Table 1: Interim Summary of Long-Term Care Facility Infection Control for COVID-19 and Other Respiratory Pathogens

Topic	Guidance for Long-term Care Facilities (LTCFs)	Implementation Tools
Entry screening	Facilities are required to ensure that everyone (including staff, residents, guests, etc.) entering the facility is aware of infection prevention and control practices and that visitors defer non-urgent visitation if they: 1) are ill; 2) had a positive COVID, Flu, or RSV test; or 3) had a known close-contact exposure with someone with COVID-19. Facilities should alert visitors ahead of time about the visitation expectations, which could be accomplished via emails to the community and families, information posted to Facility website, and information provided through new resident admission packets for families. Facilities must post visual alerts and signage at entrance with visitor protocols. Facilities may choose to have an individual performing screening at entry, but are not required to do so, nor are they required to maintain written entry screening logs. Temperature screening is not required. Facilities with a COVID-19 case among staff or residents in the previous 14 days shall post signs at all entrances indicating the facility's COVID-19 status in the building.	Refer to visitation template tools.
Visitation	Other than requesting visitors to defer non-urgent visitation as described in "entry screening" above, there are no restrictions on visitation. Facilities should ensure to the best of their ability that visitors follow the masking requirements	Refer to visitation template tools.

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Topic	Guidance for Long-term Care Facilities (LTCFs)	Implementation Tools
	as described below, physically distance from other residents and staff as reasonable, and conduct visits in the resident's room, as feasible. In general, visitation should be allowed for all residents at all times. However, as stated in CMS memorandum QSO-20-39-NH REVISED, "During peak times of visitation and large gatherings (e.g., parties, events) facilities should encourage physical distancing." The facility may restructure the visitation policy, such as asking visitors to schedule their visit at staggered timeslots throughout the day, and/or limiting the number of visitors in the facility or a resident's room at any time, to reduce the risk of COVID-19 transmission. Note: These strategies could be applied during holidays or when a high volume of visitors is expected, for the purposes of reducing crowding. There is no limit on length of visits, in general, as long as the visit poses no risk to or infringes upon other residents' rights.	
Hand hygiene	Hand hygiene is required immediately before touching resident or handling invasive devices, before moving from work on a soiled to clean part of the body, after touching a resident or exiting a resident room, after contact with blood or body fluids, and immediately after glove removal.	CDC Hand Hygiene Resources
Ventilation	Facilities should maximize ventilation in facilities by opening windows when safe to do so, running exhaust fans (e.g., bathroom exhaust fan) as often as possible, and using portable HEPA filtration units in rooms and common areas.	Additional information available via CDC Ventilation in Buildings Guidance.
Environmental Disinfection	Cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) should be performed for high touch surfaces, resident care areas, and common areas at least twice daily. Terminal disinfection should be conducted upon patient discharge.	Refer to List N; the disinfectant selected should also be appropriate for other pathogens of concern at the facility

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Personal Protection Equipment (PPE) Supply	Facilities are required to maintain necessary levels of PPE to respond to communicable disease cases or outbreak.	Use the CDC's Burn Rate Calculator to proactively plan supply needs. For outbreak scenarios when historical supply data is unavailable, see OHA's COVID-19 Outbreak PPE Calculator.
PPE for Transmission-Based Precautions	Refer to At-A-Glance Infection Control Guidance for Respiratory Pathogens. Staff caring for residents with suspect or confirmed COVID-19 are required to wear a fit-tested N95 respirator, eye protection, gown, and gloves. Public health may recommend unit-wide use of N95 and eye protection if facility is experiencing an outbreak to reduce the risk of transmission from asymptomatic/presymptomatic individuals. It may be appropriate to implement extended use of N95s and eye protection for the sequential care of a large volume of COVID-19 patients. Extended use should not be used when other organisms are present (e.g., multidrug-resistant organisms, RSV). Gowns and gloves are to be used for one resident, one encounter.	Signage must be placed immediately outside of resident rooms to alert about transmission-based precautions and IPC protocols. Sample signage available via WA Department of Health.
Universal use of N95 respirators and eye protection	Facilities must provide education to staff that, as community spread of COVID-19 increases, the potential for encountering asymptomatic or pre-symptomatic patients with COVID-19 infection also increases. Facilities should consider proactive use of N95 respirators and eye protection when recommended by public health or when state metrics indicate elevated levels of COVID-19 activity. Full PPE (as described above) is required for direct care of residents with suspect or confirmed COVID-19. During outbreaks, N95 respirators and eye protection for all staff on affected units is strongly recommended.	CDC Appendix: Metrics for Community Virus Transmission.

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Communal Activities During Outbreaks	Facilities should encourage communal activities in periods without outbreak activity while adhering to core principles of infection prevention and control. During COVID-19 and other respiratory outbreaks, it is recommended, although not required, that facilities avoid communal activities and dining until outbreak is over (e.g., no new COVID-19 cases have been identified for 14 days). If reintroducing communal activities before this period is over, facilities are required to reinforce basic infection control during the activity (i.e., masking, physical distancing, ventilation, hand hygiene, and disinfection). The following three items are strongly recommended: 1. Use broad-based (unit- or facility-based) outbreak testing (as opposed to contact tracing approaches) to identify COVID-19 cases. 2. Screen for new symptoms of COVID-19 or other respiratory illnesses at least daily and immediately before group activities. 3. Minimize crowding as much as possible during activities or dining by staggering participation or meal times. Residents who are on transmission-based precautions (i.e., isolation or quarantine) must not participate in communal activities and dining until the criteria to discontinue precautions has been met.	
Masking	Although masking or the use of face coverings (i.e., source control) will not be required via OHA OAR 333-019-1011 as of **April 3, 2023**, it remains required for individuals in long-term care facility settings, including staff, residents, and visitors, who: • Have suspected or confirmed COVID-19 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); *[Implementation note: non-urgent visitation should be deferred for ill visitors until they meet CDC criteria for healthcare settings to end isolation. LTCF staff should follow return to work criteria, masks should be worn if return to*	For comprehensive guidance, please review the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic published 5/8/2023.

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	work occurs before all conventional return to work criteria are met as part of incremental implementation of contingency or crisis strategies to address temporary staffing shortages.] Or, • Had close contact (residents and visitors) or a higher-risk exposure (HCP) with someone with COVID-19 infection, for 10 days after their exposure; Or, • Reside or work on a unit or in area of the facility experiencing a COVID-19 outbreak or other outbreak of respiratory infection; universal use of source control could be discontinued as a mitigation measure once no new cases have been identified for 14 days; Or, • Have otherwise had source control recommended by public health authorities. Facility-wide source control or targeted use of source control for higher-risk areas (e.g., when caring for residents with moderate to severe immunocompromise) should be considered during periods of higher levels of community SARS-CoV-2 or other respiratory virus transmission. If a resident is genuinely unable to mask due to a medical condition in response to the criteria above, facilities should take steps to reduce the risk of illness spread. Facilities may have masking policies that are more, but not less restrictive, than described above (i.e., facilities may require masking in broader contexts than described above).	CMS Guidance for Nursing Facilities: Please review QSO-20-39-NH-revised for comprehensive guidance CDC Appendix: Metrics for Community Virus Transmission. Refer to OHA Contact Tracing Guidance.
Staff COVID-19 Vaccination	Effective **May 11, 2023**, workers in health care settings, including LTCFs, will no longer be required to be fully vaccinated against COVID-19 under OHA rule.	5/10/2023 announcement available here.

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	Effective August 5, 2023, CMS published a final rule which ended the requirements related to staff vaccination for all provider types.. It is strongly recommended that those who work or live in a LTCF be up to date with COVID-19 vaccines.	
LTCF COVID-19 Vaccination Reporting	Nursing facilities are required to report weekly COVID-19 vaccination data to comply with CMS requirements. Facilities that report vaccination data through the National Healthcare Safety Network (NHSN) may, in lieu of reporting this information directly to OHA, report the information to OHA through NHSN. Starting July 1, 2023, OHA will export nursing facility data from NHSN monthly for the first week of each month for inclusion on the LTCF COVID-19 Vaccination Dashboard. Community-based care facilities will be required to report COVID-19 vaccination data on a monthly cadence, effective **July 1, 2023**. Facilities will report vaccination data for the first week of each month and will have until the end of that same month to complete reporting to OHA.	Resident Tracking Tool can be found here, and the Staff Tracking Tool here. OHA LTCF COVID-19 Vaccination Dashboard (updated monthly as of July 2023) COVID-19 Vaccination Tracking and Reporting in Long-term Care Facilities (LTCFs) Frequently Asked Questions COVID-19 Vaccination Quick Start Reporting Guide
NHSN LTCF COVID-19 Reporting Module	CMS continues to require nursing facilities to report into the National Healthcare Safety Network's (NHSN) LTCF COVID-19 Module. Due to the Public Health Emergency ending on May 11, 2023, the LTCF COVID-19 Module Surveillance Pathways will undergo various updates. Please check NHSN website for updates.	NHSN LTCF COVID-19 Module NHSN Nursing Home Data Dashboard
COVID-19 Testing	**Admission/Readmission Testing:** Admission testing remains recommended in LTCFs, but is ultimately at the discretion of the LTCF. Residents who leave the facility for 24 hours or longer should generally be managed as an admission. Note: It continues to be best practice that LTCF residents, who are evaluated in a hospital for symptoms not associated with COVID-19 infection,	Additional information via CDC Guidance HCP with COVID-19 or exposure.

Topic	Guidance for Long-term Care Facilities (LTCFs)	Implementation Tools
	can be transferred or returned to their home facility without a negative COVID-19 test. Testing is recommended prior to hospital discharge in the event of a known exposure to COVID-19 or if the resident has symptoms consistent with COVID-19.	Refer to OHA Contact Tracing Guidance. As of June 30, 2023, coordination support for accessing testing through the Oregon State Public Health Laboratory will no longer be available in the same capacity. LTCFs are encouraged to utilize commercial laboratories for COVID-19 outbreak testing. Abbott BinaxNOW rapid antigen tests can be requested by using this form. Supply will be available until supply expires or is exhausted. To administer BinaxNOW tests, LTCFs must have a CLIA Certificate of Waiver; instructions for completing an application can be found on page 3 of the CMS CLIA brochure How to Obtain a CLIA Certificate of Waiver.
	Routine Screening Testing: Screening testing of asymptomatic healthcare personnel is no longer required, but a facility may use discretion to perform screening testing of staff.	
	Higher-risk exposures and close contacts: Asymptomatic residents and staff with close contact should have a series of three viral tests (at least 24 hours after the initial exposure and, if negative, again 48 hours after first negative; and if negative again, 48 hours after second negative test – typically day 1, with exposure being day 0, day 3 and day 5). • Asymptomatic staff must follow recommended infection control practices. Work restrictions are not necessary for staff that remain asymptomatic (unless certain circumstances warrant it such as staff unable to wear source control as recommended for 10 days following exposure). • Asymptomatic residents do not require transmission-based precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These patients should still wear source control for 10 days following the exposure and serial testing should be conducted on those who have not recovered from SARS-CoV-2 infection in the prior 30 days.	
	Outbreak Testing: • ODHS is in the process of amending OAR 411-060 to align with the CDC testing recommendation. CDC recommendations include broad-	

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	based testing (“unit-wide” or “facility-wide”) or contact tracing options in response to identification of a staff or a resident COVID-19 case. • ODHS is expected to adopt contact tracing or broad-based testing options; however, facilities should continue to utilize broad-based testing when the facility does not have the experience and resources to perform individual contact tracing or should contact tracing efforts fail to control ongoing transmission. • An outbreak investigation and initial testing would not be triggered when a resident with known COVID-19 is admitted directly into transmission-based precautions, or when a resident known to have close contact with someone with COVID-19 is admitted directly into transmission-based precautions and develops COVID-19 before precautions are discontinued.	
Return to Work & Staffing Shortage Mitigation	Ill staff can return to work after: 1. Recovery, as defined by 24 hours since last fever without medications and improvement in symptoms 2. AND meeting time-based criteria: ▪ COVID-19: 7 days since onset for COVID-19 if negative viral test obtained between days 5-7 (otherwise, 10 days); ▪ FLU: 7 days since flu symptom onset; ▪ RSV: After recovery of symptoms for RSV. In contingency staffing shortage scenarios, facilities may allow infected staff to return after 5 days if willing and well-enough to work. In crisis-scenarios only, facilities may allow ill staff to work before 5-days have passed. Crisis-level strategies should be: 1) used to the minimum extent necessary, and 2) paired with broad infection control strategies (e.g., well-fitting masks, testing,	

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	ventilation, hand hygiene, and disinfection). Facilities should discuss the use of crisis-level strategies with their LPHA and licensing agency to ensure they have exhausted available options.	
Resident Cohorting During COVID-19 Outbreak	Cohorting residents with the same infectious disease diagnosis (e.g., COVID-19) in a single area is strongly recommended as it allows dedicated HCP to work only with residents with known COVID-19. This decreases the risk of transmission from infected to uninfected residents.	
Reporting of cases and outbreaks	Facilities must report to their Local Public Health Authority (LPHA) within 24 hours or on a timeline otherwise specified when: • ≥ 2 epi-linked cases of COVID-19 are identified within a 7-day period. Being from the same institutional cohort (e.g., unit, floor, shift, worksite) is sufficient to meet epi-link criteria. • ≥ 2 cases of acute respiratory illness (e.g., unknown respiratory illness, Influenza, RSV) are identified in residents or staff with onset within a 72h period Facilities should alert LPHAs about deaths or hospitalizations associated with respiratory outbreaks. Facilities must also alert their facilities licensing agency if a COVID-19 outbreak is identified and upon clearance of the prior respiratory outbreak. Note: An increased outbreak reporting threshold does not eliminate the need for facilities to conduct internal investigation steps in response to a single case. This includes placing index case on appropriate isolation or implementing work restriction per CDC Infection Control Guidance, using appropriate PPE, testing exposed individuals via contact tracing or unit-based testing, placement of signage at entry for 14 days since last identified case, and conducting environmental disinfection. These steps help prevent early spread.	LPHA contact: www.healthoregon.org/lhddirectory Nursing Facilities Licensing: nf.licensing@odhsoha.oregon.gov Community-Based Care Facility Licensing: cbc.team@odhsoha.oregon.gov CDC Infection Control Guidance

UPDATE LOG

March 14, 2023. Updated masking section in accordance with recission of OAR 333-019-1011 (OHA Masking Requirements in Health Care Settings), effective April 3, 2023. Mask requirements and recommendations are listed in accordance with current CDC/CMS guidance and is provided separately for CBC and NF settings.

May 18, 2023: Updates outbreak reporting thresholds for LTCFs in line with recent changes to OHA Investigative Guidelines. Added key internal actions necessary when single case of COVID-19 is identified in a facility to prevent spread. Aligns with CDC Infection Control Guidance Updates (May 8, 2023) regarding admission testing in LTCFs and source control (masking) recommendations. Added link to OHA-developed PPE burn rate calculator for use during outbreaks of COVID-19. Updated COVID-19 vaccination and COVID-19 vaccination reporting requirements for LTCFs. Added section about the NHSN LTCF COVID-19 Reporting Module for reference.

August, 2023: Added links for updated OHA guidance documents: Visitation Template Tools and LTCF Contact Tracing. Removed information about Nurse Crisis Teams, as they are no longer routinely operational. Updated CMS staff vaccination guidance added.

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