GEORGIA DEPARTMENT OF PUBLIC HEALTH

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STATE OF GEORGIA
DEPARTMENT OF PUBLIC HEALTH
ADMINISTRATIVE ORDER
LONG-TERM CARE FACILITIES REOPENING GUIDANCE

WHEREAS, on March 14, 2020, Governor Brian P. Kemp issued Executive Order 03.14.20.01, declaring a Public Health State of Emergency in Georgia due to the impact of Novel Coronavirus Disease 2019 (COVID-19); and

WHEREAS, on March 16, 2020, the Georgia General Assembly concurred with Executive Order 03.14.20.01 by joint resolution; and

WHEREAS, the Public Health State of Emergency has been extended as provided by law; and

WHEREAS, the Centers for Disease Control and Prevention ("CDC") recommends that all states and territories implement aggressive measures to slow and contain transmission of COVID-19 in the United States; and

WHEREAS, the cumulative number of positive cases of COVID-19 in the state of Georgia continues to grow; and

WHEREAS, COVID-19 presents a severe threat to public health in Georgia; and

WHEREAS, COVID-19 is a severe respiratory disease that is transmitted primarily through respiratory droplets produced when an infected person coughs or sneezes; and

WHEREAS, beginning March 13, 2020, Georgia long-term care facilities began implementing guidance from the Centers for Medicare and Medicaid Services ("CMS") that outlined recommended restrictions to normal operations in an attempt to mitigate the entry and spread of COVID-19; and

WHEREAS, public health mitigation efforts remain critically important, especially in long-term care settings where residents may be more vulnerable to virus exposure, and the state acknowledges that it is equally important to consider the quality of life and dignity of the residents who reside in these settings; and

WHEREAS, using recent guidance from CMS, the state has collaborated with appropriate agencies, long-term care associations, and other stakeholders on how to responsibly ease restrictions in long-term care facilities while COVID-19 remains in communities across the state; and

WHEREAS, I have determined that it is necessary and appropriate to adopt guidance for long-term care facilities, which for the purposes of this Order includes intermediate care facilities, personal care homes, and skilled nursing facilities as defined by O.C.G.A. §31-6-2; nursing homes as defined by Ga. Comp. R. & Regs. r. 111-8-56-.01(a); inpatient hospice as defined by Code Section 31-7-172 and licensed pursuant to O.C.G.A. §31-7-173; and assisted living communities and all facilities providing assisted living care pursuant to O.C.G.A. §31-7-12.2.

NOW, THEREFORE, in accordance with O.C.G.A. §§ 31-2A-4, 31-12-4, and Governor Kemp's Executive Orders,

IT IS HEREBY ORDERED as follows:

Section 1.0 Recommendations for Progression Through Phases

1. Because staffing levels and access to supplies and testing may vary by facility and because the pandemic is affecting facilities and communities in different ways, decisions about relaxing restrictions in a facility should include the following considerations:

    a. *Case status in local community*: Facilities in communities with high incidence of COVID-19 are at increased risk for introduction of COVID-19 into the facility. Recommendations based on surveillance data are listed for each phase. These are subject to change as knowledge evolves.

    b. *Case status in the facility*: Absence of any new facility-onset resident COVID-19 cases, or any staff cases. Note: staff includes volunteers, consultants, ancillary staff, such as environmental services staff, in addition to direct care providers.

    c. *Written plans to support reopening*: In accordance with Code section 31-7-12.5, the long-term care facility will maintain and publish for its residents and their representatives or legal surrogates policies and procedures pertaining to infection control and mitigation within their facilities and update such policies and procedures annually; and as part of the facility's disaster preparedness plan required pursuant to subsection (c) of Code Section 31-7-3 and Department of Community Health rules and regulations, include an epidemic and pandemic plan for influenza and other infectious diseases which conforms to department and federal CDC standards that contains the following minimum elements:

        i. Protocols for surveillance and detection of epidemic and pandemic diseases in residents and staff;
        ii. A communication plan for sharing information with public health authorities, residents, residents' representatives, or their legal surrogates, and staff;
        iii. An education and training plan for residents and staff regarding infection control protocols;
        iv. An infection control plan that addresses visitation for all reopening phases, social excursions, cohorting measures, sick leave, and return-to-work policies, and testing and immunization policies;
        v. A screening protocol for all visitors and healthcare workers that includes temperature checks, questions about signs and symptoms and exposures to a COVID-19 contact in the past 14 days

(regardless of vaccination status) and entry denial for those with reported or observed signs, symptoms or exposures;

vi. COVID-19 Management and treatment protocols for residents developed, updated, and overseen by the clinical lead;

vii. Protocols to vaccinate residents and staff, including procedures to vaccinate newly admitted residents and hired staff, for residents and staff that decline vaccination; and for residents and staff that have been exposed or are COVID-19 positive;

viii. Maintain line list of resident and staff COVID-19 vaccination and post-COVID status;

ix. A surge capacity plan that addresses protocols for contingency staffing and supply shortages;

x. An infection preventionist (nursing home) or designated individual (assisted living/personal care home) with dedicated time for on-site infection prevention implementation and monitoring (CDC recommends one, on-site infection preventionists per ≥ 100 bed facility and for those facilities that offer on-site ventilator or hemodialysis services, regardless of size; smaller facilities should consider their population and services to meet infection control needs [see https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html]);

xi. Risk assessment for reopening following an outbreak or levels of high community transmission (see Infection Control Risk Assessment and Directions under DPH Resources at https://dph.georgia.gov/covid-19-long-term-care-facilities);

xii. A visitation policy that includes a facility's considerations to safely manage visits for all residents. See window, outdoor and indoor visitation in Section 3.0 and CDC Updated Infection Prevention and Control Recommendations at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html; and

xiii. If the facility has any unoccupied rooms, or any unused faucets, water fountains, ice machines or any other water source that has not been used in >30 days, establish a safe water plan (see https://www.cdc.gov/coronavirus/2019-ncov/php/building-water-system.html).

d. *A testing plan*: Based on recommendations listed in Section 4.0. At minimum, the plan should consider the following components:

i. Testing of all symptomatic residents and staff, outbreak response testing, and testing of asymptomatic staff;

ii. Arrangements with commercial laboratories to test residents using tests able to detect SARS-CoV-2 virus (e.g., polymerase chain reaction (PCR)). Antibody test results should not be used to diagnose active SARS-CoV-2 infection;

iii. If antigen testing is used, arrangements with a vendor and/or local health department to maintain testing supplies and interpretation of antigen tests using the CDC algorithm (https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/nursing-home-testing-algorithm-508.pdf);

iv. A procedure for addressing residents or staff that decline or are unable to be tested (e.g., symptomatic resident refusing testing in a facility with positive COVID-19 cases should be treated as positive); and

v. Protocols when influenza is circulating to test for both SARS-CoV-2 and influenza.

e. *Adequate staffing*: Facility is not under a contingency staffing plan and/or is not receiving supplemental staffing from the State. If the facility has agency staff, facility needs to ensure agency staff are well trained in infection control protocols and monitored.

f. *Access to adequate Personal Protective Equipment (PPE) for staff*: Contingency capacity strategy is allowable, such as CDC's guidance on Strategies to Optimize the Supply of PPE and Equipment (facilities' crisis capacity PPE strategy would not constitute adequate access to PPE). All staff wear all appropriate PPE when indicated.

g. *Local hospital capacity*: Ability for the local hospital to accept transfers from nursing homes.

Section 2.0 Critical Components of Infection Prevention and Control

1. The following practices are recommended throughout the pandemic. Section 3.0 provides considerations for identifying the reopening phases and infection control recommendations for each phase. Infection control questions can be directed to the district health department (https://dph.georgia.gov/document/document/directory-district-epidemiologists/download) or hai@dph.ga.gov.

   a. *Implement Universal source control for staff, residents and visitors.* Source control refers to respirators, surgical facemasks, and well-fitting cloth masks to contain a wearers' respiratory secretions when they breathe, talk, sneeze or cough. Source control policy implementation to include education and compliance monitoring for staff, residents and visitors. Mask wearers need to avoid touching the outside of the mask, and if an adjustment is needed, the wearer should use alcohol-based hand rub (ABHR) before and after mask adjustment. Masks with exhalation valves are not allowed. Follow CDC guidelines for well-fitting cloth masks for residents and visitors (https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html) and consult with a DPH Infection Preventionist for appropriate use of well-fitting face cloth masks at HAI@dph.ga.gov.

      i. Staff Source Control. All facility staff and essential healthcare personnel, regardless of their position, who may interact with residents or enter resident rooms, should wear a respirator (preferred), a surgical facemask or well-fitting cloth masks. Those facility staff, regardless of their position, who do not provide any care to the residents and who have no interaction with residents should, at a minimum, wear a surgical mask or well-fitting cloth mask while in the facility. If the facility experiences respirator and surgical mask supply shortages, refer to CDC strategies to optimize PPE (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html). If N95 respirators are not available, other options to consider are KN95, well-fitting facemask with a nose wire, selection of a facemask with ties rather than ear loops; see https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/types-of-masks.html. Consult with a DPH Infection Preventionist at HAI@dph.ga.gov for well-fitting facemask use.

      ii. Resident Source Control. Residents should wear a surgical facemask or well-fitted cloth mask if tolerated. Residents that can tolerate mask wearing should wear them at all times in the facility except when in their rooms without visitors or staff present. Cloth facemasks should be laundered daily. Consult with a DPH Infection Preventionist when using more than

one mask to ensure proper usage at HAI@dph.ga.gov. DPH does not recommend respirators for residents.

iii. Visitor Source Control. Visitors should wear at a minimum a surgical mask or well-fitted cloth mask. Cloth facemasks should be laundered daily. Facilities should consider providing masks appropriate for community transmission levels if supplies permit. If a visitor is unable or unwilling to maintain these precautions (such as children under the age of 2), consider restricting their ability to enter the facility. All visitors should maintain social distancing and perform hand washing or sanitizing upon entry to and frequently during their visit at the facility and follow additional guidance in this Administrative Order. If a visitor does not adhere to core infection control practices, they should not be allowed to visit and should be asked to leave the facility.

b. *Implement Universal PPE*. In addition to Source Control PPE:
   i. During periods of high to moderate transmission, DPH recommends that staff wear eye protection (face shield or goggles).
   ii. In communities with moderate to substantial transmission of COVID-19, CDC recommends universal eye protection (face shield or goggles) for staff (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control.html).
   iii. All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, in accordance with CDC PPE optimization strategies.
   iv. Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel).
   v. Develop PPE policies for visitors and provide PPE to visitors when supply is sufficient.
   vi. Monitor PPE use to identify when supplies will run low.

c. *Evaluate improvements to heating, ventilation, and air conditioning (HVAC) system*. HVAC and fan usage in a healthcare setting can impact infection control in the long-term care setting, particularly for respiratory diseases. DPH recommends evaluating these systems using this resource from the Minnesota Department of Health (https://www.health.state.mn.us/diseases/coronavirus/hcp/hvac.pdf).

d. *Evaluate respiratory protection program* for compliance with the Occupational Safety and Health Administration (OHSA) respiratory standard 29 CFR 1910.134 (https://www.osha.gov/laws-regs/regulations/standardnumber/1910/1910.134). The program should include medical evaluations, training, and fit testing (https://www.cdc.gov/niosh/npptl/topics/respirators/disp_part/respsource3fittest.html).

e. *Designate a COVID-19 unit.*

   i. Create a plan for management of COVID-19 positive residents.

   ii. Designate a COVID-19 unit or cluster of rooms with dedicated staff for cohorting and managing care for residents who test positive with COVID-19. This unit also houses admitted residents with a history of COVID-19 that have not met criteria for discontinuation for transmission-based precautions.

iii. Assign dedicated staff to work on the COVID-19 care unit and provide separate facilities and entrance/exit for these staff. These staff should have separate breakrooms and bathrooms.

iv. If the predetermined COVID-19 unit is not be feasible based upon the number of positive residents and the types of rooms available, matching resident gender for room assignments, or a high census, consider the following:

1. Install temporary physical barriers/screens/curtains that separate residents by at least 6 feet.
2. Transport COVID-19 residents to a dedicated facility in consultation with your local health department.

f. *Designate an observation unit for admissions/re-admissions.* Designate an observation unit or cluster of rooms to manage new admissions and readmissions that are not fully vaccinated and have an unknown COVID- 19 status. The observation unit needs to be separate from the COVID-19 unit. In the observation unit, residents are monitored for 14 days.

g. *Manage new resident admission and re-admission placement.*

i. Residents with confirmed COVID-19 who have not met criteria for discontinuation of transmission-based precautions should be placed in the designated COVID-19 care unit.
ii. New admissions and readmissions whose COVID-19 status is unknown or are not fully vaccinated should be placed in the observation unit.
iii. With the exception of compassionate care visits, residents in quarantine should not have visitors until they have met criteria for discontinuation of transmission-based precautions.
iv. A resident may be placed in the general population (and not in the observation unit) if the following criteria are met:

1. Resident has fully recovered from COVID-19 and completed transmission-based precautions.
   AND
2. Is within 3 months of COVID-19 onset (either first positive test or symptom onset, whichever occurred first)
   AND
3. Is asymptomatic.

OR

1. Is fully vaccinated (i.e., ≥ 2 weeks following receipt of second dose in 2-dose series or ≥ 2 weeks following receipt of one dose of a single-dose vaccine)
   AND
2. Has not had prolonged close contact (within 6 feet for a cumulative total of ≥ 15 minutes over a 24-hour period) with someone with SARS-CoV-2 infection in the past 14 days.

v. Facilities located in areas with minimal (<5% positivity) to no community transmission might consider using a risk-based approach for determining which residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with

someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the community prior to admission. The risk assessment needs to consider the facility's certainty of and ability to collect the needed risk data.

vi. Note: we do not recommend quarantine for residents undergoing hemodialysis at outpatient clinics or for resident day outpatient visits. For residents returning from outpatient visits, DPH recommends increased signs and symptom monitoring.

h. *Create a plan to respond to widespread testing results.*

i. If widespread testing is being conducted in the facility, the facility should not move residents until test results are available and should be prepared to assess relocation once results are received.

ii. If a facility decides to relocate residents who have been exposed but test negative, the following should occur:

1. Residents should be quarantined for 14 days in a private room on transmission-based precautions. If a private room is not available, leave the resident in place until a single room is available.
2. Close daily monitoring for COVID-19 signs and symptoms (i.e., screen 3 times a day)
3. If a resident becomes symptomatic, they should be retested.

i. *Manage exposed and symptomatic residents.*

i. When a resident develops COVID-19 symptoms, test the resident in their room and wait for results before moving the resident. If the symptomatic resident has a roommate, ensure that the roommate is tested and leave the roommate in place unless the facility has an available single room to which to move them. Vaccinated residents should quarantine following exposure to an individual with confirmed or suspected COVID-19 (within 6 feet for a cumulative total of ≥ 15 minutes over a 24-hour period). Currently, CDC does not have data on the potential for transmissibility of COVID-19 from vaccinated individuals.

ii. If testing indicates a positive resident with a negative roommate, move the positive resident to the COVID-19 care unit and leave the roommate in the room by themselves. For the negative resident, quarantine in place for 14 days.

iii. Ensure ventilation system is effective to reduce transmission; see https://www.health.state.mn.us/diseases/coronavirus/hcp/hvac.pdf.

Section 3.0 Recommended Mitigation Steps by Pandemic Phase

1. Facilities may use discretion to be more restrictive in certain areas, where deemed appropriate through internal policies, as long as the restrictions are consistent with any applicable federal requirements. Additional guidance for assisted living communities is provided in Section 6.0 and for long-term care facilities with memory care units in Section 7.0.

a. Phase II guidance will serve as the least restricted phase a facility may operate in until further guidance is issued.

b. Many senior care communities that include assisted living programs attached to skilled nursing facilities or are a part of a continuing care retirement community or senior living campus have commonly shared kitchen facilities. In the current public health mitigation environment, facilities should not routinely share direct care, dietary, or environmental services staff who may have contact with residents or tenants in other segments of the senior living operations. If there are identified cases of COVID-19 in other service delivery areas of the campus, there should be no sharing of staff between those care systems unless the same criteria and guidance are being followed.

	Phase I	**Phase II**
Phase Identification	Phase I is designed for vigilant infection control during periods of heighted virus spread in the local community, and low resident vaccination rates. 14-day COVID-19 county positivity classification = RED. AND <70% of residents are vaccinated (defined as fully vaccinated). OR New facility-onset cases COVID-19 (regardless of community transmission rate or facility resident vaccination rate) in the last 14 days.	Facility may decide to initiate Phase II upon alignment with all of the following: • One-time baseline testing of residents and direct care staff has been conducted (see Section 4.0) AND • No new facility-onset of COVID-19 cases in the last 14 days. AND • 14-day COVID-19 county positivity classification = RED, with >70% residents vaccinated. OR • 14-day COVID-19 county positivity classification – YELLOW or GREEN (regardless of facility vaccination rate).
Data Sources to Identify Pandemic Phases	Facilities have two data sources from which to choose for identifying the phase for reopening: • Georgia Department of Public Health (DPH) Long-term Care Facility (LTCF) County Test Positivity Report posted Mondays at https://dph.georgia.gov/covid-19-long-term-care-facilities • CMS County Test Positivity Report: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg	

	Phase I	**Phase II**
	Long-term care facilities can choose either data source to identify phases, should use this data source consistently and document this selection in their reopening and testing plans (see Section 1.0: 1(c)-(d)).	
Window Visitation	Window visits in the residents' room may be feasible during outbreaks. See Section 5.0 for detailed recommendations. Window visits at a window not in the resident's room (i.e., resident needs to be transported to a common area with a window) can be conducted for non-symptomatic and non-COVID-19 positive residents unless the facility is undergoing an outbreak. See Section 5.0 for detailed recommendations. During inclement weather, facilities may construct window visitation booths. These structures should incorporate infection control practices, such as floor to ceiling dividers between visitors and residents, limited visitation periods (i.e., 15 minutes), separate entrances for residents and visitors, and cleaning and disinfection between use.	
Outdoor Visitation	Outdoor visitation is preferred when possible given the lower risk of transmission due to increased space and airflow, even when the resident and visitor are fully vaccinated. See Section 5.0 for details on outside visitation. If the facility is undergoing an outbreak, outside visits may occur if the facility has staffing to effectively support outbreak containment and observation of outside visits. Outdoor visits are only for non-symptomatic and non-COVID positive residents.	
Indoor Visitation	For facilities with an outbreak: • COVID-19 positive residents (regardless of vaccination status) should defer visitation until transmission-based precautions are discontinued, with the exception of compassionate care visits. • Consider pausing visitation during an outbreak. Consult with the local health department or state (hai@dph.ga.gov) on considerations for	To provide indoor visitation, the facility must have completed one-time baseline testing (see Section 4.0) and be without any new facility onset COVID-19 cases for 14 days. Each facility must determine their capacity to manage visits, based on considerations, such as staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits. Facilities should develop a visitation policy which addresses the following, at minimum: • Limit the number of visitors per resident at one time and the total number of visitors at one time based on the size of the building, size and configuration of visitation area and resident needs (i.e., compassionate care visits) to support social distancing and infection control protocols.

	Phase I	**Phase II**
	pausing visitation during an outbreak. For facilities <u>without an outbreak</u>: • Limited visitation may be allowed for fully vaccinated residents; facilities need to determine the number and schedule of visits to reduce the potential for importing the virus from the community into the facility. • Unvaccinated residents should be limited to compassionate care visits only.	• Consider scheduling visits for a specified length, so all residents can receive visitors. • Include infection control practices, such as proper hand hygiene, universal source control, social distancing, and overall facility supervision of safe practices related to visitors and social distancing. • Ask visitors to agree to adhere to infection control practices and have staff need to monitor adherence, particularly for those that may have difficulty, such as children. Visitors that are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. • Ideally encourage visitation for residents after full vaccination status is achieved (i.e., ≥ 2 weeks after completion of second dose in 2-dose series or ≥ 2 weeks following completion of 1-dose in single-dose series.) • Incorporate appropriate PPE use, including providing PPE, helping visitors to don and doff if needed and providing signage on PPE use. • Screen visitors upon entry. Visitors unable to pass the screening or comply with infection control practices like masks should refrain from visiting (See Section 1.c.v). • Offer rapid testing of visitors if feasible (see Section 4.0). • Limit visitor movement within the facility; visitors should enter the facility and go to directly to the resident room or designated visiting area. • Identify designated areas for visitation to ensure safe distancing overall and facility supervision of safe visitation practices. Unless the resident cannot leave their room, visits for residents in shared room should not be conducted in the resident's room. If a resident is unable to leave their room, an unvaccinated roommate should not be present during a visit. • Ensure visitors are socially distance from other residents and staff. It is noted that fully vaccinated residents may engage in close contact while wearing a surgical facemask or well-fitted mask with appropriate hand hygiene before and after physical contact. • Request visitors to document in a visitor log their name, contact information, and location within the facility to support contact tracing if needed.

	Phase I	Phase II
End of Life and Compassionate Care Visitation	Compassionate care situations include residents recently admitted struggling to adapt to a new home, recent grief from loss, experiencing weight loss and dehydration, and those exhibiting signs of emotional distress. Compassionate care visits also include clergy and are required under the federal disability rights law. For compassionate care visits, the following protocols apply: • Screen visitors upon arrival • Assist visitors with PPE donning and doffing • Escort to and from the resident's room • Limit visitor access to other areas within the facility • Conduct ongoing assessment of resident need for compassionate visits including but not limited to, end of life care • Continuously monitor residents for social distancing, placement of mask (correct usage) and placement of furniture to support social distancing. • Instruct residents and visitors to avoid touching the outside of their masks (it is contaminated) and if an adjustment is needed to perform hand hygiene before and after. • Instruct visitors to conduct hand hygiene frequently during visit; at a minimum upon entrance to the facility, exit from the resident's room, and exit from the facility. • Instruct residents to perform hand hygiene prior to leaving their room and don a mask (if tolerated). Upon re-entry to the facility or re-entry to their room, perform hand hygiene. • Resident location: Residents that are COVID positive, are symptomatic and awaiting test results, and residents on quarantine in the Observation Unit must remain in their rooms. • Facilities should develop policies and procedures to support compassionate care visits for all Phases, including for vaccinated residents and unvaccinated residents with SARS-CoV-2 infection. Policies and procedures need to include infection control protocols for safe visitation and visitation options. Should an indoor compassionate care visit occur during an outbreak, unvaccinated visitors should be instructed to self-isolate at home during the period of the visits and to quarantine after the final visit. Visitors should also notify the facility if they become symptomatic or test positive for COVID-19 within 14 days of a facility visit.	
Non-essential healthcare personnel	Allow entry of non-essential healthcare personnel/contactors unless they are subject to a work exclusion due to exposure to COVID-19 or fail facility screening. Workers are expected to follow facility infection control precautions, including social distancing, hand hygiene, and surgical facemask or well-fitted cloth mask. The number and schedules of non-essential healthcare workers must align with facility policy to be able to maintain infection control protocols, including screening, testing,	

	Phase I	**Phase II**
	source control, and social distancing. During an outbreak, consider temporarily limiting or pausing non-essential staff entry.	
Resident trips outside the facility for non-medically necessary reasons	Non-medically necessary trips should be avoided. Telemedicine should be used whenever possible.	Non-medically necessary trips outside the building should be limited. Trips may be allowed for COVID-19 negative residents or residents that meet discontinuation of transmission-based precautions and are asymptomatic (regardless of vaccination status). Residents with multiple co-morbidities and immunodeficiencies (i.e., at increased risks for severe illness) are not recommended to participate in non-medically necessary resident trips. For limited non-medically necessary trips away from the facility: • The resident must wear a surgical mask or well-fitted cloth face; and • Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. Transportation staff should don PPE after facility entry to ensure clean PPE are used in facility. • Transportation staff should use alcohol-based hand rub (ABHR) upon entry and exit to the facility. Residents should use ABHR prior to leaving facility and upon re-entry. • Transportation equipment shall be sanitized between transports. • Resident screening for signs and symptoms three times a day for 14 days upon return.
Resident trips outside the facility for medically necessary reasons	For medically necessary trips away from the facility: • The resident must wear a surgical mask or facemask if tolerated. • The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment. • Transportation staff, at a minimum, must wear a surgical mask or well-fitted cloth mask. Additional PPE may be required. • Transportation staff should use alcohol-based hand rub (ABHR) upon entry and exit to the facility. Residents should use ABHR prior to leaving facility and upon re-entry. • Transportation equipment shall be sanitized between transports. • Resident screening for signs and symptoms three times a day for 14 days upon return.	

	Phase I	Phase II
Social excursions outside the facility	Occasionally, family may wish to take a resident on a day trip away from the facility. The following guidelines are provided: • Excursions are not allowed for residents on transmission-based precautions. • Families are to be educated on appropriate infection control, including mask wearing, social distancing, hand hygiene, and avoidance of crowds and poorly ventilated indoor spaces. A best practice is to have the family sign an acknowledgement of the facility's social excursion policy before resident release. • Fully vaccinated residents may follow the community guidelines for visiting for friends and family in a private setting; see https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html. • Upon return, the family and resident need to report if they have had a close contact (within 6 feet for a cumulative total of ≥ 15 minutes over a 24-hour period) with an individual with SARS-CoV-2 infection. • Upon return to the facility, the resident does not need to be quarantined unless the resident was absent from the facility for ≥ 24 hours or if the facility is uncertain that the resident and family followed the facility excursion policy. • If a resident is outside the facility for ≥ 24 hours, the facility should follow its admission placement policy as outlined in Section 2.0, 1. g.	
Communal dining	• Communal dining limited to residents not exhibiting any signs or symptoms and only if the facility has completed baseline testing (see Section 4.0). Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). • A limited number of individuals in a dining area at one time, not to exceed 50 percent of capacity unless that would be less than 10 people. • If staff assistance is required, appropriate hand hygiene (ABHR preferred) must occur between residents as well as use of appropriate PPE. • All tables, chairs, and dining area to be cleaned and disinfected after each use. • During an outbreak, communal dining should not occur in units where facility-onset cases were identified. If outbreak testing indicates ongoing transmission in multiple units, facility communal dining should be paused until outbreak is contained.	
Screening of Residents and Staff	• Resident screening each shift for a minimum of 3 times a day. It should be clearly documented in the facility policies when shift screenings should occur and how it is tracked. • Staff screening and documentation at the beginning of each shift. • For facilities in GREEN community status, residents should be screened at least once per day.	
Group Activities	If a facility has an outbreak, the doors on affected residents' rooms should remain closed if tolerated and facility group activities should be	• Small group activities may occur with social distancing, hand hygiene, and use of a surgical mask or well-fitted cloth mask and no more than 10 people or such that social distancing is maintained. • Staff and residents are to wear source control face coverings at all times.

	Phase I	**Phase II**
	paused until the outbreak is contained. When a facility is not undergoing an outbreak, small group activities (≤10 participants) as described for Phase II can be implemented.	• Facilities should establish resident cohorts for activities (i.e., the same group of residents dine and engage in activities consistently). • All communal high-touch surfaces should be disinfected after residents or staff vacate an area. • Prioritize outdoor settings for activities when possible. • Restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss). • These guidelines will be updated as CDC provides additional data.
Salons	Entry of beautician or barber should be paused during an outbreak. When an outbreak is not occurring, the facility needs to conduct a risk assessment to determine if it can safely manage these staff and offer services for COVID-19 negative, and asymptomatic residents (see Infection Control Risk Assessment and Directions under DPH Resources at https://dph.georgia.gov/covid-19-long-term-care-facilities)	Entry of beautician or barber should be evaluated based on a facility risk assessment to determine if it can safely include these staff at its facility for COVID-19 negative and asymptomatic residents (see Infection Control Risk Assessment and Directions under DPH Resources at https://dph.georgia.gov/covid-19-long-term-care-facilities). All applicable rules for operation of salon facilities set forth in the Governor's Executive Orders shall be followed. Additionally, the following requirements shall be followed: • The beautician or barber should largely remain in the salon area and avoid common areas of the facility. When in common areas for entry/exit, hygiene and meals, the beautician and barber must social distance from staff, residents, and visitors. • Hood dryers are preferred. • Residents must wear a face mask during their salon visit. • The same guidelines need to be followed for trimming beard with two exceptions: (1) facemask removal only for the time to trim facial hair and (2) no other residents in the salon.
On site gym or fitness center	Gyms should be closed during an outbreak. If an outbreak is not occurring, gym access is limited to COVID-19 negative or asymptomatic residents who meet criteria for discontinuation of transmission-based	Gym access is limited to COVID-19 negative or asymptomatic residents or residents who meet criteria for discontinuation for transmission-based precautions. All applicable rules for operation of gyms and fitness facilities set forth in the Governor's Executive Orders shall be followed. Physical therapy is addressed under medically necessary visits (see Resident trips outside the facility for medically necessary reasons).

	Phase I	**Phase II**
	precautions. Visitors should not be allowed in gyms. Physical therapy is addressed under medically necessary visits (see: Resident trips outside the facility for medically necessary reasons).	
Testing	• Facility shall report progress towards completion of baseline testing for staff and residents, as described in Section 4.0. • See additional testing guidance in Section 4.0.	• See testing guidance in Section 4.0.
Testing and Resident Management	See Section 2.0 for further details on setting up a COVID Unit, an Observation Unit, and Management of Positive and symptomatic residents and their roommates.	
Phase regression	• Not Applicable.	• A facility will continue to monitor for the presence of COVID-19 in their buildings. This will occur through daily resident screening and staff screening before each shift and through the review of the facility COVID-19 data, which includes COVID-19 cases, availability of PPE, laboratory testing, and alcohol-based hand rub. • If one or more staff or facility-onset resident is confirmed positive for COVID-19 the facility will return to Phase I. Once 14 days have passed with no additional residents or staff testing positive for COVID-19, the facility has demonstrated the ability to mitigate the spread of COVID-19 and may return to Phase II of the reopening process. • The facility also returns to Phase I when the data criteria for Phases II are no longer met.

References: Facilities should consult these authorities on a regular basis to ensure current understanding of guidance and recommendations:

- CMS website: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
- CDC website: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html
- GA Department of Public Health Website: https://dph.georgia.gov/
- District health department; see district health department (https://dph.georgia.gov/document/document/directory-district-epidemiologists/download).
- Georgia Department of Public Health: email hai@dph.ga.gov.

Section 4.0 Testing Requirements and Guidance

1. Testing requirements and recommendations for nursing homes and other long-term care facilities are summarized below:

	Nursing homes	**Other long-term care facilities**
Baseline testing	CMS Required	Required for Personal Care Homes with 25 beds or more and Assisted Living Communities under O.C.G.A. 31-7-12.6
Test Symptomatic Residents and Staff	CMS Required	DPH Recommended
Outbreak Testing	CMS Required	DPH Recommended
Serial Testing of Staff during non-outbreak status	CMS Required	Not DPH Recommended

2. On May 18, 2020, CMS issued QSO-20-30-NH, Nursing Home Reopening Recommendations for State and Local Officials. The document provides guidance for State Survey Agencies and other state officials to determine how nursing facilities may begin to lift restrictions previously imposed to mitigate the spread of COVID-19. CMS indicates in the above referenced QSO memorandum that testing will be a critical part of a facility lifting restrictions on operations.

3. On August 25, 2020, CMS has issued interim final rules requirement for testing of residents and staff (https://www.cms.gov/files/document/covid-ifc-3-8-25-20.pdf), and on August 26, 2020, CMS issued QSO-20-38-NH (https://www.cms.gov/files/document/qso-20-38-nh.pdf), which provides some details on requirements for resident and staff testing.

   a. *Antigen, PCR and Serology Tests.*

      i. All long-term care facilities need to arrange with a commercial laboratory to conduct nucleic acid (i.e., PCR) testing for SARS-CoV-2 (see Section 1.0: 1(c)-(d)). As part of this arrangement, facilities need to have a procedure in place to retain supplies at their facility or to receive them via overnight shipping. Although antigen testing may be conducted in many circumstances, nursing homes need to maintain access to PCR testing for confirmatory testing.

ii. The U.S. Department of Health and Human Services (HHS) announced the distribution of rapid, antigen point-of-care (POC) testing devices to some facilities. On August 26, 2020, CMS issued QSO-20-38-NH (https://www.cms.gov/files/document/qso-20-38-nh.pdf), which specifies nursing homes with a CLIA waiver (https://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/Downloads/HowObtainCertificateofWaiver.pdf) can meet testing requirements using the POC devices. Other long-term facilities may apply for a CLIA waiver to provide point of care antigen testing.

iii. If antigen testing is available, it can be used for rapid testing of symptomatic residents and staff, and all negative antigen tests for these individuals must be followed by collection and shipment of a specimen for PCR testing within 48 hours. Clinicians should use their judgment to determine if a resident has signs or symptoms compatible with COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html) and whether the resident should be tested. Most residents with confirmed COVID-19 have developed fever and/or symptoms of acute respiratory illness (e.g., cough) but some infected residents may present with other symptoms (e.g., altered smell or taste) as well. Clinicians are encouraged to consider testing for other causes of respiratory illness, for example influenza, in addition to testing for SARS-CoV-2 depending on resident age, season, or clinical setting; detection of one respiratory pathogen (e.g., influenza) does not exclude the potential for co-infection with SARS-CoV-2.

iv. Antigen tests may be used to test asymptomatic staff to meet CMS nursing home staff serial testing requirements based on local incidence of COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html). Facilities should follow CDC test considerations (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-antigen-testing.html) and interpretation guidance (https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/nursing-home-testing-algorithm-508.pdf).

v. Antigen tests may be used to test asymptomatic residents and staff as part of a COVID-19 outbreak response. Facilities should follow CDC test considerations and interpretation guidance. COVID-19 outbreaks must be reported to the district health department; this includes reporting positive residents or staff identified through PCR or antigen testing.

vi. Antigen Test Results. U.S. Health and Human Services requires reporting of all antigen point of care tests (i.e., positive, negative, inconclusive or equivocal, and invalid). For nursing homes, DPH strongly recommends nursing homes report antigen point of care testing results using NHSN. For other long-term care facilities (e.g., assisted living and personal care homes ≥25 beds), DPH offers a point-of-care test reporting portal at https://sendss.state.ga.us/sendss/!ncov_poc.login.

vii. PCR Test Results Laboratories report all positive and negative results for PCR to the DPH.

viii. CDC is evaluating the performance of commercial antibody (serology) tests for SARS-CoV-2. At this time, DPH does not recommend serology testing as the sole basis for diagnosis of COVID-19 in residents or staff. In certain situations, serologic assays may be used in conjunction with viral detection tests to support clinical assessment of persons who present late in their illness.

b. *Mandatory Baseline Testing.*

i. O.C.G.A. 31-7-12.6 requires all long-term care facilities to complete one-time baseline testing for all residents and direct care staff no later than September 28, 2020. Direct care staff includes any employee, facility volunteer, or contract staff who provide to residents any personal services, including but not limited to, medication administration or assistance, assistance with ambulation and transfer, and essential activities of daily living, such as eating, bathing, grooming, dressing, toileting, or any other limited nursing services.

ii. All long-term care facilities must conduct baseline testing for all residents and direct-care staff before progressing to Phase II. Baseline testing can identify asymptomatic and pre-symptomatic residents and healthcare workers so that informed decisions can guide appropriate steps for containment. Baseline testing should include testing all staff and residents except individuals previously testing positive in the past 3 months.

c. *Additional Testing Guidance for Residents and Staff.*

i. Immediately test any resident or staff with symptoms.

ii. Asymptomatic residents or staff who have previously tested positive for SARS-CoV-2 (by PCR or antigen detection methods) and recovered (i.e., have met criteria for removal from isolation or return to work) should not be retested for 3 months. CDC has reported prolonged PCR positive tests without evidence of infectiousness. In one study, individuals were reported to have positive COVID-19 tests for up to 12 weeks post initial positive. Residents and staff who develop new symptoms of COVID-19 should be retested regardless of previous infection.

iii. Consider testing any staff who had close contact with an individual and exposure is considered high risk (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html), either at work or in the local community that has tested positive for COVID-19. For certain exposures believed to pose a high risk, CDC recommends that exposed staff be excluded from work for 10 days following the exposure. When testing is readily available, performing testing during the 14-day post-exposure period can be considered to more quickly identify pre-symptomatic staff who could contribute to SARS-CoV-2 transmission. Facilities that elect to perform post-exposure testing of staff should be aware that testing only identifies the presence of virus at the time of the test. It is possible that staff can tested negative because they are in the early stages in their infection when the sample is collected. In such situations, repeat testing can be considered.

iv. Staff that decline testing should be treated as having a positive or unknown COVID-19 status. The facility should make recommendations based on whether they are in conventional, contingency, or crisis capacity status (https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html).

v. Facilities need to follow their respective policies regarding staff testing as a condition of employment.

d. *Testing for Indoor Visitors.*

i. Recommend testing of indoor visitors if feasible, particularly those that visit more than once per week. Visitors may be tested weekly using an on-site rapid test or they may provide test results representing the testing conducted in the past 2-3 days.

e. *Outbreak Response Testing.*

In the event of an outbreak (one or more cases in a staff or a facility-onset resident case), facilities should conduct testing every 3 to 7 days of all staff and residents except those previously testing positive in the past 90 days (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html).

i. Testing should be conducted every 3 to 7 days until there are no new cases among staff or nursing-home onset cases among residents for the previous 14 days (at a minimum testing should be conducted twice). Testing in response to an outbreak is required by CMS for nursing homes as of August 25, 2020 (see https://www.cms.gov/files/document/covid-ifc-3-8-25-20.pdf).

ii. Once a facility is no longer conducting weekly outbreak response testing, it should immediately return to testing any residents or staff with symptoms.

iii. The trigger to resume weekly outbreak response testing is the identification of a facility-onset case in a resident or a case in a staff member.

iv. Direct care staff and staff directly exposed to residents through job responsibilities (e.g., environmental services) declining testing should be treated as having a positive or unknown COVID-19 status. The facility should make recommendations based on their current status: conventional, contingency, and crisis capacity (https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html).

f. *Serial Testing of Asymptomatic Nursing Home Staff.*

i. On August 26, 2020, CMS issued QSO-20-38-NH (https://www.cms.gov/files/document/qso-20-38-nh.pdf), Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care Facility Testing Requirements. The County Positivity Rate is posted at this CMS web site: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg. The following information is from QSO-20-38-NH. More information on County Positivity Classification be found here:
   1. DPH LTCF County Test Positivity Report posted Mondays at https://dph.georgia.gov/covid-19-long-term-care-facilities.
   2. CMS County Test Positivity Report: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg.

Community COVID-19 Activity	County Positivity Classification	Minimum Testing Frequency
Low	Green	Once a month

Medium	Yellow	Once a week*
High	Red	Twice a week*

*This frequency presumes availability of Point of Care Testing on-site at the nursing home or testing by a laboratory where turnaround is <48 hours. If the 48-hour turnaround time cannot be met due to community testing shortages, limited access or inability of laboratories to process tests within 48 hours, the facility should document its efforts to obtain quick turnaround test results with the identified laboratories and contact with local or state health departments.

ii. The nursing home should begin testing all staff at the frequency prescribed in the Routine Testing table based on the county positivity rate reported in the past week. Nursing homes should monitor their county positivity rate every other week (e.g., first and third Monday of every month) and adjust the frequency of performing staff testing according to the table above.

iii. If the county positivity rate increases to a higher level of activity, the nursing home should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity are met.

iv. If the county positivity rate decreases to a lower level of activity, the nursing home should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency. See QSO-20-38-NH (https://www.cms.gov/files/document/qso-20-38-nh.pdf) for more details.

g. *Test Result Reporting.*

i. All long-term care facilities should report resident and staff cases (including baseline testing) to their district health department and all data required to the State COVID Long-Term Care Facility Database at (https://covid19.hfrddb.dch.ga.gov [Open with Explorer]; Password: $RFV3edc@WSX1qaz). Nursing homes also need to report all mandated data required to National Healthcare Safety Network (NHSN); see Section 8.0 for conferring rights to the State of Georgia.

ii. Pursuant to O.C.G.A. 31-7-12.5, long-term care facilities must also notify residents and their representatives or legal surrogates by 5:00 P.M. the next calendar day following the occurrence of either a single confirmed infection of COVID-19 or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other.

iii. All on-site antigen testing conducted by long-term care facilities must be reported to DPH for all testing completed for each individual tested. CMS reporting requirements can be found here (https://www.hhs.gov/sites/default/files/covid-19-laboratory-data-reporting-guidance.pdf). See Section 4. Part 3.a.vii and viii for more information on reporting test results.

Section 5.0 Guidance for Time Outdoors, Window Visits, and Outdoor Visits

1. This section provides guidelines for allowing residents to have time outdoors, outdoor visits, and window visits. This guidance also includes recommendations for safe transport of residents to participate in these activities. Georgia long-term care facilities should follow these guidelines to offer outdoor and visitation guidance for its residents.

2. *Safely Transporting Residents to Have Time Outdoors, Window Visits, and for Outdoor Visits.*

    a. Staff should wear face mask and eye covering (face shield or googles) and any other appropriate PPE.
    b. Resident should wear a surgical mask or well-fitted cloth mask if tolerated.
    c. Resident treatments should be performed in the resident's room (except in emergency situations).
    d. Prior to departing room, the resident should void/have incontinence care provided and put on clean clothes/gown. The resident should use soap/water for hand hygiene after using the bathroom.
    e. If resident utilizes a dedicated wheelchair/assistive device, staff should use multiple appropriate disinfectant wipes to wipe down all parts of the chair/device (e.g., handles, arm rest, seat back, seat, and wheels—clean areas from cleanest to dirtiest) following the disinfectants instructions for use (dwell/contact/kill time) and prior to resident being placed in wheelchair and/or prior to exiting their room, and again upon exiting the common areas, dining room, therapy gym, etc.
    f. Prior to departing room, ensure that the resident has performed hand hygiene with alcohol-based hand rub or washed hands with soap and water (if hands are visibly soiled) and donned clean clothes. Teach the resident how to properly perform hand hygiene with alcohol-based hand rub and soap/water. Validate comprehension by return demonstration by staff.
    g. Staff should perform hand hygiene before and after resident contact (after leaving resident in visitation area and prior to retrieving resident) as well as other hand hygiene indications.
    h. Upon re-entry to the facility, staff and residents should perform hand hygiene.

3. *Allowing Residents to Have Time Outdoors.*

    a. Resident time outdoors is not recommended during widespread outbreaks.

    b. Current COVID-19 positive residents, residents with COVID-19 signs or symptoms, and residents in quarantine in the Observation Unit are not eligible for time outdoors.

        i. Assess the size of the outside space. Determine how many residents/staff can safely go out at once while adhering to social distancing. Assess the necessity for social distancing of residents (i.e., roommates, spouses, siblings).
        ii. Consider marking areas to support maintaining social distancing in designated outdoor space.
        iii. Staff must accompany residents outside. While residents are outside, at least one staff member should be present.

iv. Residents who are suspected or confirmed of having COVID-19 should not go outside.
v. Determine the route to travel to get outside. The route should not go through the COVID-19 Unit or Observation Unit.
vi. Prior to leaving their room, the resident should don a mask and perform hand hygiene. If the resident cannot tolerate wearing a mask, they must adhere to social distancing.
vii. Follow the safe transport procedures to allow residents to have time outdoors, socially distanced.
viii. When erecting open tents or other structures outdoors to support outdoor visitation, ensure that such structures allow for natural ventilation and do not require mechanical ventilation, such as an air conditioner or fan.

4. *Window Visits.*

a. Window visits in the residents' room may be feasible during outbreaks. Window visits requiring moving the resident from their room should not occur during outbreaks.

b. Window visits that require moving the resident from their room are not recommended for current COVID-19 positive residents, residents with COVID-19 signs or symptoms, and residents in quarantine in the Observation Unit. These residents can participate in window visits in their room.

i. <u>Determine if it is appropriate for your facility have window visits</u>:

1. Consider if your residents have access to ground-floor windows and staffing to support window visits.
2. If not, all residents have access to ground-floor windows, evaluate if the facility has an area with windows to which it can safety transport residents.

ii. <u>Issue a communication to your families regarding your plans for window visits.</u>

1. Explain that with residents with dementia may not understand the rules of this type of visit and may become confused or frustrated. Residents may also become confused or scared if someone walks up to their window.
2. Families need to plan for a window visit and notify the facility to make sure the resident is prepared to greet them and has access to a phone.
3. For residents without window access, families will need to make appointments.

iii. <u>For residents with windows in their rooms:</u>

1. If the resident's window will be open, the resident should stay three feet from the window and wear a face mask. Family members at the window outside the building, should sit 3 feet away from the window and wear a surgical mask or well-fitted cloth mask.

2. Visitors need to practice social distancing during the visit and stay in family group or sit 6 feet apart from other family group/visitors.
3. Staff should monitor window visits and provide support, such as providing a telephone for communication if needed.

iv. <u>For residents without windows in their rooms:</u>

1. Evaluate if your facility has a ground-floor common area with windows that can accommodate socially distanced residents inside and distanced visitors outside.
2. Request that families make appointments in advance for window visits in common areas and have at least one staff monitor window visits.
3. Limit the number of residents and visitors to ensure residents and visitors are socially distanced and set a policy for visit duration.
4. Disinfect all surfaces in the visitation area, including chairs and tables.

5. *Outdoor Visits.*

a. <u>Facility-related recommendations</u>

The facility visitation policy should address the following, at minimum:

i. Establish a schedule for visitation hours. Determine number of visitors and visits. Visits to be by appointment only, or as coordinated by the facility, based on facility ability to manage infection control practices and social distancing.
ii. Ensure adequate staff must be present to allow for helping transport residents and to assist with cleaning and disinfecting any visitation areas, as necessary.
iii. Ensure that staff maintain visual observation but provide as much distance as necessary to allow for privacy of the visit conversation.
iv. Have a system to ensure visitors are screened for signs and symptoms of COVID-19 at a screening location designated outside the building.
v. Have a system to ensure residents and visitors always wear a mask.
vi. Designate outdoor visitation spaces to be accessible to visitors without walking through the facility.
vii. Ensure outdoor visitation spaces support social distancing of at least 6 feet between the visitor and resident.
viii. Provide alcohol-based hand rub to persons visiting residents and provide signage or verbal reminders of correct use.
ix. Ensure cleaning and disinfection of visitation area between each use.
x. Establish additional guidelines as needed to ensure the safety of visitations and their facility operations. These guidelines must be reasonable and must consider the individual needs of residents.
xi. Consider weather conditions when permitting outdoor visitation. Visits may be prohibited or cancelled if weather conditions pose a potential safety risk.

xii. Ensure that open tents or other structures outdoors to support outdoor visitation allow for natural ventilation and do not require mechanical ventilation, such as an air conditioner or fan.

b. Resident-related recommendations

i. Residents who have had COVID-19 must no longer require transmission-based precautions as outlined by the CDC and DPH guidelines in order to participate in outdoor visitation.
ii. Residents must wear a mask as tolerated.

c. Visitor-related recommendations

i. Wear a mask, or other face covering, during the entire visit unless medically contraindicated.
ii. Use alcohol-based hand rub upon entering and exiting the visitation area.
iii. Participate in active screening for signs and symptoms of COVID-19 and attest to COVID19 status if known. This should be done at a designated location outside the building.
iv. Walk around rather than through the facility to get to the outdoor visitation area.
v. Sign in and provide contact information.
vi. Control visitors under age 12 years who accompany them and ensure they comply with social distancing requirements.
vii. Control pets who accompany them
viii. Maintain 6 feet social distance.
ix. Stay in designated visitation locations.

Section 6.0 Considerations for Assisted Living Communities

1. In contrast to nursing homes, assisted living communities may have small units or apartments that residents may occupy by themselves. Residents may function more independently and may need some assistance with activities of daily living, like dressing and bathing. Family members and friends may come to visit residents and to also take them on visits outside the facility. Most of the guidelines provided in this document apply to assisted living communities, and the following modifications are provided.

2. The visitation guidelines listed above apply to assisted living community residents.

3. During Phase I, assisted living community residents should also not leave the facility except for resident trips outside the facility within the parameters described in Section 3.0. However, for facilities in Phase II, the facility may designate different leave policies for its residents and will educate its residents on appropriate infection control measures, such as social distancing, hand hygiene, and wearing a surgical mask or well-fitted cloth mask.

4. Because residents may be in single rooms, cohorting of roommates may not apply. Residents that are symptomatic or confirmed with COVID-19 can be isolated in their rooms. Place contact precaution and CDC COVID-19 PPE signs (https://www.cdc.gov/coronavirus/2019-

ncov/downloads/COVID-19_PPE_illustrations-p.pdf) on the resident's door and provide PPE for staff use before entering the resident's room.

5. Moving confirmed positive COVID-19 residents in an assisted living community takes planning and consideration. Assisted living residents have a full apartment of furniture and personal affects. We do not recommend moving residents, except as a last resort. Staff moving items for either positive or suspect COVID-19 residents must wear full PPE for a COVID-19 resident while in the resident's room.

6. The facility must ensure that a suspect or confirmed COVID-19 resident has appropriate access to medical care.

7. The facility must ensure that residents in the assisted living community have COVID-19 screenings as outlined in this document.

8. Before progressing beyond Phase I, ensure facility is not under a contingency staffing plan and any agency staff are trained in infection control protocols and monitored.

9. Any cluster of illness should be reported immediately to your district health department and COVID-19 is included on the DPH Notifiable Disease List (https://dph.georgia.gov/epidemiology/disease-reporting).

10. A resident with COVID-19 might be able to remain in the facility if the resident:

    a. Is able to perform their own activities of daily living or a consultant personnel (e.g., home health agency) can provide the level of care needed with access to all recommended PPE and training on proper selection and use;
    b. Can isolate in their room for the duration of their illness;
    c. Can have meals delivered;
    d. Can be regularly checked on by staff (e.g., checking in by phone during each shift (if resident has a phone) or visits by home health agency and assisted living community staff who wear all recommended PPE); and
    e. Is able to request assistance if needed.

11. All long-term care facilities should report their baseline and ongoing testing numbers for residents and staff to their district health department and to the State COVID Long-Term Care Facility Database at (http://168.62.42.231/dchcovid19/Reports.aspx [Open with Explorer]; Password: $RFV3edc@WSX1qaz). Assisted living communities also have the option to report data to the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 module (https://www.cdc.gov/nhsn/ltc/covid19/index.html) weekly.

12. Additional recommendations for assisted living can be found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html.

Section 7.0 Considerations for Memory Care Units

1. Memory care units are dedicated wings or units that provide specialized care for individuals with cognitive impairment, such as Alzheimer's disease or another dementia. In Georgia, these units are found in nursing homes, assisted living communities, and personal care homes. Implementing infection prevention strategies in memory care units is especially challenging, as residents can be mobile and may not be able to follow recommended infection prevention practices, such as social distancing, washing their hands, avoiding touching their face, and wearing a surgical mask or well-fitted cloth mask for source control.

2. In addition to the guidance provided in this document, the following is provided:
   a. Dedicate personnel to work only on memory care units when possible and try to keep staffing consistent. Limit personnel on the unit to only those essential for care.
   b. Continue to provide structured activities, which may need to occur in the resident's room or be scheduled at staggered times throughout the day to maintain social distancing.
   c. Provide safe ways for residents to continue to be active, such as personnel walking with individual residents around the unit or outside.
   d. Frequently clean and disinfect often-touched surfaces in the memory care unit, especially in hallways and common areas where residents and staff spend a lot of time.
   e. Continue to ensure access to necessary medical care, and to emergency services if needed and if in alignment with resident goals of care.
   f. Increase the frequency of hand hygiene for staff and residents.

3. When a resident on a memory care unit is suspected or confirmed to have COVID-19, consider the following:
   a. Given that memory care residents may be ambulatory and often cannot follow infection prevention recommendations, consider that all residents and unit staff may have been exposed.
   b. Interactions with memory care residents can be unpredictable, so include eye protection (face shield or goggles) for all staff on the memory care unit. Eye protection is in addition to other PPE recommendations.
   c. Before moving a positive resident to a COVID-19 unit, consider if the COVID-19 unit staff can manage a memory care resident.

4. Additional guidance can be found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html.

Section 8.0 Reporting to the National Healthcare Safety Network (NHSN)

1. DPH strongly recommends that nursing homes report data to the NHSN LTCF COVID-19 module.

2. Nursing homes may also confer rights (share data) in NHSN to the Georgia Department of Public Health group prior to entering Phase I. Instructions for conferring rights can be found here.

3. Assisted living communities and personal care homes larger than 25 beds may submit data to NHSN and confer rights to the State of Georgia if they wish, but they are not required to do so.

4. More details regarding the NHSN LTC Module are found at https://www.cdc.gov/nhsn/ltc/covid19/index.html.

This Administrative Order shall take effect at 5 p.m. on April 7, 2021, and unless amended, terminated, or otherwise superseded, shall remain in effect until the conclusion of the Public Health State of Emergency initially declared by Executive Order 03.14.20.

SO ORDERED, this 7th day of April 2021.

Kathleen E. Toomey, M.D., M.P.H.
Commissioner
State Health Officer