 2020 LBSA added four MDH videos on proper hand hygiene and use of Personal Protective Equipment (PPE) to its mandatory training. These videos are located both in SumTotal, and on the LBSA LINK, which is the organization's electronic bulletin board. The link to these videos is here under Medical Topics: https://internal.laurabaker.org/2012-training-manual.

Staff and clients have been encouraged to undertake consistent handwashing routines, after having been in a public place, prior to and after eating, after using the toilet, or after blowing your nose, coughing, or sneezing. Staff and clients have been directed to avoid touching eyes, nose, and mouth with unwashed hands.

Tissues for proper cough/sneeze etiquette and trash receptacles are available throughout LBSA Center and the residences.

Paper towels and trash receptacles have been placed in locations so a paper towel can be readily disposed of if/when operating the door.

In Community Services residences where more than one client uses the restroom, sinks could be an infection source, so clients are asked to avoid placing toothbrushes directly on counter surfaces. Totes or other appropriate containers are used for personal items so they do not touch the bathroom countertop. Oak Street clients have their own bathroom, so cross-contamination is not expected to be an issue.

2. Cleaning and disinfecting

LBSA follows MDH and CDC guidance for frequent cleaning and disinfecting of our program space, especially shared spaces. House Directors have received training from the health staff with regard to strategies for cleaning, including frequency of cleaning, and ensuring sufficient coverage of surfaces and dry time. Specifically, we have implemented the following in our residential households:

- Established a sanitation schedule and checklist, identifying surfaces/equipment to be sanitized, the agent to be used, and the frequency at which sanitation occurs (*See Appendix 5*).
- Ensure high-touch surfaces such as doorknobs, light switches, stair rails, counters, tables and chairs, phones, keyboards, program equipment, games, remotes and other shared items are regularly cleaned and disinfected.
- Minimize the use of shared supplies (e.g. arts and crafts, office supplies) that cannot be sanitized and consider using designated bins for clean and used items.
- Use EPA-registered disinfectants recommended by the CDC: https://www.epa.gov/coronavirus. Laura Baker uses a one-step germicidal disinfectant cleaner. This has been provided to all residences on the Oak Street campus, along with helpful tips for cleaning. For the most part, CS residences purchase their own supplies for cleaning and disinfecting.
- Oak street residences are cleaned by housekeeping staff at least once daily. All common areas are wiped with disinfectant, and client rooms (if accessible) are also wiped down. If not accessible, staff or client with staff assistance take responsibility for cleaning in client rooms.
- All client clothing, bed linens and towels are washed individually so that a client's possessions are not co-mingled with that of another. When washing towels, bedding, and other items, staff and clients are directed to use the warmest appropriate water setting and dry items completely.

With regard to LBSA Center and the commercial kitchen on the Oak Street campus, common and high touch areas are cleaned daily, and 8 disinfectant stations have been set up throughout LBSA Center, including all conference rooms, library, assembly room, kitchens, copy rooms, and bathrooms. The disinfectant stations have one step germicidal disinfectant cleaner, paper towels and helpful tips for cleaning (*See Appendix 6*).

3. Screening and policies for staff and clients exhibiting signs/symptoms of COVID-19

LBSA monitors staff and clients for signs of illness. The list of potential symptoms is posted in each residence and includes:

- Fever
- Chills
- New cough
- Shortness of break
- New sore throat
- New muscle aches
- New headache

- New loss of smell or taste

In LBSA residences, staff must complete a daily assessment of these symptoms at the commencement of his/her shift, including taking his/her temperature. This information is maintained in a log that is kept on the residence (*See Appendix 7*).

If staff exhibit one or more symptoms, he/she must immediately contact a supervisor and will be asked to leave work if ill. Staff are encouraged to contact his/her health care practitioner and seek testing for COVID-19 if warranted. Depending on the outcome of such contact with a health care practitioner and/or testing, staff may be required to be out of work per the guidelines established by MDH for either quarantine or isolation (*See Appendix 8 – COVID-19 Recommendations for Health Care Workers*).

Staff assess clients for these symptoms once/day. If a client shows symptoms of COVID-19, staff should move them away from other people, preferably to his/her own room. Contact with the client should be minimized as much as feasible. In addition:

- Place a mask over the person's mouth and nose (if he/she tolerates it).
- Staff should already be wearing a surgical mask, but should additionally don eye protection and gown if having prolonged close contact with the client. Initial supplies are available on each house.
- Contact the supervisor and nurse for further evaluation and directions. This may include contacting the client's healthcare provider for additional guidance regarding treatment and/or seeking testing.
- If someone presents with severe acute respiratory illness, they will require hospitalization. 911 may need to be called for symptoms like shortness of breath, difficulty breathing, and/or a bluish hue to the lips, in addition to the ones mentioned earlier. Notify the dispatch personnel if the individual has already tested positive for COVID-19, or let them know the person is being evaluated for COVID-19. If possible, put a facemask on the client before emergency medical services arrive.

At LBSA Center, staff working in the center are screened daily for signs and symptoms using the same checklist and log. Screening will additionally be performed by new hires entering the building and by any person expecting to be in the building for more than 10 minutes, including vendors, licensors, and other individuals attending meetings.

Should staff or clients be determined to have a positive case of COVID-19, LBSA will contact MDH and will follow their directives. This includes conducting necessary exposure assessments for co-workers and clients with whom staff or client has come in contact (*See Appendix 1*).

Proper notification will also be provided by Program Directors to affected staff, clients, client representatives and case managers. House Directors and other supervisors should ensure that emergency contact information for staff and clients is kept up to date.

4. Social distancing

At this time, LBSA is restricting gatherings of clients and staff in the households to no more than 10 individuals at a time. Typically, there are fewer than 10 individuals (staff and clients) in any household at a given time. Clients are encouraged not to visit inside the house of another client living in a different residence. Staff supervised outdoor visits among clients in small numbers are permitted, so long as clients have been assessed for ability to maintain distance and/or wear a mask, and avoid touching others. Guidelines regarding outdoor visits with friends and family are addressed in Section 7 of this plan.

LBSA additionally is refraining from intermixing household groups. If intermixing of groups becomes necessary, LBSA will limit the number of groups that intermix and keep records of staff and clients that intermix through t-logs. This may be necessary for contacting individuals in the event a clients or staff tests positive for COVID-19.

In the residences, staff should limit entering clients' rooms as much as possible to reduce potential for cross-contamination, unless required for supervision. Staff should continue to stagger their breaks to maximize social distancing.

At LBSA Center, the following protocols have been implemented to promote social distancing:

- Some staff are working remotely from home or are limiting their hours in LBSA Center.
- Some staff are coming into LBSA Center at times when other staff are not present.
- Common areas such as conference rooms, assembly rooms, lobby, and copier rooms have been assessed for maximum capacity and signs have been posted to limit numbers of people in these rooms at a given time.
- Tables and chairs have been rearranged to maximize space between people.
- Meetings are being held remotely when possible. When not possible, numbers will be limited to no more than 10 individuals in a meeting room accommodating the planned number of individuals. Individuals will wear masks during the meeting. They will disinfect the room and shared equipment upon completion of use.
- A clear barrier has been erected between the receptionist and lobby entrance where visitors wait.
- Signs are posted asking visitors to LBSA to maintain social distancing of at least 6 feet.
- Masks are to be utilized when not in the personal workplace, including in hallways, copy and mail rooms, conference rooms, library, kitchen and bathrooms.
- Deliveries are left in the front foyer.

5. Food preparation and meals

Food preparation and meals have been adjusted in the households to promote social distancing. In the Oak Street residences, food is prepared in the Millis Hall kitchen and delivered by a staff of the dietary department to staff in the household. Household staff then plate client meals individually so that

multiple people are not using the same serving utensils. In the CS residences, staff prepare meals and plate client meals individually.

Meals times are staggered such that there are no more than 2 clients at the table per setting. Clients wishing to eat meals in another area of the home, such as the living room or their room, may do so.

Staff assisting clients with eating, thus necessitating prolonged close contact, will wear necessary PPE during mealtime, including a surgical mask and face shield.

Food, including condiments, and beverage may not be shared between clients.

Staff will eat at separate times from the clients.

6. Ventilation

LBSA staff have evaluated its air conditioning and circulation systems and have worked to maximize the amount of fresh air being brought in, while limiting air recirculation. Furnace and AC systems in LBSA Center and in some of the houses are supplemented with air exchange. Using contracted maintenance services, LBSA ensures ventilation systems are properly used and maintained.

7. Visitors

During warmer weather months, LBSA has prioritized client visits in outdoor locations, as the safest option for clients and visitors. LBSA will continue with outside visits for as long as is practicable. If a visit has been arranged with a family member, friend, or day services staff, these visits are held outside in a designated visitation area. The following guidelines have been established for those outside visits:

- Visits will be arranged ahead of time with the House Director.
- Only 3 visitors will be permitted at a time.
- Visits will be allowed outside of the client residence in a location designated by the House Director. Generally speaking, they should remain in this designated location.
- Time of visits will be up to 60 minutes/visit.
- Up to 3 visits/week.
- Visitors will undergo symptom screening upon their arrival, including screening for fever (see *Appendix 7*). If there are indications that the visitor is symptomatic, the visitor will need to depart immediately.
- Visitors will use alcohol-based hand rub upon their arrival and at the end of the visit.
- Visitors will wear masks for the duration of the visit. If visitors do not have a mask, one will be provided.
- Visitors will maintain a 6-foot distance from the client.
- There should be no physical contact between the client and visitor.

The change in weather necessitates having options for visiting within the residences. Each residence will identify a location or locations for visitation. In some cases, the location will be a common area that can be set aside for private visits (i.e. basement area, all season porch) and in other cases, visits will occur in the client's bedroom. For indoor visits, the following guidance will be used:

- Visits will be arranged ahead of time with the House Director.
- Visitors will be screened for COVID-19 symptoms prior to entrance, using the same screening criteria as that for clients and staff (*see Appendix 7*).
- Provide visitors with hand sanitizer or access to a handwashing area, and facemasks if they current do not have them one.
- Encourage social distancing between clients and their visitors.
- If visits take place in a client bedroom, the door should remain closed.
- Ideally, visits will be limited to 1 hours, not more than twice/week, and no more than 2 people visiting at a time.
- Clean and disinfect the visiting room after each visit.
- Encourage clients to wash their hands after interacting with a visitor.

Visitors are asked to sign an acknowledgement of the visit guidelines. This, along with t-logs, additionally serves as the record of the visit in the event contact needs to be made due to an exposure.

With regard to LBSA Center, visitors will follow the guidelines that are outlined in Section 4. Social Distancing.

8. Transportation

LBSA direct support staff working with any client are required to wear a surgical facemask for the duration of their shift; this requirement extends to any vehicle, whether private or LBSA-owned, when transporting a client.

LBSA limits the number of people in the vehicle (2 people/car and 3 people/van, including clients and staff) and asks that clients spread out to maintain social distancing as much as possible. To the extent feasible, there should be only one client/row.

When using air conditioning in the vehicle, staff are asked not to use recirculating air.

If clients are being transported to a day services program or work, staff should remind clients to wear a facemask or face covering, wash their hands, and follow social distancing guidelines while they are away.

If clients are being transported by day services staff or using public transportation, LBSA staff should confirm that drivers are wearing a mask. If this is not the case, staff should contact a supervisor so that this can be properly addressed with the agency providing transportation.

9. Communication and training about the plan

LBSA has made this plan available to all staff on the LINK, and in each household. A copy of the plan is also posted on the LBSA Center kitchen bulletin board.

LBSA has posted the plan to the Family Portal on its website and will be made available in hard copy format to any client, client representative or case manager who requests it. The plan is available to the Commissioner upon request.

LBSA will provide training on the plan to all staff via SumTotal, will ensure staff are capable of implementing it, and will update staff on any changes to the plan.

Staff with concerns about the COVID-19 Preparedness Plan or questions about their rights should contact MNOSHA Compliance at osha.compliance@state.mn.us, 651-284-5050 or 877-470-6742.

10. MDH Guidance Followed by LBSA

The Minnesota Department of Health has published extensive guidance for variety of employers, health care facilities, community organizations and individuals. While LBSA will work to adhere to all relevant guidance issued by MDH, LBSA will specifically follow the published guidance for providers delivering 245D licensed residential services in adult foster care homes, community residential settings, supervised living facilities, and intermediate care facilities, including:

- Interim Guidance on the Prevention of COVID-19 for Employees and Persons Who Use Services in Licensed Group Homes (PDF); and

- Interim Guidance on the Management of COVID-19 for Employees and Persons Who Use Services in Licensed Group Homes (PDF).

This guidance can be found in *Appendix 9*.

APPENDIX 1

Risk Assessment for LBSA Staff Potentially Exposed to COVID-19

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:	Yes	No
ii. Face shield:	Yes	No
iii. PAPR:	Yes	No
b. Respiratory protection:	Yes	No
i. N95 respirator:	Yes	No
ii. Surgical facemask:	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 any breach in PPE:

_____
_____

6. Was the person diagnosed with confirmed COVID-19 infection wearing a facemask (cloth masks are acceptable)? Yes No

   If yes, at any point, was their facemask 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 of respiratory secretions or aerosols (including but not limited to 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 STAFF 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:

- ☐ Staff not using all recommended PPE but did not have prolonged close contact* with resident.
- ☐ Staff had prolonged close contact* with patient/resident:
  - ☐ STAFF wearing all recommended PPE and adhering to all recommended infection control practices.
  - ☐ STAFF is wearing surgical facemask but no eye protection while positive patient or resident is wearing surgical facemask or alternative/cloth mask.
  - ☐ STAFF wearing a surgical facemask and eye protection, regardless of gown and gloves, AND aerosol-generating procedures (see description above) were not performed while STAFF was present.
  - ☐ STAFF wearing a respirator, eye protection, gown and gloves AND an aerosol-generating procedure (see description above) was performed while STAFF was present.

High risk includes any of the following:

- ☐ STAFF had prolonged close contact* with patient/resident:
  - ☐ STAFF not wearing surgical facemask or respirator.
  - ☐ STAFF not wearing eye protection and positive patient or resident is not wearing a surgical facemask or alternative/cloth mask.
  - ☐ STAFF not wearing all recommended PPE (respirator, eye protection, gown and gloves) AND an aerosol-generating procedures (see description above) was performed while STAFF was present.
  - ☐ STAFF has sustained breach in PPE for >15 minutes 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
- ☐ STAFF had prolonged close contact* with positive co-worker:
  - ☐ STAFF wearing surgical facemask and eye protection, regardless of PPE worn by positive co-worker
  - ☐ STAFF wearing surgical facemask but no eye protection while positive co-worker is wearing surgical facemask or alternative/cloth mask

High risk includes any of the following:

- ☐ Direct contact with infectious secretions or excretions of positive STAFF (e.g., being coughed on) without wearing recommended PPE (eye protection, surgical facemask, gown and gloves)
- ☐ STAFF had prolonged close contact* with positive co-worker:
  - ☐ STAFF not wearing surgical facemask, regardless of PPE worn by positive co-worker
  - ☐ STAFF wearing surgical facemask but no eye protection and positive co-worker is not wearing surgical facemask or alternative/cloth mask

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

APPENDIX 2

How to Clean and Store Your Eye Protection

When should I wear eye protection?

Eye protection is to be worn when staff are in "prolonged close contact" with residents. This is defined as 15 minutes or more, within 6 feet, or when having contact with bodily fluids. Err on the side of caution...if you think there is a risk of splatter, wear a face shield.

Preparing to Remove and Clean your Face Shield

1. Find an uncluttered flat area to do your cleaning, and wipe down the surface with a disinfecting cleaner and let dry.
2. Place 2 paper towels on the surface. One will be used for your dirty face shield, and one for the clean face shield.

Removing, Cleaning and Storing Face Shield

1. Remove the face shield from the back, using the head band or ear pieces. The outside of face shield is considered dirty/contaminated, so do not remove by grabbing the front, clear part of the face shield.
2. Place the dirty face shield on the designated "dirty" paper towel.
3. Put on clean pair of gloves.
4. Carefully wipe the inside of the shield, followed by the outside of the face shield using a clean cloth saturated with neutral detergent solution or cleaner wipe.
5. Wipe or carefully rinse the outside of face shield or goggles with clean water.
6. Fully dry (air dry or use clean absorbent towels) on your designated "clean" paper towel.
7. Place face shield into a paper bag with your name for the next use. Try not to grab the front, clear part o the face shield when placing into bag.
8. Remove gloves and perform hand hygiene.

APPENDIX 2

How to Use, Re-use and Store Your Surgical Facemask

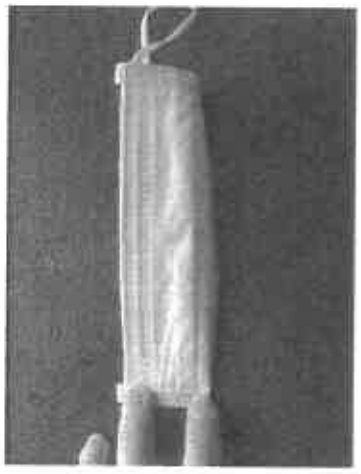
Putting Your Mask On

1. Clean your hands using proper hand hygiene.
2. Determine the inside and outside of the masks. Some masks have different color (the white side is typically the inside) but if the mask has the same color on both sides, MARK the mask on the outside with a Sharpie so that you can tell which side goes out.
3. Loop elastic over your ears. Pull it down so that it's covering under your chin; secure it to your face by pinching over your nose. Be sure it's on nice and secure. AVOID TOUCHING THE OUTSIDE OF THE MASK.
4. Clean your hands again using proper hand hygiene.

Taking Your Mask Off

1. Before removing the mask, perform hand hygiene.
2. Remove mask using the ear loops. AVOID TOUCHING THE OUTSIDE OF THE MASK.
3. Inspect the mask to be sure it can be reused. Has it been compromised? Is it wet? Visibly soiled? If it is, throw it away, then perform hand hygiene. If the mask is OK to reuse, prepare it for storage. (Next step)

Storing Your Mask for Re-Use



1. Fold the mask in half (lengthwise), so the outside surfaces are touching each other (the dirty part should be on the inside of the fold). Place it carefully into your clean bag. Fold over the top if you're using a paper bag; if using a plastic baggie, leave it open. Put your name on the bag.
2. Perform hand hygiene.
3. To reapply the mask, first perform hand hygiene, then open the mask storage bag.
4. Grasp the mask by the elastic ear loops or ties to remove it from the bag, then look to see where the outside of the mask is by locating your identifying mark. AVOID TOUCHING THE OUTSIDE OF THE MASK.
5. Use the ear loops to put it on and tuck it under your chin. Secure it to your face at the bridge of your nose. Perform hand hygiene, and stay safe and healthy!

Face Mask Reminders

- Do not touch the outside of your mask while it is on your face.
- Do not pull your mask below your nose or chin while you're wearing it.
- Do not leave the mask dangling or improperly fitted to your face.

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

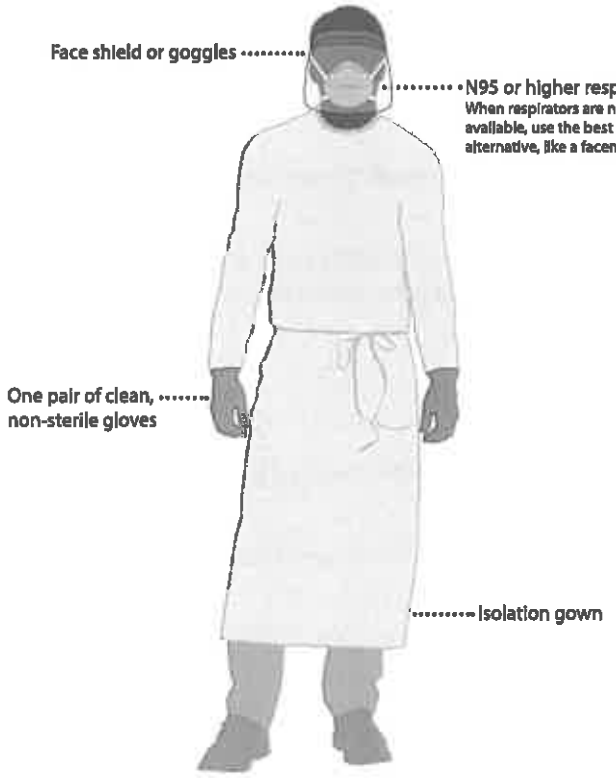
Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

- **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



Acceptable Alternative PPE – Use Facemask

CDC

www.cdc.gov/coronavirus

CS316124-A 06/03/2020

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.** When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. **Put 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.

Clean Your Hands!

How to wash your hands with soap and water:

- Use soap and warm, running water.
- Keep fingers pointing down.
- Rub hands vigorously for 20 seconds. Wash all surfaces:
  - Backs of hands
  - Wrists
  - Between fingers
  - Tips of fingers
  - Thumbs
  - Under fingernails
- Dry vigorously with paper or clean cloth towel.
- Turn off faucet with towel and open door with towel.

How it works:

- The soap suspends the dirt and soils.
- The friction motion helps pull dirt and greasy or oily soils free from the skin.
- Warm running water washes away suspended dirt and soils that trap germs.
- Final friction of wiping hands removes more germs.

How to clean your hands with an alcohol-based handrub:

- Apply a dime-sized amount of handrub gel to the palm of one hand or use an alcohol-based handrub wipe.
- Rub hands together covering all surfaces of hands and fingers until handrub is absorbed.

How they work:

- Act quickly to kill microorganisms
- Reduce bacterial counts on hands

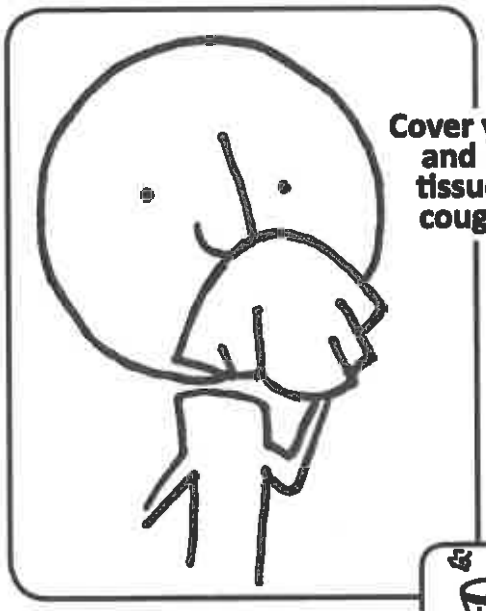
Wash your hands with soap and water when your hands are visibly soiled. If soap and water is not available, use alcohol-based handrub (wipes or gel).

Food handlers in restaurants, schools, delis and grocery stores must wash their hands with soap and water before applying hand sanitizers.
[Minn Rules Chap. 4626.0070 - 4626.0085]

MDH Minnesota Department of Health
Food Safety Center
651-296-5614
www.health.state.mn.us
10/2007

Stop the spread of germs that make you and others sick!

Cover your Cough



Cover your mouth and nose with a tissue when you cough or sneeze

or

cough or sneeze into your upper sleeve, not your hands

Put your used tissue in the waste basket.

You may be asked to put on a surgical mask to protect others.

Clean your Hands

after coughing or sneezing.

Wash with soap and water

or

clean with alcohol-based hand sanitizer.

DEPARTMENT OF HEALTH

Infectious Disease Epidemiology, Prevention and Control
PO Box 64975, St. Paul, MN 55164
651-201-5414 or 1-877-676-5414
www.health.state.mn.us

APIC

3/2020

APPENDIX 5

Weekly Household Cleaning Schedule and Checklist

The following items in common areas should be cleaned twice/day. If your house has contract housekeeping that cleans these items daily, staff need only do one additional cleaning. Note HK for cleaning completed by contract housekeeping.

For the week of: _____ **to** _____

	SUN		MON		TUE		WED		THU		FRI		SAT	
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
tables														
doorknobs														
light switches														
countertops														
handles														
desks														
phones														
keyboards														
tablets														
remotes														
toilets														
faucets														
sinks														

APPENDIX 6

PH7 Q Disinfectant helpful tips.

Spray Disinfectant on paper towel and wipe surface to be cleaned

Point the spray nozzle at the floor, Adjust spray valve on bottle to a fine mist.

DO NOT SPRAY DIRECTLY ON KEYBOARDS, COMPUTERS OR COPIERS

Control your overspray so you do not get chemical on sensitive areas accidentally.

Treat it much like spraying Lysol. If you wouldn't spray Lysol on a specific surface, then do not use this chemical on that surface. If you accidently spray a sensitive surface, just wipe it dry promptly and you will be fine. Do not let the chemical sit on a sensitive surface for any duration.

The chemical needs 5 to 10 minutes to obtain a full effect. To do this is just dampen the towel, wipe the surface and let airdry.

Please send a fixit when your bottle is empty, and our staff will fill it to the correct mixture.

Should you have any other questions,

Please contact Kimmy Clean

Mike Delbow at 612 501 2678

LBSA staff, please be aware that there is a growing number of symptoms potentially related to COVID-19. If you or a resident has any of the symptoms below, please contact the health team and/or supervisor for further evaluation.

Health Screening Checklist

Have you had any of the following symptoms since your last day at work or the last time you were here that you cannot attribute to another health condition?

Please answer "Yes" or "No" to each question. Do you have:

- ☐ Fever (100.4 F or higher), or feeling feverish?
- ☐ Chills?
- ☐ A new cough?
- ☐ Shortness of breath?
- ☐ A new sore throat?
- ☐ New muscle aches?
- ☐ New headache?
- ☐ New loss of smell or taste?

DEPARTMENT OF HEALTH

Symptom Screening

If "yes" Notify health team immediately before start of shift.

Date	Time	Name	Temperature	Shortness of Breath		New or Changed Cough		Sore Throat		Chills		Headache		Muscle Pain		Loss of taste/ smell		*Exposure	
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
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				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____
				Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No_	Yes_	No____

Monitor symptoms prior to shift and throughout shift for staff and clients *Known or suspected exposure to Covid-19 within past 14 days

APPENDIX B

STAY SAFE MN

COVID-19 Recommendations for Health Care Workers

Health care workers (HCW) living with a person suspected of having COVID-19, or who have been exposed to a patient or coworker with COVID-19, have expressed concerns regarding self-quarantine and exclusion from work. Minnesota Department of Health (MDH) continues to prioritize testing for symptomatic health care workers as well as hospitalized individuals and residents in congregate care settings. Exclusion of exposed asymptomatic health care professionals from work for prolonged periods might impact health care system capacity. Consequently, MDH and the health care community must balance workforce challenges with the need to prevent further spread of the virus that causes COVID-19 in health care settings.

Diagnostic testing of HCW for COVID-19

HCW with fever and/or respiratory symptoms that are concerning for COVID-19 remain a priority at MDH Public Health Laboratory for testing. Because of the potential implications for COVID-19 spread and severe disease, testing is strongly encouraged for, but not limited to, those working in congregate care or with immunocompromised individuals, and those who worked while ill.

HCW exposure to COVID-19

MDH and health care organizations are cooperating to identify, manage, and monitor HCW who have had unprotected (high-risk) exposure to a patient or coworker with confirmed COVID-19. HCW with these exposures are identified through risk assessment, if all necessary PPE has not been worn or available in a setting with confirmed COVID-19, and through identification of PPE breaches when PPE is routinely and correctly used.

MDH recommends that HCW with high-risk exposures participate in voluntary quarantine for 14 days after the exposure. However, if the facility is experiencing a staffing shortage that cannot otherwise be resolved, asymptomatic high risk HCW may be asked to return to work during the voluntary quarantine period, provided the HCW wears a surgical face mask for source control. However, high-risk employees can choose not to return, with worker protections under Minn. Rule 144.4196.

HCW in voluntary quarantine after an unprotected exposure to a COVID-19-positive person, and HCW who are in close contact to a household member or intimate partner with confirmed or suspected COVID-19, should follow the recommendations below to keep themselves, patients, and coworkers safe.

Recommendations for HCW in contact with persons having confirmed or suspected COVID-19

These recommendations are relevant for HCW who have had a high-risk workplace exposure to COVID-19 and HCW with household, intimate or close community contacts who have confirmed or suspected COVID-19.

- These HCW are advised to limit interactions with the public as much as possible for 14 days after preventive measures are put into place, adhering to social distancing and working from home, if possible. At this time, this remains the preferred option.
- If these limitations to social interaction are not possible, the HCW should take on a non-direct patient care role (e.g., telemedicine, phone triage), when feasible.
- If it remains necessary for the HCW to continue providing direct patient care during this 14 day period, they should:
  - Avoid seeing high-risk patients (e.g., elderly and immunocompromised persons and those with co-morbidities).
  - Practice diligent hand hygiene and wear a surgical face mask at all times.
  - Monitor themselves closely for any new symptoms associated with COVID-19 (i.e., measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or loss of taste or smell), and measure their temperature daily before going to work.
  - Remain at home and notify their supervisor if they develop respiratory symptoms OR have a measured body temperature of ≥100°F.
  - If at work when fever or respiratory symptoms develop, the HCW should immediately notify their supervisor and go home.
  - Notify their supervisor of other symptoms (e.g., fever <100°F, nausea, vomiting, diarrhea, abdominal pain, runny nose, fatigue), as medical evaluation might be recommended.

HCWs living with someone who has symptoms consistent with COVID-19 should separate themselves from the ill household member within the home as much as possible.

- HCWs might consider temporarily moving into alternative accommodation, if available, to maintain distance from the ill household member. Given family and caregiver responsibilities, this will not be feasible for many HCWs.

All HCW are at some risk for exposure to COVID-19 during widespread community transmission, whether in the workplace, at home, or in the community. Instead of 14-day work exclusion for asymptomatic HCW who have had a workplace exposure, or who have an ill household member or intimate contact, health care facilities might shift priority to reporting of recognized exposures, regular self-monitoring for fever and respiratory symptoms, testing HCWs with recognized high-risk exposures and refraining from work when ill. This approach is relevant for facilities with sufficient PPE to ensure that high-risk exposures are unlikely, have the ability to actively assess PPE breaches after every employee's shift, and are committed to exclusion of ill staff.

Guidance for ill HCW with confirmed or suspected COVID-19

As recommended above, any HCW who becomes ill with respiratory symptoms OR fever (≥100°F) should communicate with their supervisor and stay out of work. HCW with this clinical presentation are considered to have a suspected or confirmed (with laboratory testing) diagnosis of COVID-19. CDC has provided Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance) (www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html). A non-test-based strategy is recommended and includes:

- For HCWs with mild to moderate illness who are not severely immunocompromised:
  - At least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); AND,
  - At least 10 days have passed since symptoms first appeared.
  - Practice of diligent hand hygiene and wearing a surgical facemask at all times until 14 days after illness onset.
- For HCWs with severe to critical illness or who are severely immunocompromised:
  - At least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath); AND,
  - At least 20 days have passed since symptoms first appeared.

A test-based strategy is no longer recommended to determine when to allow HCW to return to work but could be considered in specific situations to allow the HCW to return to work sooner than the non-test-based strategy.

Asymptomatic HCWs with laboratory-confirmed COVID-19 should be excluded from work for 10 days following specimen collection. HCWs who are severely immunocompromised but remain asymptomatic throughout their infection should be excluded from work for 20 days following specimen collection. If these individuals subsequently develop symptoms since their positive test, their return to work should be guided by the recommendations for confirmed COVID-19, above.

HCWs who present to work or screen positive with cold or flu symptoms should leave work immediately and be tested for COVID-19 using RT-PCR. If the HCW does not get tested or tests **positive**, follow the COVID-19 work exclusion and isolation guidance outlined above. If **negative** and the HCW is still experiencing symptoms, the HCW should follow the guidance below:

- If the persistent symptoms are consistent with an established chronic health condition, the HCW may return to work after consultation with their manager and occupational health department. Evaluation of acute symptoms by the HCW's health care provider might also be indicated.
- If persistent symptoms are not consistent with a known chronic health condition, the HCW should be evaluated by a health care provider.
  - If the health care provider **provides an alternate diagnosis**, criteria for return to work should be based on that diagnosis.

- If the health care provider does NOT provide an alternate diagnosis and the HCW does NOT have a known high-risk exposure to a person with confirmed COVID-19, the HCW should remain isolated and not return to work until at least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath).
- If the health care provider does NOT provide an alternate diagnosis and the HCW does have a known high-risk exposure, the HCW should obtain a second SARS-CoV-2 RT-PCR test. The HCW should remain isolated until the test results are known. Minnesota continues to experience high levels of community transmission, and the potential consequences of working with COVID-19 are serious.
  - If positive, follow the COVID-19 work exclusion and isolation guidance outlined above.
  - If negative, the HCW can return to work following the test-based strategy if at least 24 hours have passed since resolution of fever and symptoms are improving.

Guidance for recovered HCW who are exposed to COVID-19 positive patients

A HCW with past confirmed COVID-19 infection should return to work based on the non-test based strategy recommended above. Within three months of COVID-19 symptoms starting or positive RT-PCR test for SARS-CoV-2, an asymptomatic HCW with a high-risk exposure to a confirmed COVID-19-positive person does not need to be quarantined or retested but should self-monitor for symptoms consistent with COVID-19. If symptoms develop, the exposed HCW should be assessed and potentially tested for SARS-CoV-2, if an alternate etiology is not identified. However, if the HCW has a high-risk exposure to a confirmed case three months or more after onset of their initial illness, the HCW should follow the quarantine and work exclusions outlined above.

Many facilities are experiencing significant staffing shortages. It might be necessary for these HCW to continue to work, as long as they remain asymptomatic, wear a surgical mask for source control, and practice diligent hand hygiene. In this situation, the HCW should also follow the recommendations above, in "Recommendations for HCW in Contact with Persons Having Confirmed or Suspected COVID-19."

MDH does not currently recommend using serological tests to determine whether a previously infected HCW can continue to work after experiencing a new exposure to a person with COVID-19. There are currently insufficient data regarding immunological response and protective immunity after COVID-19 infection. Because the interval between resolution of illness and development of any protective immunity is also unknown, viral carriage and transmission to others during this period cannot be ruled out.

MDH recognizes that there might be a shortage of HCW in some areas and for some facilities. MDH recommends utilizing the options outlined in Defining Crisis Staffing Shortage in Congregate Care Facilities: COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html).

Definitions

The following definitions are from CDC: Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance) (www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html).

SARS-CoV-2 Illness Severity Criteria were adapted from the NIH COVID-19 Treatment Guidelines.

Mild illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FIO2) <300 mmHg, or lung infiltrates >50%.

Critical illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

In pediatric patients, radiographic abnormalities are common and, for the most part, should not be used as the sole criteria to define COVID-19 illness category. Normal values for respiratory rate also vary with age in children, thus hypoxia should be the primary criterion to define severe illness, especially in younger children.

Severely immunocompromised: For the purposes of this guidance, CDC used the following definition:

- Some conditions, such as being on chemotherapy for cancer, untreated HIV infection with CD4 T lymphocyte count <200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions.
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions.
- Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

Resources

- CDC: Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19) (www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)
- CDC: Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance) (www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html)
- CDC: Duration of Isolation and Precautions for Adults with COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html)
- Defining Crisis Staffing Shortage in Congregate Care Facilities: COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html)
- CDC: Strategies to Mitigate Healthcare Personnel Staffing Shortages (www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html)
- CDC: If You Are Sick or Caring for Someone (www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/index.html)
- Rapid IgM/IgG SARS-CoV-2 Tests (www.health.state.mn.us/diseases/coronavirus/hcp/sarscov2test.pdf)

APPENDIX 9

STAY SAFE MN

Interim Guidance on the Prevention of COVID-19 for Employees and Persons Who Use Services in Licensed Group Homes[1]

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

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

This document provides guidance for persons who use services, their staff, and administrators on how to best prevent the introduction of COVID-19 in a group home setting. For more information on the management of COVID-19 cases in group home settings, please visit the links to additional MDH resources at the end of this document. This guidance is intended to advise providers on best practice recommendations in these settings and does not mandate specific actions.

[1] In this document, the term group home refers to providers delivering 245D licensed residential supports and services in adult foster care homes, community residential settings, supervised living facilities, and intermediate care facilities (ICF/DD).

Preventing COVID-19 among persons who use services

As in other congregate living settings that have daily movement of staff in and out of the building or unit, the implementation of universal source control and the use of interventions to limit virus spread among persons who use services are paramount. MDH recommends that the following general measures be implemented in group homes. Outside of these guidelines, group home providers need to stay updated on current state and federal requirements based on their license type.[2]

Monitoring for symptoms

Staff should educate persons who use services to make them aware of symptoms associated with COVID-19 or underlying conditions that require emergency care. Serious symptoms may include, but are not limited to: severe difficulty breathing, persistent chest pain or pressure, or new confusion or inability to rouse. Ensure persons who use services and their staff know who to ask for help or how to call 911.

Staff should monitor all residents at least daily for symptoms of COVID-19 (e.g., fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell). Other less common symptoms could include gastrointestinal symptoms like nausea, vomiting, or diarrhea.[3]

- If a pulse oximeter is available, staff should monitor pulse oxygenation status at least once a day. If a resident has oxygenation saturation less than or equal to 94%, refer them for further evaluation and possible treatment.[4]
- Persons who use services with a fever or symptoms of COVID-19 are a high priority for testing. Because of the potential for rapid spread of COVID-19 in congregate settings, testing is strongly encouraged for those living in these settings. Staff and administrators having difficulty identifying a testing site can contact their local public health department or MDH to identify testing resources in their area.[5]

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[2] Please refer to updated guidance from the Centers for Medicare & Medicaid Service (CMS) at CMS: Policy & Memos to States and Regions (www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions) and DHS: Latest information about COVID-19 from Licensing (mn.gov/dhs/partners-and-providers/licensing/licensing-covid/).

[3] Symptoms of COVID-19 can be found on CDC: Symptoms of Coronavirus (www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html).

[4] Pulse Oximetry and COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/pulseoximetry.pdf)

[5] Minnesota COVID-19 Response: Find Testing Locations (mn.gov/covid19/for-minnesotans/if-sick/testing-locations/index.jsp)

Persons who use services with COVID-19

For guidance on ways to support persons who use services with suspected or confirmed COVID-19, please refer to MDH: Interim Guidance on the Management of COVID-19 for Employees and Persons Who Use Services in Licensed Group Homes (www.health.state.mn.us/diseases/coronavirus/groupmanage.pdf).

Considerations to reduce disease transmission

Gatherings of persons who use services and their staff in the home (e.g., meal times, entertainment) should be carefully considered and redesigned, as necessary, to reduce prolonged[6] close contact[7] in the home.

- Non-direct care or support activities that require close contact are not recommended.
- Consider staggering schedules and arranging tables and chairs to be at least 6 feet apart for group activities and meals.
- In order to protect themselves and others, persons who use services should be encouraged and reminded to practice diligent hand hygiene and practice social distancing (staying at least 6 feet apart, or as far apart as able).
- Encourage persons who use services to wear a face covering for source control when in shared spaces or when close contact with other individuals in the home is likely to occur.

For additional suggestions on ways to reduce disease transmission in group homes, visit CDC: Guidance for Group Homes for Individuals with Disabilities (www.cdc.gov/coronavirus/2019-ncov/community/group-homes.html).

Alternative activities

Staff and residents in the group home should work together to identify ways to help residents have meaningful activities during the day within the bounds of these infection control recommendations. Examples may include interacting with friends and family via remote communication or electronic media, working on independent living skills, and other forms of remote participation in community events.

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[6] Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. Until more is known about transmission risks, it is reasonable to consider an exposure of 15 minutes or more as prolonged.

[7] Close contact is defined as being within 6 feet of a person with confirmed COVID-19 or having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19.

Considerations for visitors

Persons who use services retain their rights to associate with other persons of their choice in the community and to choose their visitors and time of visits. Be mindful that restricting these rights without a rights restriction in place may violate licensing standards. During the peacetime emergency, all Minnesotans have had to limit visitors who would normally come into their homes. Providers should help persons who use services make informed decisions about visits that take into account the risks and benefits to the person who uses services and to others whom they interact with.

In order to best protect all persons in the group home, consider the following when planning visits to the home:

- Consider screening of visitors and essential volunteers, for fever and other symptoms associated with COVID-19 before they enter the home and exclude those who are ill
- Consider limiting non-essential visitation to one visitor per resident per day
  - Group home providers should communicate with persons who use services in the home to identify friends or family that are essential to preserving their physical or mental health.
- If a household member is in isolation or quarantine because of a known infection or exposure, make agreements to postpone visitation to the home until individuals have been cleared of infection or have completed their quarantine period.
- When possible, restrict visits to private rooms to avoid visiting in common areas
  - Outdoor visits should be encouraged as conditions allow.

If you have concerns that the rights of a person who uses services have been violated, these concerns may be reported to DHS Licensing Intake at 651-431-6600 or by filing a complaint with the Minnesota Adult Abuse Reporting Center (MAARC) at 1-844-880-1574. For general questions about rights in 245D licensed settings, call the Home and Community-Based Services (HCBS) Helpdesk at 651-431-6624. For more information about supporting persons who use services to make informed decisions, see DHS: Guide to encouraging informed choice and discussing risk (www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-293178).

Considerations for Nebulizers and other Aerosol-Generating Procedures

For nebulizer treatments, open suctioning, or other procedures that may generate aerosols, providers should refer to MDH guidance on Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf). To reduce risk of disease transmission, consider switching from nebulizer treatment to metered-dose inhalers, if available and if the person who uses services can tolerate it.

Situations in which exposures cannot be ruled out

If a person who uses services plans to visit or stay with a family member or engage in activities for which exposure cannot be ruled out (e.g., day program participation, vacation), staff should discuss the following with the person who uses services and/or their guardian prior to the visit or activity:

- The risk of exposure for the planned visit or activity,
- The need for social distancing during the visit,
- Additional steps will need to be taken when the person who uses services returns to ensure other residents and staff remain safe.

It is important to educate persons who use services, families, guardians, and staff who are leaving the home on ways to further reduce the risk of disease transmission when they return to the group home. More information regarding informed choice through person-centered conversations and activities can be found at the following websites:

- DHS: Person-Centered, Informed Choice and Transition Protocol (mn.gov/dhs/partners-and-providers/program-overviews/long-term-services-and-supports/person-centered-practices/pc-ic-tp-faq/)
- Disability Hub MN: Informed Choice (disabilityhubmn.org/hub-partners/work-toolkit/policy-and-practice/informed-choice)

Since COVID-19 could develop within 14 days of an exposure, the risk of disease transmission following activities for which exposure cannot be ruled out is also 14 days. Examples of steps to further reduce the risk of disease transmission include:

- Eating meals in a private room or in common areas at least 6 feet apart
- Having a dedicated bathroom or cleaning and sanitizing the bathroom after each use
- Wearing a face mask when in communal areas
- Performing frequent hand hygiene

As personal protective equipment (PPE) supply allows, best practices would also include the use of eye protection,[8] medical-grade face masks,[9] and if possible, gowns and gloves by staff for all care

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[8] CDC has reported that protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays. For more information see 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#manage_access).

[9] Please note cloth or alternative masks are acceptable means for source control in limiting exposures to other staff; however, for staff providing direct resident care, cloth masks are not considered PPE.

provided to persons who use services in the group home and who have engaged in an activity for which exposures cannot be ruled out in the past 14 days.

- Consider use of PPE in these situations carefully in order to assure sufficient supply for staff caring for any persons who use services who could display symptoms of COVID-19 in the future.

Admission or re-admission of persons who use services with no clinical concern for COVID-19

Persons who use services with no clinical concern for COVID-19 can be admitted or re-admitted to HCBS-CRS or HCBS-RS licensed group homes following the provider's normal procedures. ICF/DD facilities should continue to follow admission guidance as directed by the Centers for Medicaid and Medicare Services (CMS). Additional considerations that group homes may consider to reduce the risk of asymptomatic transmission among newly admitted persons who use services include:

- A pre or post-admission self-quarantine for 14 days (if the person who uses services agrees)
- Testing asymptomatic persons who use services (with the person's or their legal representative's consent) either prior to admission or immediately upon admission, and if available at day 7 and 14
  - Test results should not be used as the only criteria for admission since a negative test does not guarantee a person who uses services won't develop symptoms
- Within the first 14 days after admission, as PPE supply allows, staff could use eye protection,[10] medical-grade face masks,[11] and if possible, gowns and gloves for all care provided to the person who uses services
- Redesign the common areas, such as dining and living rooms, to encourage social distancing

Preventing COVID-19 among staff

For staff working in the group home

[10] CDC has reported that protective eyewear (e.g., safety glasses, trauma glasses) with gaps between glasses and the face likely do not protect eyes from all splashes and sprays. For more information see 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#manage_access).

[11] Please note cloth or alternative masks are acceptable means for source control in limiting exposures to other staff; however, for staff providing direct personal care, cloth masks are not considered PPE.

The following recommendations are intended for employees who work in licensed residential settings. Staff and other essential professionals (e.g., home care, hospice) should be screened for fever or other symptoms associated with COVID-19 before entering the group home. Non-essential staff should not be allowed in the group home. In situations where it becomes necessary for staff in non-direct care roles to enter the building (e.g. building maintenance), these staff members need to follow the same screening and infection control measures as essential staff.

Staff screening

Active screening for, and documentation of, body temperature and symptoms should be used to identify and exclude symptomatic staff. Staff with measured or subjective fever or new symptoms as described previously should not be allowed to enter the group home and should be prioritized for testing. A template form for screening staff can be adapted from appendices of the MDH COVID-19 Toolkit: Information for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf).

PPE considerations

To keep the risk of exposure low for staff, all staff should wear surgical face masks and eye protection (e.g., goggles or face shield) throughout their shift for all close contact encounters with persons who use services.[12]

- Washable homemade masks are an alternative option when there is a limited supply of disposable surgical face masks; however, cloth masks are not considered PPE.
- Use of N95 or higher-level respirators are only recommended for staff who have been medically cleared, trained, and fit-tested, in the context of an employer's respiratory protection program as defined by the Occupational Safety and Health Administration (OSHA). Group home providers should document their efforts to comply with OSHA standards for N95 use. During times of extreme supply constraints, when there may be limited availability of respirators or fit test kits, employers may face challenges in fit testing staff. For additional guidance in these circumstances, group home providers should refer to CDC NIOSH Science Blog: Proper N95 Respirator Use for Respiratory Protection Preparedness (blogs.cdc.gov/niosh-science-blog/2020/03/16/n95-preparedness/).

Reuse of PPE by staff should be guided by CDC: Strategies to Optimize the Supply of PPE and Equipment (www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html).

[12] For more information see 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#manage_access).

Instruct staff on proper procedures and assure proficiency in procedures for putting PPE on (don) and taking PPE off (doff), including when caring for persons who use services who require PPE to reduce disease transmission. You can find short videos at Donning and Doffing Video Vignettes (www.health.state.mn.us/diseases/hcid/videos.html).

Keeping the environment clean

Direct staff to regularly clean and disinfect the home, especially shared areas and frequently touched surfaces, using EPA-registered disinfectants more than once daily, if possible. Clean shared bathrooms at least twice daily and stock them with hand soap and paper towels. Staff should limit entering the bedroom of persons who uses services as much as possible, to reduce potential for cross-contamination.

Group home providers should also keep the following items in common areas for use by persons who use services and staff:

- Soap or alcohol-based hand sanitizers that contain at least 60% alcohol
- Tissues
- Trash baskets
- Cloth face coverings that are washed after each use or disposable masks

Planning for staffing shortages

Staffing shortages are likely to occur if persons who use services or staff develop COVID-19. Group homes should plan for emergency staffing prior to having a positive COVID-19 case. Possible staffing options might include recruiting former or retired employees, using temporary staffing agencies, using furloughed staff from day program providers, using emergency respite or other service modifications, health care coalitions and working with local public health to identify any other local staffing resources.

For staff living with people with COVID-19

The following recommendations are intended for employees who work in licensed residential settings and who, outside of the group home setting, have household contacts or intimate partners with a confirmed or suspected case of COVID-19.

The employee should separate himself or herself from the ill household member within the home as much as possible. The employee might consider temporarily moving into an alternative accommodation, if available, to maintain distance from the ill household member. Given family and caregiver responsibilities, this will not be feasible for many employees.

Employees who are household or intimate contacts of people with a confirmed or suspected case of COVID-19 are advised to stay away from work and limit interactions with the public for 14 days

after the last known exposure with the ill household contact or after preventive self-isolation measures are put into place. MDH recommends that employees with high-risk exposures either in the home, community, or workplace participate in voluntary quarantine for 14 days after the exposure. If the facility is experiencing a staffing shortage that cannot otherwise be resolved, asymptomatic high-risk employees may be asked to return to work during the voluntary quarantine period, provided the employee follows the recommendations described below. High-risk employees can choose not to return with worker protections under Minn. Rule 144.4196.

If it remains necessary for the employee to continue providing direct resident care during this 14-day quarantine period, they should:

- Avoid providing care to or interacting directly with high-risk persons who use services (e.g., elderly and immunocompromised persons, and those with co-morbidities).
- Practice diligent hand hygiene and wear a medical-grade face mask at all times when in the worksite during the 14-day period. They must keep the mask on at all times when providing care and when within 6 feet of any other person. Wearing a medical-grade face mask is preferred over a cloth or fabric face covering during this 14-day period, but if none are available, a cloth or fabric face covering must be worn.
- Monitor themselves closely for symptoms associated with COVID-19 and measure their temperature daily before going to work.
- Remain at home and notify their supervisor if they develop symptoms or have a measured or subjective fever.
- Immediately notify their supervisor if at work when fever or symptoms of illness develop.

Group home employees who may have COVID-19 are a high priority for testing. Because of the potential for rapid spread of COVID-19 in congregate settings, testing is strongly encouraged for those working in these settings. Staff and administrators having difficulty identifying a testing site can contact their local public health department or MDH to identify testing resources in their area.

Follow Statewide Update and Executive Orders

Staff, visitors, persons who use services, and administrators of group homes must stay in compliance with statewide mandates. More information on current statewide requirements can be found at Minnesota COVID-19 Response (mn.gov/covid19/).

Prepare for COVID-19 Vaccine

It is important to begin thinking about how persons who receive services and staff in group homes will receive COVID-19 vaccine when it becomes available to them. As part of the preparation process, group home providers may consider developing a COVID-19 vaccination plan, which may include:

- Contacting local public health to establish a method for receiving updates on local/regional planning related to COVID-19 vaccine.
- Establishing a relationship with a local pharmacy that may be able to provide vaccine services in the local area.

For more information on COVID-19 vaccination, see:

COVID-19 Vaccine Information for Health Professionals (www.health.state.mn.us/diseases/coronavirus/hcp/vaccine.html)

Interim COVID-19 Vaccination Plan: Executive Summary (www.health.state.mn.us/diseases/coronavirus/vaxplansumm.html)

Resources

- CDC: COVID-19 Guidance for Shared or Congregate Housing (www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html)
- CDC: Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance) (www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html)
- CDC: If You Are Sick or Caring for Someone (www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/index.html)
- CDC: Guidance for Group Homes for Individuals with Disabilities (www.cdc.gov/coronavirus/2019-ncov/community/group-homes.html)
- CDC: Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)
- MDH: COVID-19 Testing in Group Homes: Frequently Asked Questions (www.health.state.mn.us/diseases/coronavirus/groupfaq.pdf)
- MDH: Donning and Doffing Video Vignettes (www.health.state.mn.us/diseases/hcid/videos.html)
- MDH: Health Care Coalitions (www.health.state.mn.us/communities/ep/coalitions/index.html)
- MDH: Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf)
- MDH: Interim Guidance on the Management of COVID-19 for Employees and Persons Who Use Services in Licensed Group Homes (www.health.state.mn.us/diseases/coronavirus/groupmanage.pdf)
- Minnesota Responds Medical Reserve Corps (mnresponds.org/)

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10/29/2020

APPENDIX 9

MINNESOTA DEPARTMENT OF HEALTH

STAY SAFE MN

Interim Guidance on the Management of COVID-19 for Employees and Persons Who Use Services in Licensed Group Homes[1]

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

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

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

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

Recommendations for Persons Who Use Services

Staff should monitor all persons who use services at least once a day for fever or symptoms of COVID-19[2] and maintain a low threshold to test persons with even slight changes in their health status. Older adults and persons with disabilities may not display typical symptoms of illness. Less common symptoms could include gastrointestinal symptoms like nausea, vomiting, diarrhea, or low pulse oxygenation.[3]

Anyone who tests positive for COVID-19 is considered to have a confirmed diagnosis while persons experiencing symptoms compatible with COVID-19 are considered to have a suspect diagnosis, even with no laboratory testing.

Diagnostic Testing of Symptomatic Persons Who Use Services

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

Staff and administrators should assist persons who use services to coordinate testing. The person's primary care physician may be able to provide COVID-19 testing or may need to refer the resident to an alternative testing site. Persons who use services, staff, or administrators having difficulty identifying a testing site can contact their local public health department or MDH to identify testing resources in their area.[4]

The type of test currently used for clinical decision-making is the Reverse Transcription Polymerase Chain Reaction (RT-PCR) test. This test is used to identify whether someone has detectable viral material present at the moment the specimen was collected. People who test negative on one day could still develop illness or eventually test positive. Testing of people who do not have symptoms is recommended when the following criteria are met:

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[2] Symptoms currently associated with COVID-19 can be found on CDC: Symptoms of Coronavirus (www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html).

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

[4] Minnesota COVID-19 Response: Find Testing Locations (mn.gov/covid19/for-minnesotans/if-sick/testing-locations/)

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

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

- For more information on appropriate testing strategies for people who are not showing symptoms, see Evaluating and Testing: COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/eval.html).
- For more information on COVID-19 testing in group homes, see COVID-19 Testing in Group Homes: Frequently Asked Questions (www.health.state.mn.us/diseases/coronavirus/groupfaq.pdf).

Please note, people who were previously identified as a positive case, have clinically recovered from COVID-19, and then are identified as a contact of a new case should follow the most up-to-date CDC guidance for quarantine and testing recommendations as these recommendations will likely differ from people who have not previously tested positive. More information on this topic can be found at CDC: Duration of Isolation and Precautions for Adults with COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html).

Care of Persons Who Use Services with COVID-19

Staff should monitor ill persons who use services, including documentation of temperature, symptoms, and pulse oximetry results at least three times daily to quickly identify persons who require transfer to a higher level of care. For persons who use services who require nebulizer treatments or open suctioning, providers should follow MDH guidance on Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf).

Staff who provide direct care should use all appropriate PPE as follows: For prolonged[5] close-contact[6] encounters, staff should wear a surgical face mask or respirator and eye protection (e.g., face shield, goggles, or safety glasses with side shields).

- Protective eyewear with gaps between the glasses and face likely do not protect eyes from all splashes and sprays.
- Gowns and gloves should also be worn when contact with secretions or bodily fluids is anticipated or for any encounters that require extensive body contact (e.g., rolling, toileting).
- Washable homemade cloth face coverings are not considered PPE, so staff should wear a surgical face mask or respirator for any prolonged close-contact encounters with persons who use services and are suspected or confirmed to have COVID-19.
- Use of N95 or higher-level respirators are only recommended for staff who have been medically cleared, trained, and fit-tested, in the context of an employer's respiratory protection program, as defined by the Occupational Safety and Health Administration (OSHA). Group home providers should document their good faith efforts to comply with OSHA standards for N95 use. During times of extreme supply constraints, when there may be limited availability of respirators or fit test kits, employers may face challenges in fit testing workers. For additional guidance in these circumstances, group home providers should refer to CDC NIOSH Science Blog: Proper N95 Respirator Use for Respiratory Protection Preparedness (blogs.cdc.gov/niosh-science-blog/2020/03/16/n95-preparedness/).
- If performing an aerosol-generating procedure,[7] staff should wear gown, gloves, eye protection, and respirator.

CDC: Strategies to Optimize the Supply of PPE and Equipment (www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html) should also be put into place.

Persons who use services with confirmed or suspected COVID-19 should have a single-person room with a private bathroom and a door that closes. If a private bathroom is not possible, an alternative option would be to dedicate a separate bathroom in the home for those who are positive. Staff should clean and disinfect the frequently used areas of the bathroom after each use by the person who is

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[5] Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. Until more is known about transmission risks, it is reasonable to consider an exposure of 15 minutes or more as prolonged.

[6] Close contact is defined as being within 6 feet of a person with confirmed COVID-19 or having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19.

[7] MDH: Aerosol Generating Procedures and Patients with Suspected or Confirmed COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf)

COVID-19 positive and clean and disinfect the entire bathroom at least twice per day, or more frequently after times of heavy use.

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

- Wear a surgical face mask (preferable if available) or alternative face covering, such as tissues, to cover their mouth and nose.
- Perform hand hygiene immediately before or after leaving their room.
- Practice social distancing to remain at least 6 feet from others.

Considerations for Visitors

Staff, other persons who use services, or visitors (e.g., outreach workers or family) who can provide essential supports should not be restricted from visiting people with COVID-19. Group home managers and staff should help persons who use services make informed decisions about visits that take into account the risks and benefits to the person who uses services and to others who they interact with. Persons who use services retain their rights to associate with other persons of their choice in the community and to choose their visitors and time of visits. Be mindful that restricting these rights without a rights restriction in place may violate licensing standards. If you have concerns that the rights of a person who uses services have been violated, these concerns may be reported to DHS Licensing Intake at 651-431-6600 or by filing a complaint with the Minnesota Adult Abuse Reporting Center (MAARC) at 1-844-880-1574. For general questions about rights in 245D licensed settings, call the Home and Community-Based Services (HCBS) Helpdesk at 651-431-6624. For more information about supporting persons who use services to make informed decisions, see DHS: Guide to encouraging informed choice and discussing risk (www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs-293178).

Further information to help visitors prevent the virus's spread can be found at:

- CDC: Caring for Someone Sick at Home (www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/care-for-someone.html).
- MDH: 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).

Discontinuing Use of PPE for the Care of Persons Who Use Services Who Have COVID-19

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

- **For persons who displayed no symptoms and who are not severely immunocompromised, follow CDC's time-based strategy**, which recommends using PPE until at least 10 days have passed since the date of the first positive test.
  - If a person displayed no symptoms at the time of the positive test result but then developed symptoms during the 10 day isolation period, the isolation period will need to be "reset" based on the symptom onset date and meet the criteria for persons who displayed symptoms as described below.
- **For persons who displayed symptoms and who are not severely immunocompromised, follow CDC's symptom-based strategy:**
  - 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 persons with severe to critical illness or who are severely immunocompromised, MDH recommends that PPE be used for care of these persons until:**
  - At least 20 days have passed since symptoms first appeared (or 20 days since the date of the first positive test, if asymptomatic) **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.
- In some rare circumstances, depending on the nature of immunosuppression and concern about continued use of PPE, persons with immunocompromising conditions could undergo a test-based strategy to discontinue PPE use. In this case, consultation with an expert in infectious diseases may help interpret test results.

- For additional information see CDC: Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance) (www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html).

Admission or Readmission of Persons Who Use Services with COVID-19

Group homes may accept persons recently diagnosed with COVID-19 as long as the home can follow the CDC guidance and use all appropriate PPE to provide care. If a group home provider is not able to adhere to the CDC recommendations, it must wait until the PPE requirements are no longer needed to provide safe care to the recently diagnosed person. For information on appropriate infection control strategies for persons who recently had COVID-19 symptoms and are planning to return or be admitted to the group home please refer to MDH: 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).[8]

For guidance on admissions/re-admissions for persons returning or being admitted to the group home with no clinical concern for COVID-19 (including persons discharged from hospitals where a case of COVID-19 was present but the person had no known exposure), please refer to MDH: Interim Guidance on the Prevention of COVID-19 for Employees and Persons Who Use Services in Licensed Group Homes (www.health.state.mn.us/diseases/coronavirus/guidegroup.pdf).

Recommendations for Employees

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

Diagnostic Testing of Symptomatic Staff

Testing of symptomatic staff in group homes is a high priority and strongly encouraged because of the severe potential for COVID-19 to spread in congregate settings. Staff with symptoms compatible with COVID-19 should contact their primary care physician to be evaluated and

[8] "Transmission-Based Precautions" for COVID-19 are infection control practices to be used in addition to standard precautions like frequent hand hygiene and include use of all appropriate PPE (e.g., mask/respirator, eye protection, gown, and gloves), as resources allow. CDC: Transmission-Based Precautions (www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html).

appropriately tested for COVID-19 and other causes of respiratory illness. Employers may also develop their own plans to coordinate testing of their employees. Staff and administrators having difficulty identifying a testing site can contact their local public health department or MDH to identify testing resources in their area.

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

Return to Work Guidelines

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

If employees were not tested or had an initial negative test for COVID-19 AND have an alternate diagnosis:

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

If staff test negative but have symptoms of COVID-19 and do not have an alternative diagnosis:

- **If the persistent symptoms (symptoms have not improved when RT-PCR test results are reported) are consistent with an established chronic health condition, the staff may return to work after consultation with their manager and occupational health department. Evaluation of acute symptoms by the staff's health care provider might also be indicated.**
- **If persistent symptoms are not consistent with a known chronic health condition, the staff member should be evaluated by a health care provider.**
  - **If the health care provider provides an alternate diagnosis, criteria for return to work should be based on that diagnosis.**
  - If the health care provider **does not** provide an alternative diagnosis and the staff person **does not** have a known high-risk exposure to a person with confirmed COVID-19, the staff person should remain isolated and not return to work until at least 24 hours have passed since recovery, defined as resolution of fever without the use of fever-reducing medications and improvement in symptoms (e.g., cough, shortness of breath).
- If the health care provider **does not** provide an alternate diagnosis and the staff person **does** have a known high-risk exposure to a person with confirmed COVID-19, the staff person should obtain a second SARS-CoV-2 RT-PCR test. The staff person should remain isolated until the

test results are known. Minnesota continues to experience high levels of community transmission, and the potential consequences of working with COVID-19 are serious.

- If positive, follow the COVID-19 work exclusion and isolation guidance outlined below for staff that test positive for COVID-19.
- If negative, the HCW can return to work if at least 24 hours have passed since resolution of fever and symptoms are improving.

If staff test positive or do not get tested/evaluated for COVID-19:

- If symptomatic, follow the CDC's symptom-based to determine when they may return to work. After returning to work, staff should continue to wear a face mask (procedure or surgical mask, not a cloth face covering) for source control at all times until symptoms are completely resolved or 14 days after symptom onset, whichever is longer. Staff should self-monitor for symptoms and seek re-evaluation if respiratory symptoms recur or worsen.
- If asymptomatic, follow the CDC's time-based strategy to determine when they are able to return to work: CDC: Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance) (www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html).

Recommendations for Owners, Administrators, and Program Directors

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

Perform Risk Assessments for Exposed Staff and Persons

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

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

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

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

For classification of persons who use services' exposures from prolonged close contact with another person who uses services, visitor, or staff, MDH recommends following CDC: Public Health Recommendations for Community-Related Exposure (www.cdc.gov/coronavirus/2019-ncov/php/public-health-recommendations.html) and maintaining a low threshold for testing if they have any change in health status.

If your PPE supply allows, persons who use services who have had exposures should be cared for using all recommended COVID-19 PPE until 14 days after last exposure. Please note, PPE has an important role in source control; however, the level of source control provided is not well-studied and so we cannot say these protocols are 100% effective in every circumstance. Therefore, persons who have had prolonged, close contact with a positive staff member, regardless of the level of PPE worn, are considered to have been exposed. To keep the risk of exposure low for staff, when caring for these persons it is recommended that staff wear a medical or surgical face mask, gloves, gown, and eye protection (goggles or face shield that covers all sides of the face) for 14 days following the last date of exposure to the positive staff member. As testing resources allow, these persons should be prioritized for testing.

People who have clinically recovered from COVID-19 and then are identified as a contact of a new case within 3 months of symptom onset of their most recent illness do not need to be quarantined or retested for SARS-CoV-2. However, if a person is identified as a contact of a new case 3 months or more after symptom onset, they should follow quarantine recommendations for contacts. For more information on information for people who have previously tested positive and recovered, see CDC: Duration of Isolation and Precautions for Adults with COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html).

MDH Assistance with Risk Assessment and Infection Control

MDH has a team dedicated to following up on staff exposures in congregate settings, including group homes. A representative of the MDH response team will attempt to contact the facility within 24 hours of being notified of a person who uses services or staff member testing positive for

COVID-19. The response team will assist the group home in performing the risk assessment process; however, it is recommended that group home managers be familiar with the process and begin implementation of risk assessments and appropriate staff exclusion prior to being contacted by MDH. Following the initial call with the response team, a representative from MDH or DHS will contact the group home management to address any immediate issues in the home and link the management and staff to appropriate resources.

Continue to Implement Infection Control and Prevention Measures

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

- If available, licensed nurses play a critical role in the response to COVID-19 in group homes. Identify them as infection preventionists who educate, monitor, and audit all aspects of this guidance.
- As much as possible, limit the number of people allowed in recreational areas as well as the kitchen and dining area at one time, so that everyone can stay at least 6 feet apart from each other.
- Provide COVID-19 prevention supplies such as soap, alcohol-based hand sanitizers (containing at least 60% alcohol), tissues, trash baskets, and cloth face coverings that are washed or discarded after each use.
- Instruct staff to clean and disinfect shared areas (such as dining areas, laundry rooms, and elevators) and frequently touched surfaces using EPA-registered disinfectants more than once a day, if possible.
- Make sure that shared rooms have good air flow from an air conditioner or an opened window.
- Encourage persons who use services, staff and visitors to perform diligent hand hygiene and wear a cloth barrier for source control throughout the day, if tolerable.
- Ensure protocols requiring staff to wear appropriate PPE, as available, throughout their shift and that staff are trained and comfortable with these PPE protocols.
- Instruct staff to perform hand hygiene on arrival to the group home, before and after person encounters, before putting on PPE, after removing PPE, before and after eating, and prior to leaving the group home. Ensure that staff are trained and comfortable with these hand hygiene measures.
- Conduct end-of-shift assessments with staff to identify PPE breaches and potentially concerning exposures of staff to persons with COVID-19.
- Remain diligent for the potential re-introduction of COVID-19 into your facility. It is not yet known how long the immune response offers protection to those who have been infected.

Plan for Potential Staffing Shortages

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

For more information please see MDH: Defining Crisis Staffing Shortage in Congregate Care Facilities: COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html).

Communicate to Persons Who Use Services, Families, and Staff

Group home providers should reassure persons who use services, families, and staff how they will keep everyone safe:

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

For Persons Who Attend Adult Day Center or Day Service Facility

If a person who receives services in a group home tests positive for COVID-19, and also attends either an adult day center or day service facility, the group home must notify the day service provider of the positive case in order to assist the day provider with identifying potential exposures to the COVID-19 positive person.

If a person who receives services in a group home has a high-risk exposure, or lives in a home with either a COVID-19 positive staff or resident, the group home must follow DHS guidance before the person should return to the adult day center or day service facility. For more information please see DHS: Latest information abot COVID-19 from Licensing (mn.gov/dhs/partners-and-providers/licensing/licensing-covid/).

Follow Statewide Updates and Executive Orders

Staff, visitors, persons who use services, and administrators of group homes must stay in compliance with statewide mandates. More information on current statewide requirements can be found at Minnesota COVID-19 Response (mn.gov/covid19/).

Resources

- CDC: COVID-19 Guidance for Shared or Congregate Housing (www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html)
- CDC: Criteria for Return to Work for Healthcare Personnel with SARS-CoV-2 Infection (Interim Guidance) (www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html)
- CDC: If You Are Sick or Caring for Someone (www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/index.html)
- CDC: Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)
- MDH: Interim Guidance on the Prevention of COVID-19 for Employees and Persons Who Use Services in Licensed Group Homes (www.health.state.mn.us/diseases/coronavirus/guidegroup.pdf)
- MDH: Aerosol-Generating Procedures and Patients with Suspected or Confirmed COVID-19 (www.health.state.mn.us/diseases/coronavirus/hcp/aerosol.pdf)
- MDH: COVID-19 Testing in Group Homes: Frequently Asked Questions (www.health.state.mn.us/diseases/coronavirus/groupfaq.pdf)
- CDC: Duration of Isolation and Precautions for Adults with COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html)

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