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## Updated Interim Guidance for Nursing Homes and Other Long-Term Care Facilities and Programs: Phased Reopening

| Summary of Changes to Guidance Since August 13, 2020 Release   |
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| <b>Newly Added Definitions:</b>  |
| Facility-associated Case of COVID-19 Infection in a Staff Member   |
| <b>Newly Added Guidance Sections:</b>  |
| PPE Capacity Categories  |
| Mitigation Strategies for Staffing Shortages   |
| Volunteer Guidance   |
| <b>Revised Sections:</b>   |
| Universal Source Control and Hand Hygiene – added qualifier to requirement for resident mask wearing outside of room                       |
| Testing Plan and Response Strategy – added CMS requirements for staff testing  |
| Returning to a previous CMS phase – added that facilities should update their reopening status in the online portal when regressing phases |
| Virtual visitation changed to include teleconferencing   |
| State-authorized personnel requirements added  |
| Pre-screening visitor requirement change to include electronic screening methods   |
| Phase 1 addition of outdoor visitation allowed   |
| Phase 2 addition of indoor visitation allowed, statement about required visitation added   |
| Phase 2 addition of beauty salon and barber shop allowed   |
| Phase 2 addition of volunteer guidance   |

This interim guidance provides guidelines for nursing homes and other long-term care (LTC) facilities regarding restrictions that were instituted to mitigate the spread of COVID-19. The guidance in this document is specifically intended for facilities as defined in the Nursing Home Care Act (210 ILCS 45), and also applies to Supportive Living Facilities, Assistive Living Facilities, Shared Housing Establishments, Sheltered Care Facilities, Specialized Mental Health Rehabilitation Facilities (SMHRF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), State-Operated Developmental Centers (SODC), Illinois Department of Veterans Affairs

facilities and Medically Complex/Developmentally Disabled Facilities (MC/DD). Modifications for specific categories of LTC facilities and programs are provided in the Appendix.

### **Non-discrimination Statement**

It is essential that healthcare institutions operate within an ethical framework and consistent with civil rights laws that prohibit discrimination in the delivery of healthcare. Specifically, in allocating healthcare resources or services during public health emergencies, healthcare institutions are prohibited from using factors including, but not limited to race, ethnicity, sex, gender identity, national origin, sexual orientation, religious affiliation, age, and disability. For additional information please refer to: *Guidance Relating to Non-Discrimination in Medical Treatment for Novel Coronavirus 2019 (COVID-19)*, located at: <https://coronavirus.illinois.gov/sfc/servlet.shepherd/document/download/069t000000AiOFZAA3?operationContext=S1>

### **Background**

The risk of COVID-19 transmission within nursing homes and other LTC facilities is high due to congregate living. In addition, residents of these facilities are highly vulnerable to severe illness from COVID-19 due to advanced age and underlying health conditions. Therefore, decisions to alter restrictions should be undertaken with care and caution. At the same time, the Illinois Department of Public Health (IDPH) acknowledges the importance of considering the quality of life of residents.

Early in the pandemic, the Centers for Medicare and Medicaid Services (CMS) mandated the highest level of mitigation for nursing homes (QSO-20-14-NH, revised March 13, 2020). Restrictions included exclusion of all visitors, except in certain compassionate care situations, together with cancellation of communal dining and all group activities. CMS subsequently issued guidance for phased reopening of nursing homes (QSO-20-30-NH, "Nursing Home Reopening Recommendations for State and Local Officials," May 18, 2020; FAQ, June 23, 2020). Phases 1, 2, and 3 in this document correspond to the CMS numbering convention. CMS released additional guidance regarding visitation on September 17, 2020 (QSO-20-39 NH).

This IDPH guidance document draws on currently available best practice recommendations. It is largely based on the CMS sources cited above, together with interim guidelines from the Centers for Disease Control and Prevention (CDC). IDPH will revise and update this document as needed, based on accrued experience, new information, and future guidance from CMS and CDC.

## Definitions

*Facility-onset case (New)* – following the definition from CMS (QSO-20-30-NH): “a COVID-19 case that originated in the facility; not a case where the facility admitted an individual from a hospital with known COVID-19 positive status, or an individual with unknown COVID-19 status that became COVID-19 positive within 14 days after admission.”

*Facility-associated case of COVID-19 infection in a staff member –(New)* “a staff member who worked at the facility for any length of time two calendar days before the onset of symptoms (for a symptomatic person) or two calendar days before the positive sample was obtained (for an asymptomatic person) until the day that the positive staff member was excluded from work.” (CDC Contact Tracing for COVID-19, found at: <https://www.cdc.gov/coronavirus/2019-ncov/php/contact-tracing/contact-tracing-plan/appendix.html#contact>)

*Staff* – following the definition from CDC: “[Staff] include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the health care setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).”

*State-authorized personnel* – State-authorized personnel include, but are not limited to: Representatives of the Office of the State Long-Term Care Ombudsman Program, the Office of State Guardian, Office of Health Care Regulation and the Legal Advocacy Service; and community-service providers or third parties serving as agents of the State for purposes of providing telemedicine, transitional services to community-based living, and any other supports related to existing consent decrees and court-mandated actions, including, but not limited to, the Prime Agencies and sub-contractors of the Comprehensive Program serving the Williams and Colbert Consent Decree Class Members.

## Eligibility criteria for advancing to successive CMS phases

Each individual facility must meet specific requirements to advance to each successive CMS phase. Thus, different facilities in the same community may be in different phases of reopening. The eligibility requirements for advancing are as follows:

- Case status in the community.** The State is divided into 11 geographic Illinois COVID-19 regions for the purpose of monitoring and mitigating resurgence of COVID-19. Indicators are calculated daily for each region and compared to pre-established threshold values for: (a) test positivity rate; and (b) a composite metric of COVID-19 hospital admissions and hospital resource capacity.<sup>1</sup> Both indicators must have been

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<sup>1</sup> <https://www.dph.illinois.gov/regionmetrics>

within their target ranges for at least 14 days before long-term care facilities in that region can advance to the next CMS phase.

- **Case status in the facility.** A facility must spend a minimum of 14 days in a given CMS phase, with no new facility-onset COVID-19 cases or facility-associated COVID-19 infections in a staff member, before advancing to the next CMS phase.
  - A certified local health department may require an interval longer than 14 days for its jurisdiction.
  - If a resident develops facility-onset COVID-19 or a staff member develops facility-associated COVID-19 infection, the facility must immediately revert to the highest level of mitigation and start the CMS phases over.
- **Staffing level.** The facility has sufficient staffing that it is not operating with a contingency or crisis staffing strategy, as defined by CDC.<sup>2</sup> Also refer to Mitigation Strategies for Staffing Shortages section below.
- **PPE supply and usage; essential cleaning and disinfection supplies to care for residents.** The facility has sufficient personal protective equipment (PPE) that it is not operating at crisis capacity, as defined by CDC.<sup>3</sup> (The facility may operate at contingency PPE capacity.) All staff must wear appropriate PPE when indicated. Also refer to PPE Capacity Categories section below.
- **Universal screening.** The facility must have a written policy that states where, when, how, and by whom screening will be performed and recorded. The facility must use a checklist-based screening protocol, administered verbally and recorded in written or electronic format, for each person entering the facility, including all staff, visitors, and other persons. The facility must deny access if any findings are positive. The facility must retain screening records according to the facility's record retention policy, but not for less than 30 days. Screening must check for each of these exclusion criteria:
  - measured body temperature of 100.0 degrees Fahrenheit or more,<sup>4</sup>
  - symptoms of COVID-19, as listed by CDC,<sup>5</sup>
  - diagnosis of COVID-19 before completing the appropriate period of isolation,<sup>6</sup> or
  - prolonged close contact with a person with COVID-19 while not using appropriate PPE during the prior 14 days.<sup>7</sup>All residents are to be screened for elevated body temperature, pulse oxygen level, and symptoms of COVID-19, as listed by CDC, at least daily.
- **Universal source control and hand hygiene.** All staff are trained in proper hand hygiene.<sup>8</sup> Everyone entering the facility must perform hand hygiene upon entry. Everyone entering the facility must wear face masks or respirator, as appropriate, and additional PPE, as appropriate, except during breaks in designated break areas. All residents must wear a cloth face covering or face mask if possible when outside of their

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<sup>2</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

<sup>3</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

<sup>4</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

<sup>5</sup> <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

<sup>6</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

<sup>7</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

<sup>8</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

rooms and when staff enter their rooms.

- If, due to a medical condition or a disability, a resident cannot tolerate or would be unable to remove a cloth face covering or face mask, then a face shield may be substituted as a second-best alternative.
- If, due to a medical condition or a disability, a staff member cannot tolerate a face mask, and the staff member requests a reasonable accommodation under the Americans with Disabilities Act or the Illinois Human Rights Act, then the employer will determine whether such an accommodation can be provided while fully protecting the health and safety of that employee, other staff members, and residents of the facility, and without causing an undue hardship to the employer.

□ **Testing plan and response strategy.** A written COVID-19 testing plan and response strategy is in place, based on contingencies informed by the CDC<sup>9</sup> and, as applicable, CMS requirements.<sup>10</sup>

- The testing plan specifies the method(s) and locations of testing (laboratory and/or point-of-care).
- *The testing plan includes:*
  - Initial testing of all residents and staff (“facility-wide baseline testing”).
  - In response to an outbreak, a single facility-onset COVID-19 infection in a resident, or a single new case of facility-associated COVID-19 infection in a staff member, testing of all previously negative residents and staff occur. Repeated retesting continues, generally every 3 to 7 days, until the testing identifies no new cases of COVID-19 infection among residents or staff for a period of at least 14 days. Thereafter, retesting of staff occurs at the minimum testing frequency required by CMS.<sup>10</sup>
  - Immediate testing of residents or staff with signs/symptoms of COVID-19.
  - If a facility has had no new cases within the past 14 days, then retesting of staff occurs as follows:

- **Serial testing of staff occurs and the minimum testing frequency is based on county positivity rates (based on CMS data)<sup>11</sup> and CMS requirements (see CMS chart below).<sup>12</sup>**

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

\*This frequency presumes availability of Point of Care testing on-site at the nursing home or where off-site testing turnaround time is <48 hours.

- However, if the local health department endorses a higher frequency of testing for staff at facilities within its jurisdiction, based on other

<sup>9</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

<sup>10</sup> <https://www.federalregister.gov/documents/2020/09/02/2020-19150/medicare-and-medicaid-programs-clinical-laboratory-improvement-amendments-clia-and-patient>

<sup>11</sup> <https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg>

<sup>12</sup> <https://www.cms.gov/files/document/qso-20-38-nh.pdf>

factors for COVID-19 transmission,<sup>13</sup> then facilities in that jurisdiction may need to test staff at the higher frequency.

- In a facility that has had no cases within the past 14 days, periodic retesting of staff can be done on a fractional basis (for example, 50% of the staff on each testing occasion), provided that all staff are tested at the target frequency. A positive finding still must trigger immediate, facility-wide testing.
- *For nursing homes and other LTC facilities:*
  - Asymptomatic persons with a history of a positive COVID-19 test generally should not be retested.
  - A policy is in place for addressing residents and staff that refuse testing in each of the following situations: (a) symptomatic, or (b) asymptomatic.
  - Testing results are reported to IDPH and certified local health department in accordance with applicable regulations; records are retained according to the facility's record retention policy.
  - The response plan includes provisions for designating resident care areas with dedicated staff if residents become symptomatic ("PUI unit") or test positive for COVID-19 (COVID-19 unit).<sup>14,15</sup>
  - The facility must submit its testing and response plan to IDPH.

### **Personal Protective Equipment (PPE) Capacity Categories (New)**

There are three types of PPE capacity categories:

- conventional (normal operations without shortages),
- contingency capacity (measures used temporarily during periods of PPE shortages), and
- crisis capacity (strategies implemented during periods of shortages even though they do not meet U.S. standards of care).

Facilities can consider crisis capacity strategies when the supply is not able to meet the facility's current or anticipated utilization rate. CDC's optimization strategies for PPE offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted.

**As PPE availability returns to normal, health care facilities should promptly resume standard practices.**<sup>16</sup>

As specified in the guidance for PPE, a NIOSH-approved N95 equivalent or higher-level respirator is recommended when caring for suspected or confirmed patients with COVID-19.<sup>16</sup> Facilities would be considered in crisis capacity, if their supply of N95s does not meet the anticipated demand as calculated by the CDC Burn Rate Calculator available at, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html>. KN95 masks are not considered NIOSH-approved N95 respirators and are considered a crisis

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<sup>13</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html>

<sup>14</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

<sup>15</sup> <https://www.cdc.gov/coronavirus/2019-ncov/community/community-mitigation.html>

<sup>16</sup> <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/>

level strategy option.

Facilities must satisfy eligibility criteria to advance through CMS phases of reopening. **In order to advance, facilities must not be operating at crisis capacity.**

### **Mitigation Strategies for Staffing Shortages (New)**

*The Illinois Department of Public Health does not support staff working while ill. Mitigation strategies listed below are intended to be used in the order that they appear.*

#### **Contingency Capacity Strategies to Mitigate Staffing Shortages**

1. Attempt to hire additional staff; rotate staff; offer overtime, bonus, or hazard pay to support patient care activities.
2. Contact staffing agencies to identify additional health care personnel (HCP) to work in the facility. Be aware of Illinois-specific emergency waivers or changes to licensure requirements or renewals for select categories of HCP.
3. Determine if there are alternate care sites with adequate staffing to care for patients with COVID-19 (e.g., sister facilities in same network or other COVID-19 designated facilities where residents could be transferred to for care).
4. Reach out to Illinois Helps for staffing assistance (<https://illinoishelps.net/>).
5. As appropriate, request HCP postpone elective time off from work.

#### **Care Strategies**

1. Bundle care activities or determine if any tasks could be postponed or offered every other day or on an alternate schedule (e.g., showers could possibly be given every other day unless necessary to maintain skin integrity). Resume routine care activities as soon as staffing allows.
2. Shift HCP who work in other areas to support patient care activities in the facility. Facilities will need to ensure these HCP have received appropriate orientation, appropriate and adequate PPE, and training to work in areas that are new to them.

**NOTE: Document all attempts to augment staffing needs (date, time, and effort made)**

#### **Crisis Capacity Strategies to Mitigate Staffing Shortages**

1. Implement regional plans to transfer patients with COVID-19 to designated health care facilities, or alternate care sites with adequate staffing.
2. Implement plans (see contingency capacity strategies above) to *allow asymptomatic HCP who have had an unprotected exposure to SARS-CoV-2, but are not known to be infected, to continue to work.*
  1. If shortages continue despite other mitigation strategies, consider implementing criteria to allow asymptomatic HCP with suspected or confirmed COVID-19 who are well enough and willing to work but have not met all return to work criteria to work.
  2. If not already done, allow HCP with suspected or confirmed COVID-19 to perform job duties where they do not interact with others (e.g., patients or other HCP), such as in

telemedicine services; or provide direct care only for patients with confirmed or suspected COVID-19, preferably in a cohort setting.

**Additional crisis strategies can be found at the following CDC website:**

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

### **Procedure for moving between CMS phases**

**Advancing to the next CMS phase.** A facility must satisfy all the criteria and must spend a minimum of 14 days in a given CMS phase, with no new, facility-onset COVID-19 cases and no new facility-associated case of COVID-19 infection in a staff member before advancing to the next CMS phase. The facility's administration performs a self-assessment of the facility's state of readiness for advancing, using the checklist of criteria provided above in the section, "Eligibility criteria." To mark advancement to the next CMS phase, the administrator or designee first attests to the facility's readiness and intent to advance, via the online portal found at <https://redcap.link/LTCreopening>.

The facility then notifies residents, their families or guardians, the long-term care ombudsman, and the local health department of the new CMS phase and of relevant operational changes. Facilities should meet this requirement by using multiple communication channels, such as email listservs, social media, website postings, recorded telephone messages, and/or paper notification.

**Returning to a previous CMS phase.** Either of the following criteria trigger regression to an earlier CMS phase:

- If the facility identifies a new, facility-onset COVID-19 case in a resident, or a single new case of facility-associated COVID-19 infection in a staff member, in any phase of reopening, then the facility must revert immediately to the highest level of mitigation and start over in the phases of reopening.
- If any other criterion for the current CMS phase is no longer fulfilled – for example, if staffing or PPE are no longer above threshold levels, or if testing is no longer being performed at appropriate intervals – then the facility must revert to the previous CMS phase until the criterion is fulfilled.

If CMS phase regression occurs, the facility must notify residents, their families or guardians, the long-term care ombudsman, and the local health department of the new phase and of relevant operational changes. Multiple communication channels should be used, just as for notification of phase advancement. The facility should also update their CMS phase status in the online portal: <https://redcap.link/LTCreopening>.

### **Guidance for CMS Phase 1**

**Virtual visitation.** During CMS Phase 1, the facility should make virtual or teleconference (audio and visual or audio only) visitation available to all residents through videoconferencing. Virtual



or teleconference visitation should be available as frequently as possible, on a schedule that accommodates residents and their virtual visitors to the greatest extent practicable. The facility should have in place a policy and the requisite technology for virtual visitation. Virtual visitors may include, but are not limited to family, friends, and clergy.

**Outdoor visitation.** *[This section supersedes a previous IDPH guidance document, "Outdoor Visitation Guidance for Long-Term Care Facilities," June 18, 2020.]*

During CMS Phase 1, all residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure should be allowed to receive outdoor visitors safely, provided facility grounds have suitable space for the requirements described below. Residents in isolation or quarantine cannot receive visitors.

To conduct outdoor visitation, the facility must formulate a written visitation policy. This policy must balance clinical and safety considerations of infection control with the resident's right to receive visitors [42 CFR § 483.10(f)(4)]. The facility should develop a short, easy-to-read fact sheet on visitation policy for residents and visitors, distribute to residents, and post on the facility's website. Visitors are required to comply with the facility's visitation policy. If a visitor refuses to follow the facility's policy during the visit, then staff may end the visit.

The outdoor visitation policy must address the following points:

- Designate outdoor space for visitation.
  - Visits may take place under a canopy or tent without walls.
  - Outdoor space must have separate ingress and egress which do not require visitors to enter the facility's building. Visitors must not enter the facility at any time.
- Measure the designated outdoor space and determine the number of residents and visitors that can be accommodated at one time in that area with at least 6-foot separation between residents and their visitors
  - Consider marking the ground to show how visitors can place themselves with at least 6-foot separation.
  - Post maximum number of residents and visitors that can occupy the area.
  - Post signage to cue 6-foot separation, face covering, and hand hygiene.
  - Set up dispensers for alcohol-based hand rub.
- Designate outdoor visitation hours when staff for screening and supervision of visitors will be available.
- Limit visitation to two visitors at a time per resident. The visitors, if two, must be from the same household. Specify whether exceptions can be made for compassionate care situations.
- Create an appointment schedule with time slots for each visitation area.
  - Schedule visits by appointment only; specify start, end time, and location for each visit.
  - Limit sign-ups to the allowed number of visitors in each time slot and visitation area.

- If demand for appointment slots exceeds availability, set limits on the number of slots per week or per day for each resident
- Pre-screen visitors by phone using its checklist-based screening protocol (see section on Universal Screening, above) or through electronic screening methods, required less than 24 hours in advance; re-screen with the same protocol on arrival, as for all other persons entering the facility, including temperature check. (Facilities cannot require viral testing of visitors as part of screening unless they offer point-of-care testing at no charge.)
- Maintain a record of all visitors with contact information, for potential contact tracing.
  - Record date and time of visit, name, address, telephone and, if available, email address.
  - Make records available to IDPH and local health department for inspection and, as needed, for contact tracing; retain at least 30 days.
- Notify all visitors upon arrival that if they develop symptoms of COVID-19 within three days after visiting, they must immediately notify the facility.
- Supervise every visit to ensure infection control practices are utilized, including that visitors keep at least a 6-foot separation between themselves and the resident, that the visitor continually wears a cloth face covering or face mask, and that the visitor practices proper hand hygiene. The facility may determine whether supervision is continuous or intermittent.
- If feasible, the facility may construct an outdoor conversation booth for residents unable or unwilling to wear a mask.
  - The conversation booth is constructed as a three-sided box with transparent walls at least 3 feet higher than the seated height of the occupant and the visitor.
  - The resident sits inside the box and the visitor sits opposite the front wall.
- Clean and disinfect seating and other touched surfaces in the visitation area between visitors.
- The long-term care facility must submit its outdoor visitation policy upon request to IDPH or the certified local health department.

**Indoor compassionate care visitation.** In-person indoor visitation is generally prohibited, except in situations of compassionate care when outdoor visitation is not practicable.

- Indoor compassionate care visits are considered on a case-by-case basis. Situations warranting consideration are not limited to the end of life. Other cases that may be considered could include a resident whose health status has sharply declined or a resident whose close relative or close friend recently passed away.
- Pre-screen compassionate care visitors by phone using a written, checklist-based screening protocol (see section on Universal Screening above) or through electronic screening methods less than 24 hours in advance; re-screen with the same protocol on arrival, as for all other persons entering the facility, including temperature check. (Facilities cannot require viral testing of visitors as part of screening unless they offer point-of-care testing at no charge.)
- Notify all visitors upon arrival that if they develop symptoms of COVID-19 within three days after visiting, they must immediately notify the facility.
- Compassionate care visitors are restricted to the room where the visitation will occur.
- Visits should be conducted using social distancing; however, if during a compassionate

care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following all appropriate infection prevention guidelines and for a limited amount of time. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the long-term care ombudsman program to identify the need for compassionate care visits.

**State-authorized personnel.** IDPH grants authorization for entry to State-authorized personnel. They should not be classified as visitors. All such individuals must promptly notify facility staff upon arrival and follow all screening protocols established by the facility. State-authorized personnel are required to bring their own PPE and sufficient additional PPE for donning and doffing while entering and exiting COVID-19 units. State-authorized personnel will follow the COVID-19 rules and policies set forth by their respective state agencies. *[For additional guidance, see this IDPH guidance document: "Access to Hospital Patients and Residents of Long-Term Care Facilities by Essential State-Authorized Personnel," April 17, 2020.]*

**Communal dining.** In CMS Phase 1, communal dining is not recommended but may be considered on a limited and modified basis. If it is implemented, then follow guidance for communal dining under CMS Phase 2.

**Group activities.** Engagement through technology is preferred to minimize opportunity for exposure.

- Facilities are encouraged to offer programming to engage virtually, where possible, in activities that improve quality of life, such as worship services, musical events, etc.
- In-person group activities are not recommended in CMS Phase 1 but may be considered. If group activities are implemented, do so on a limited basis and follow guidance for group activities under CMS Phase 2.

**Medical Trips.** Use telemedicine to the extent practicable. Avoid trips that are not medically necessary. For medically necessary trips away from the facility:

- Share the resident's COVID-19 status with transport staff, any attendant persons, and with the appointment destination.
- Screen the transport staff, patient, and any attendant persons for elevated temperature and COVID-19 symptoms before entry into vehicle.
- Limit occupancy in vehicle based upon ability to maintain 6-foot separation.
- Driver must wear a face mask or cloth face covering and use additional PPE as indicated by CDC guidelines; resident must wear a cloth face covering or face mask.
- Assist resident in performing hand hygiene on departure from facility and upon return to facility.
- Disinfect transport equipment and commonly touched surfaces, including vehicle handles and seatbelts, before and after transport.
- Maintain social distancing, cloth face covering or face mask, and hand hygiene throughout time spent at the destination.
- Upon return of a resident from a trip outside the facility, observe and monitor closely for development of symptoms during the following 14-day period. Decisions on whether to

place such residents into Transmission-Based Precautions, should be made by assessing the potential for exposure while away.

## **Guidance for CMS Phase 2**

All eligibility criteria for phase advancement must be met for a facility to enter CMS Phase 2. This includes the regional resurgence metrics. Thereafter, these conditions must be met continuously for the facility to remain in CMS Phase 2.

- If any resident of the facility develops new, facility-onset COVID-19 or a staff member develops facility-associated COVID-19 infection, then the facility must immediately revert to the highest level of mitigation and start the CMS phases over.
- If the facility no longer meets any other criterion for phase advancement, apart from regional COVID-19 health metrics, then the facility must revert to CMS Phase 1 until the criteria are fulfilled.
- If the facility's region no longer meets targets for health metrics, then all facilities in the region are subject to tiered mitigation.

**Visitation.** *[This section supersedes a previous IDPH guidance document, "Outdoor Visitation Guidance for Long-Term Care Facilities," June 18, 2020.]*

All residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure should be allowed to receive outdoor or indoor visitors safely. Residents in isolation or quarantine cannot receive visitors.

Outdoor visits are strongly preferable to indoor visits, weather permitting. To conduct outdoor and indoor visitation, the facility must formulate a written visitation policy. This policy must balance clinical and safety considerations of infection control with the resident's right to receive visitors [42 CFR § 483.10(f)(4)]. Facilities may not restrict visitation without a reasonable clinical or safety cause, such as high county COVID-19 positivity rate, the facility's COVID-19 status, a resident's COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factors.<sup>17</sup> For example, if a facility has had no COVID-19 cases in both residents and staff in the last 14 days and its county positivity rate is low (<5%) or medium (5-10%), they must facilitate in-person visitation consistent with this guidance. However, if the county COVID-19 positivity rate is high (>10%), then indoor visits should be limited to compassionate care only, although outdoor visitation may continue.

The facility should develop a short, easy-to-read fact sheet on visitation policy for residents and visitors. This fact sheet should include emphasis that outdoor visits are strongly preferable to indoor visits, weather permitting. The facility should distribute the fact sheet to residents and post it on the facility's website. The facility should also make printed copies available at the visitors' lobby. Visitors are required to comply with the facility's visitation policy. If a visitor refuses to follow the facility's policy during the visit, then staff may end the visit.

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<sup>17</sup> <https://www.cms.gov/files/document/qso-20-39-nh.pdf>

The visitation policy must address the following points:

- Designate places for visitation with emphasis on outdoor spaces, weather permitting.
  - Outdoor spaces (Visits may take place under a canopy or tent if at least two sides of the tent are open to allow air flow. If more than two sides of the tent are enclosed, this is considered indoors for purposes of this guidance.)
  - Indoor common areas.
  - In-room visitation is permissible, provided that:
    - Room layout allows at least 6-foot separation from the resident; or
    - if 6-foot separation is not possible due to room layout, then visitation is only permissible if a transparent room divider is in place between visitors and resident, at least 1 foot higher than the height of tallest visitor.
- Measure each visitation space and determine the number of residents and visitors that can be accommodated at one time in that area with at least at least 6-foot separation between residents and their visitors.
  - Consider marking the floor or ground to show how visitors can place themselves with at least 6-foot separation.
  - Post signage to cue 6-foot separation, face covering, and hand hygiene.
  - Post maximum number of residents and visitors that can occupy the area.
  - Set up dispenser for alcohol-based hand rub.
- Designate visitation hours when staff for screening and supervision of visitors will be available.
- Limit visitation to two visitors at a time per resident. The visitors, if two, must be from the same household. Specify whether exceptions can be made for compassionate care situations.
- Create an appointment schedule with time slots for each visitation area.
  - Schedule visits by appointment only; specify start, end time, and location for each visit.
  - Limit sign-ups to the allowed number of visitors in each time slot and visitation area.
  - If demand for appointment slots exceeds availability, set limits on the number of slots per week or per day for each resident
- Pre-screen visitors by phone using its checklist-based screening protocol (see section on Universal Screening, above) or through electronic screening methods less than 24 hours in advance; re-screen on arrival, as for all other persons entering the facility, including temperature check. (Facilities cannot require viral testing of visitors as part of screening unless they offer point-of-care testing at no charge.)
- Maintain a record of all visitors with contact information, for potential contact tracing.
  - Record date and time of visit, name, address, telephone and, if available, email address.
  - Make records available to IDPH and local health department for inspection and, as needed, for contact tracing; retain at least 30 days.
- Notify all visitors upon entry that, if they develop symptoms of COVID-19 within three days after visiting, they must immediately notify the facility.
- Allow visitors only in locations designated for the visit, not in other areas in the facility.
- Supervise every visit to ensure infection control practices are utilized, including that

visitors keep at least a 6-foot separation between themselves and the resident, that the visitor continually wears a cloth face covering or face mask, and that the visitor practices proper hand hygiene. The facility may determine whether supervision is continuous or intermittent.

- Clean and disinfect visitation area between visitors.

**State-authorized personnel.** Regarding State-authorized personnel, proceed as in CMS Phase 1.

**Volunteers:** Facilities that have formal volunteer programs consistent with IDPH Administrative Code Sections 300.1440, 330.1340, 340.1730, 350.1055, or 385.1950 may reinstate volunteer activities consistent with other portions of Phase 2 guidance. Volunteers are considered staff and are required to participate in all applicable screening and testing, as well as appropriate use of PPE and compliance with other infection prevention strategies.<sup>18</sup>

**Modified communal dining.** Communal dining may be considered with a maximum seating capacity of 25%. To conduct communal dining on a limited basis:

- Allow participation only by residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- Limit number of residents in dining area at a time to the maximum allowed by 6-foot separation. Serve diners in shifts as needed.
- Organize residents to enter the dining room one at a time and to take tables starting in the back and then filling in toward the front. After the meal, exit one at a time in reverse order, starting from the front (last in, first out).
- Residents should wear face covering or masks in the dining area when not eating or drinking.
- Maintain at least 6-foot separation between diners.
- Staff must perform hand hygiene and change PPE as appropriate in between assisting residents.
- Clean and disinfect surfaces between shifts of diners.

**Small-group activities.** Group activities may be considered for activities that improve the quality of life for residents, with a maximum of 10 residents at an activity. To conduct activities on a limited basis:

- Allow participation only by residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- Outdoor activities, such as a stroll on facility grounds, are encouraged. Outings beyond the facility grounds are not permitted.
- Provide hand sanitizer stations.
- Use a sign-up process as needed to cap attendance at 10.
- Avoid crowding on ingress and egress.
- Maintain 6-foot separation, mask or face covering, and hand hygiene.
- Sanitize items used in activity between users: game pieces, craft tools, etc.
- Avoid activities that involve multiple residents handling the same object (e.g., ball toss).

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<sup>18</sup> <https://www.dph.illinois.gov/topics-services/health-care-regulation/nursing-homes/admCodes>

- For live music, avoid vocal performances and sing-alongs. Limit performances to instruments that can be played while wearing a mask.
- Worship services should avoid singing, chanting, and group recitation.

**Beauty salons and barber shops.** To operate facility-based beauty salons and barber shops in CMS Phase 2:

- Allow services in beauty salons and barber shops only for residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- The beautician or barber is subject to the same infection control requirements as staff, including, but not limited to:
  - Testing for COVID-19 with the same frequency as for staff.
  - Screening for elevated temperature and COVID-19 symptoms.
  - Wearing a face mask, performing hand hygiene, and maintaining social distancing, except from a resident receiving service.
- The beautician or barber must remain in the salon area throughout their time in the facility. Services may not be provided in residents' rooms.
- Observe restrictions and precautions in *Personal Care Services Guidelines for Restore Illinois* at <https://dceocovid19resources.com/assets/Restore-Illinois/businessguidelines4/personalcare.pdf>. However, where IDPH guidelines in this document are more stringent, the IDPH guidance applies.
- Do not use hand-held blow dryers.

**Medically Necessary Trips.** Use telemedicine to the extent practicable. Avoid trips that are not medically necessary. For medically necessary trips away from of the facility, proceed as in CMS Phase 1.

### Guidance for CMS Phase 3

All eligibility criteria for phase advancement must be met for a facility to enter CMS Phase 3. This includes the regional resurgence metrics. Thereafter, these conditions must be met continuously for the facility to remain in CMS Phase 3.

- If any resident of the facility develops new, facility-onset COVID-19 or a staff member develops facility-associated COVID-19 infection, then the facility must immediately revert to the highest level of mitigation and start the CMS phases over.
- If the facility no longer meets any other criterion for phase advancement, apart from regional COVID-19 health metrics, then the facility must revert to CMS Phase 2 until the criteria are fulfilled.
- If the facility's region no longer meets targets for health metrics, then all facilities in the region are subject to tiered mitigation.

**Visitation.** Regarding visitation, proceed as in CMS Phase 2.

**State-authorized personnel.** Regarding State-authorized personnel, proceed as in CMS Phases 1 and 2.

**Volunteers.** Proceed as in CMS Phase 2.

**Modified communal dining.** To conduct communal dining, follow the same procedure as in CMS Phase 2, except that the number of diners per sitting may exceed limits set for Phase 2 if space allows 6-foot separation.

**Group activities.** To conduct group activities, such as resident council, chapel, game nights, book groups, and musical events:

- Allow participation only by residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- Outdoor activities on facility grounds are encouraged.
- Maintain social distancing, hand hygiene, and masking or face covering.
- For indoor activities, post the maximum number of persons that can be accommodated in the designated space while maintaining at least 6-foot separation.
- Use a sign-up process as needed to cap attendance.
- Provide hand sanitizer stations.
- Avoid crowding on ingress and egress.
- Sanitize items used in activity between users: game pieces, craft tools, etc.
- Avoid activities that involve multiple residents handling the same object (e.g., ball toss).
- For live music, avoid vocal performances and sing-alongs. Limit performances to instruments that can be played while wearing a mask.
- Worship services should avoid singing, chanting, and group recitation.
- Group outings beyond the facility grounds may be considered, provided all the above precautions are observed, along with precautions listed below for trips that are not medically necessary.
  - Outdoor outings, such as a stroll in the park, are strongly preferable to outings to indoor destinations, weather permitting.
  - Avoid mass events like festivals, fairs, and parades.
  - Avoid other locations where it may be difficult to maintain 6-foot separation.

**Beauty salons and barber shops.** To operate facility-based beauty salons and barber shops in CMS Phase 3:

- Allow services in beauty salons and barber shops only for residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- The beautician or barber is subject to the same infection control requirements as staff, including but not limited to:
  - Testing for COVID-19 with the same frequency as for staff.
  - Screening for elevated temperature and COVID-19 symptoms.
  - Wearing a face mask, performing hand hygiene, and maintaining social distancing, except from a resident receiving service.
- The beautician or barber must remain in the salon area throughout their time in the facility. Services may not be provided in residents' rooms.
- Observe restrictions and precautions in *Personal Care Services Guidelines for Restore Illinois* at <https://dceocovid19resources.com/assets/Restore-Illinois/businessguidelines4/personalcare.pdf>.



However, where IDPH guidelines in this document are more stringent, the IDPH guidance applies.

- Do not use hand-held blow dryers.

**Medically Necessary Trips.** For medically necessary trips away from the facility, proceed as in CMS Phases 1 and 2.

**Trips That Are Not Medically Necessary.** The decision on making a trip that is not medically necessary should preferably be made collaboratively by the resident, the resident’s family or health care surrogate, a facility representative, and, where appropriate, the resident’s physician. The facility representative should explain the facility’s policy regarding special precautions and/or quarantine that may be applicable following a trip away.

- Residents with symptoms consistent with COVID-19, or a confirmed case, must not make trips that are not medically necessary.
- Residents with high-risk comorbidities should avoid trips that are not medically necessary.
- Avoid use of public transportation or ride-hailing services.
- Observe the same restrictions and precautions as for medically necessary trips.

### **Procedure for applying tiered mitigation**

**Illinois Regional Metrics Leading to Tiered mitigation.** If health metrics indicate resurgence of COVID-19 within one of the 11 defined Illinois COVID-19 regions, then IDPH will consider mitigation options for various settings within that region from a tiered menu. If sustained increases in health metrics continue unabated despite initial measures, further mitigations may be added from additional tiers. Actions for long-term care facilities triggered by regional resurgence are shown in the following table:

| <b>Mitigation</b>             | <b>Tier 1</b>   | <b>Tier 2</b>                                  | <b>Tier 3</b>   |
|-------------------------------|---|--|---|
| <b>Visitation</b>             | Suspend indoor visits.<br>Continue outdoor visits.    | Same as Tier 1                                 | Suspend all visits except for EC or compassionate care. |
| <b>Communal Dining</b>        | Continue  | Continue                                       | Suspend   |
| <b>Group Activities</b>       | Continue without outside leaders or off-site outings. | Same as Tier 1, plus limit to 10 participants. | Suspend   |
| <b>Barber and Beauty Shop</b> | Suspend   | Suspend  | Suspend   |

If resurgence metrics exceed threshold within one of the 11 Illinois COVID-19 regions and mitigation measures are applied to long-term care facilities in that region, then LTC facilities must wait at least 14 days after metrics return to their target ranges before reversing tiered mitigation.

Mitigation options from a tiered menu may also be considered under other circumstances:

- A facility may voluntarily apply mitigation measures, if deemed necessary in accordance with the facility's internal policies for infection control.
- IDPH or the local health department may direct a facility to apply temporary mitigation measures pending correction of deficiencies in its infection control program that are identified in a regulatory survey.

If tiered mitigation measures are applied, then the facility must notify residents, their families or guardians, the long-term care ombudsman, and the local health department of relevant operational changes, as for phase advancement or regression.

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*In the event of a conflict between this guidance document and any previously issued interim guidance from IDPH, this guidance takes precedence.*

Questions about reopening may be directed to [DPH.LTCreopening@illinois.gov](mailto:DPH.LTCreopening@illinois.gov).

*Distribution: IL Licensed LTC Facilities, LHD Administrators, LHD Communicable Disease, IDPH Regional Offices*

## Appendix: Modifications for Other Long-Term Care Facilities and Programs

All categories of long-term care facilities covered by this guidance document should follow the recommendations provided, with modifications for specific categories of facilities and programs as provided below.

### **Assisted living facilities and other similar arrangements**

For Assisted Living Facilities (ALF), Shared Housing Establishments (SHE), Sheltered Care Facilities, and Supportive Living Facilities (SLF), the following modifications are recommended:

**Visitation.** In CMS Phases 1 and 2, the general visitation rules apply to visitation at these facilities. In CMS Phase 3, facilities should follow these modifications:

- Indoor and outdoor visits do not need to be supervised.
- Visits can be in common areas or in residents' apartments, with 6-foot separation and cloth face covering or masking by visitors and residents.

**Dining.** In all CMS phases, dining in apartments is encouraged. For dining in communal dining room, observe same rules as for other facilities in whatever CMS phase applies.

### **Facilities for people with developmental disabilities**

Facilities for people with developmental disabilities face special challenges in limiting the spread of COVID-19. Residents of these facilities may have difficulty understanding and maintaining social distance, may not be able to tolerate or safely wear cloth face coverings, and need assistance with hand hygiene. These factors may compound the risk of COVID-19 transmission in congregate living settings. An individualized approach for COVID-19 may be needed for individuals with physical and intellectual disabilities who have limited mobility and/or difficulty absorbing new information and making changes in their everyday routines.

For Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), State-Operated Developmental Centers (SODC), and Medically Complex/Developmentally Disabled Facilities (MC/DD), modifications to the guidance for nursing homes are recommended, as follows.

**Face shields for residents who cannot tolerate masks.** Residents in ICF/DD, SODC, and MC/DD facilities who cannot tolerate cloth face coverings or face masks may be able to tolerate face shields. In such cases the face shield, although less protective than a face covering or mask, may be substituted as a second-best alternative for universal source control.

**Community Day Services.** Community Day Service (CDS) programs serve individuals with I/DD and take place in a non-residential setting, separate from the participant's residential living arrangement. Residents of Community Integrated Living Arrangements (CILA), ICF/DDs and SODCs, as well as participants living with family, attend CDS programs.

Effective September 1, 2020, the Illinois Department of Human Services provided guidance that CDS providers were able to reopen.<sup>19</sup> Participation is subject to adequate facility preparation and safety precautions as well as individual risk-benefit assessments. A structured instrument, such as the "Illinois COVID-19 Risk Benefit Discussion Tool," should be used to weigh the risks and benefits of participation. Such tools are designed to facilitate discussion with the client, their family/guardian, and the service provider:

[https://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD/Illinois\\_Risk\\_Benefit\\_Tool.pdf](https://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD/Illinois_Risk_Benefit_Tool.pdf).

CDS is an essential component of active treatment for many residents of ICF/DDs. Per Long Term Care Facilities Part 350 Intermediate Care for the Developmentally Disabled Facilities Code Section 350.3730: Each resident of an ICF/DD of 16 Beds or less shall be either employed or enrolled in an external day program, off the grounds of the facility, at least 240 days per year, five hours per day. ICF/DD residents are able to attend CDS as long as there is not an active outbreak within their living unit.

### **Specialized Mental Health Rehabilitation Facility (SMHRF)**

Due to the behavioral health conditions of SMHRF residents, some consumers may have difficulty complying with the recommendations for social distancing, hand hygiene, and use of face coverings. In these cases, facilities should consider a harm reduction approach with those consumers who have difficulty with these measures. Continued engagement and encouragement will be needed.

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<sup>19</sup> <https://www.dhs.state.il.us/page.aspx?item=125473>