Key Points

- Regular surveillance for symptoms and signs: Fever, Cough, Shortness of breath or difficulty breathing, Chills, Repeated shaking with chills, Muscle pain, Headache, Sore throat, New loss of taste or smell
- Isolate the resident—droplet precautions
- Test for COVID 19 (use PPE while swabbing) and alternative treatable causes if applicable
- Use proper PPE for PUI and COVID positive and conserve PPE appropriately (see Appendix D and PPE attachment)
- Keep ill residents on designated floor/section of facility (cohorting)—see Appendix E for specific cohorting caveats and considerations
- Minimize visits into rooms by bundling patient care activities- (eg nurse to do assessment when he/she takes in meals)
- Limit aerosol generating procedures, routine labs, review medications and eliminate non-essential meds - vitamins, bisphosphonates where medically appropriate, decrease frequency of accu-checks to decrease frequency of med pass/nursing encounters
- All staff should be trained in hand hygiene, donning and doffing PPE
- Staff to notify of other places they work at that have COVID + case in facility
- Advance Care Planning is imperative, preferably before disease onset (see AMDA attachment)
- Refer to Appendix A, B, C for details on COVID Capable Facilities from AMDA and CDC
Appendix A: Managing a Facility with COVID-19 (Adapted from AMDA)

Patient Management

- When possible, care should be provided in a single-person room with the door closed.
- Resident should have a dedicated bathroom, as applicable.
- Initiate droplet precaution and contact precautions.
- Ensure isolation carts with isolation supplies and isolation signs are outside the room. Include signage of how to don and doff PPE.
- Prior to entering and exiting the unit and a patient room, healthcare personnel must perform hand hygiene by washing hands with soap and water or applying alcohol-based hand sanitizer.
- Initiate alert monitoring.
- Notification of family/DPOA for resident’s change in condition.
- Notification of Medical Director of any resident/staff with Respiratory Symptoms.
- Implement line listing of all residents with symptoms (ATTACHMENT)
- Initiate surveillance mapping of resident’s that are symptomatic.
- Suspend any Admissions until staffing and cohorting have been stabilized
- Review discharges with family, other facilities etc.
- Consider instituting “telehealth”. If telehealth system is not available healthcare providers can still communicate with patients by phone (instead of visits) reducing the number of provider visits.
- Notify your EMS system of COVID-19 presence.
- For Residents receiving Dialysis outside the facility- notify their dialysis center and request they be dialyzed in “isolation”.
- Minimize entries into patient rooms by bundling care and treatment activities.
- If resources allow, consider universal facemask for healthcare personnel while in the facility.
- If resources allow, consider having staff who provide direct care wear all recommended PPE (gown, gloves, eye protection, facemask) for the care of all residents regardless of presence of symptoms.
- If positive for fever or respiratory signs/symptoms, isolate the resident in their room and implement droplet and contact precautions.
- If possible, designate entire unit within facility to care for known or suspected COVID-10 residents, with dedicated staff who are only assigned to care for these residents.
- Restrict resident to their room (except for medically necessary purposes).
- If residents leave their room they should wear a facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others)
- Have a low threshold to transfer ill residents to a higher level of care.
- Notify hospital prior to transferring a resident with acute respiratory illness, including suspected or confirmed COVID-19.
- Stop all Nebulizers
- Keep doors closed with CPAP patients while using

Staff Management
• Take temp of all staff before beginning of shift. Record on temp log and absence of symptoms.
• Post procedure for staff if they become ill on duty.
• Assign consistent staff to same unit/hall on a consistent basis.
• Post CDC info on COVID-19
• Train staff on how to wear PPE safely.
• Ongoing staff education on proper hand hygiene.
• Observe staff – hand hygiene, donning and doffing PPE and during care.
• Complete staff competency on handwashing, and PPE proper use. (include all therapies)
• Consider setting up daycare for staff children - schools may close. (not applicable in WA)
• Educate staff to inform other facilities they work at that they are working at a facility with suspected or actual COVID19.
• Do not require a healthcare provider’s note for employees who are sick with respiratory symptoms to return to work.
• Make contingency plans for increased absenteeism caused by employee illness or illness in employees’ family members that would require them to stay home. Planning for absenteeism could include extending hours, cross training current employees, primary care model for nursing or hiring agency or temporary staff.
• Staff who are sick should have clear instructions regarding home care and when and how to access the healthcare system for face-to-face care or urgent/emergency conditions.
• If possible, identify staff that can monitor sick staff with daily “check-ins” using phone calls, emails and texts.

Environmental Management

• Increase sanitation of high touch areas and common areas including (computer screens, keyboards, elevator buttons, entry, exit buttons, door handles, knobs, counters, handrails, grab bars, therapy equipment’s, shared medical equipment such as Hoyer lifts, shower chairs, wheelchairs, remote controls etc.)
• Limit sharing of personal items between residents.
• Use dedicated medical equipment for isolated residents. Oximeter, B/P cuff, Stethoscope etc.
• Ensure supplies are available. (tissues, waste receptacles, alcohol-based hand sanitizers)
• Ensure access to alcohol-based hand sanitizer both inside and outside of patient rooms.
• Sanitize any rental equipment’s prior to use (Bariatric beds, mattress etc.)
• Consider zone cleaning - Assign staff to a zone in the facility to sanitize high touch surfaces every 3 times day.
• Create sign off sheet for staff to sign off date/time/employee name for sanitizing all high touch areas

Appendix B: from AMDA Regarding COVID Capable Facilities

How should I get my facility prepared for a COVID-19 case/outbreak?
• Facilities should identify an area for cohorting COVID-19 patients. This should be an area that can be closed off from other parts of the facility.
• There should be no sharing of equipment and supplies. Extra equipment like medication carts and wound care supplies should be planned for and available.
• Staff movement should be minimized and assignments should be adjusted
• Isolation carts and PPE supplies should be made available
• Oxygen concentrators and contingency arrangements should be made.
• Have medications meant to provide comfort, including at the end of life, available. These include morphine, lorazepam, and similar agents.
• Work with environmental services (EVS) to adjust their schedule to be available on-call if possible
• Plan for extra hospice support may be needed

We have two residents from different units with new onset respiratory symptoms. Should they be in the same room?

If two or more residents have acute respiratory symptoms suggestive of influenza, RSV or COVID-19, we suggest implementing facility-wide precautions. Until there is a confirmed diagnosis for the involved residents, they should not be cohort. Once it is known that there are two individuals with the same infection, then those individuals may be cohort if necessary.
We recommend, if possible, dedicating one hallway or unit to the care of individuals with respiratory viral syndromes. There should be consistent staffing of this unit as well (i.e., the same staff members work in this area, including staff that works on evening and night shift). If other staff needs to come into this area to perform specialized care, such as hospice care, this should be the last group of residents to receive care before that person goes home. Prioritize the use of PPE in this area of the building. If possible several nursing functions (e.g. wound care) should be performed by the assigned staff to limit staff caring across the facility. If this is done consideration should be given to the increased intensity of work during staff assignments.

Guidance from the CDC dating from 3/10/20 states that residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.

Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. Public health authorities can assist with decisions about resident placement.

We have several COVID-19 positive residents in varying stages of recovery. May we place them in the same wing? Can we cohort our COVID-19 positive residents?

Nursing facilities should identify units that can be effectively used to cohort COVID-19 patients who test positive while they are in the facility.
• COVID-19 patients should be cohort in a single unit.
• There should be dedicated nursing staff to care for COVID-19 patients. They should not work on other units.
- Equipment should not be shared between units.
- Staff providing care to multiple patients should minimize contact with test positive or suspected COVID-19 patients and should provide care to these residents last.
- Cohorting of residents with known COVID-19 is permissible as long as there is consideration of other reasons they may require different infection prevention and control procedures (e.g., recent history of *C. difficile* infection or known colonization with an extended-beta lactamase producing bacteria).

Patients with COVID-19 should be monitored closely with frequent vital signs and oximetry checks. Drops in oximetry and change in mental status may herald worsening. Supportive care measures include acetaminophen to reduce fevers, high flow oxygen, and intravenous fluids for hydration. Consider using meter-dosed inhalers with or without spacers, and oral albuterol to ease respiratory symptoms. If possible, continue to avoid nebulized treatment due to significant risk of transmission to staff.

For patients with significant respiratory illness and symptoms consider palliative and hospice care in conjunction with patient’s goals of care. For these patients, symptom relief with opioids and benzodiazepines will likely be required for end of life care.

**Can equipment like stethoscopes, blood pressure cuffs or pulse oximetry devices transmit COVID-19?**
Yes. COVID-19 is thought to be transmitted through respiratory droplets. The risk of transmission by fomites is also a concern. Respiratory droplets that land on surfaces near an individual and are later touched by a healthcare worker may lead to transmission.
In addition to following standard infection control practices on cleaning common equipment to assess residents, like thermometers or pulse oximeters, staff should be asked to clean personal equipment, such as stethoscopes before and after examining an individual, and to clean their personal devices, like cellphones, frequently.

**Environmental Cleaning**
**How do we clean the room of a resident with possible or confirmed COVID-19?**
We recommend that to minimize the exposure and optimize use of PPE, only essential clinical staff enter the rooms of residents with suspected or confirmed COVID-19. CDC recommends that nursing staff taking care of residents perform the daily cleaning of frequently touched surfaces inside the resident’s room (such as door handles, bedrails, tabletops, light switches, elevator buttons [inside and out], computers, remotes, phones etc.) with an EPA-registered, hospital-grade disinfectant that has an emerging viral pathogens claim for use against SARS-CoV-2. Staff assignment should account for extra services that the staff is providing to allow effective care of the residents.

**Are there special protocols for shared medical equipment?**
All non-dedicated, non-disposable medical equipment used for patient care should be cleaned according to facility policies.
For buildings with a COVID-19 unit or floor, we recommend dedicating some equipment for the care of residents with known COVID-19 and leaving that equipment in a designated unit.

Environmental service staff should clean the frequently touched surfaces like handrails, doorknobs and door handles, and surfaces at the nurses' stations at least twice daily and more frequently as needed. They should continue to clean the other resident rooms as their routine practice and should ensure that an adequate supply of alcohol-based hand sanitizers is in the dispensers. There should be a process in place to refill empty dispensers and restock PPE.

One of our residents with COVID-19 has gone home. What should we do for terminal cleaning of that room?

Environmental service staff should observe contact and droplet precautions when cleaning residents' rooms. Educate staff on proper use of PPE and appropriate choice of disinfectant. A facemask and eye protection should be added if splashes or sprays during cleaning and disinfection activities are anticipated. Standard practices using an EPA-registered, hospital-grade disinfectant with an emerging viral pathogens claim are recommended for use against SARS-CoV-2.

Appendix C: CDC Guidance Regarding COVID Capable Facilities

Dedicate Space in the Facility to Monitor and Care for Residents with COVID-19

- Dedicate space in the facility to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.
  - Assign dedicated HCP to work only in this area of the facility.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive).
  - Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them.
- Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected.
  - If an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved from their rooms to this location while undergoing evaluation.
  - All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator
is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn by HCP when PPE is indicated.

Evaluate and Manage Residents with Symptoms of COVID-19

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
- Actively monitor all residents upon admission and at least daily for fever (T≥100.0°F) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If positive for fever or symptoms, implement Transmission-Based Precautions as described below.
  - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- The health department should be notified about residents or HCP with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.
  - Contact information for the healthcare-associated infections program in each state health department is available.
  - Perform respiratory infection surveillance
  - If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community, follow the Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. This guidance includes detailed information regarding recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Cloth face coverings are not considered PPE and should not be worn by HCP when PPE is indicated.
    - Residents with suspected COVID-19 should be prioritized for testing.
    - Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
      - Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated HCP (see section on Dedicating Space).
      - As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
    - Increase monitoring of ill residents, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.
- Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms.
- If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation. **Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.**
  - While awaiting transfer, residents should wear a cloth face covering or facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed)
  - **All recommended PPE** should be used by healthcare personnel when coming in contact with the resident.
- For decisions on removing residents with COVID-19 from Transmission-Based Precautions refer to the [Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19](https://www.cdc.gov/coronavirus/2019-ncov/hcp/discontinuation-transmission-based-precautions.html)

**Additional Measures:**

- Cancel communal dining and all group activities, such as internal and external activities.
- Remind residents to practice social distancing and perform frequent hand hygiene.
- Have residents wear a cloth face covering or facemask whenever they leave their room, including for procedures outside of the facility.

**Healthcare Personnel Monitoring and Restrictions:**

- Because of the higher risk of unrecognized infection among residents, universal use of **all recommended PPE** for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents.

**Resident Monitoring and Restrictions:**

- Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes.
  - If they leave their room they should wear a cloth face covering or facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others)
Appendix D: PPE Guidance for “COVID Capable Facilities”

Adapted from Delmar Gardens

DEFINITIONS

Resident Care Area:
Area where residents reside and/or care is being performed

Direct Contact:
Being within approximately 6 feet of a person with COVID-19 for a prolonged period of time (greater than 10 minutes)

PPE Burn Rate: rate of consumption of personal protective equipment (PPE) **refer to burn rate calculator link at end of this guidance.

Person Under Investigation (PUI): Signs and/or Symptoms of COVID-19

I. Required PPE for ALL Direct Care Staff providing Direct Contact in Resident Care Areas include:

1. Residents Asymptomatic:
   a. Standard Mask
   b. Gloves

2. Residents (PUI) without Respiratory Symptoms:
   a. Standard Mask
   b. Gown (when providing direct contact over 10 minutes)
   c. Gloves

3. Residents (PUI) with Respiratory Symptoms (with or without fever)
   a. N-95 Respirator Mask and Face Shield or Goggles
   b. Standard Mask and Face Shield
   c. Gown
      1) Use re-useable Gown if disposable Gown unavailable
   d. Gloves

4. Residents (PUI) with Respiratory Symptoms on Aerosols (Nebulizer/C-PAPA, BI-PAP - with or without fever)
   a. N-95 Respirator Mask and Face Shield
   b. Gown
   c. Gloves

II. Required PPE for non-direct Care Staff - Admin., Dietary, Environmental, Concierge etc
(exclusions as listed below)

1. Home-made Mask
2. Scarf or Bandana acceptable if home-made mask unavailable
3. At any point that a non-direct care staff person enters a unit or room that is under isolation precautions, appropriate PPE must be donned. Refer to charge nurse or nurse manager for guidance.

*All must be laundered in the community using routine laundry services

**Extended Use of PPE:** Extended use refers to the practice of wearing the same PPE for repeated close contact encounters with several patients, without removing the PPE between patient encounters. Extended use may be implemented when multiple patients are infected with the same pathogen and are placed together in a dedicated area.

**Re-Use of PPE:** Re-use refers to the practice of using the same PPE for multiple encounters with patients but removing it (“doffing”) after each encounter. The PPE is stored in between encounters to be put on (“donned”) again prior to the next encounter with a patient.

*Decisions for extended use or limited re-use should be made ONLY with consultation with your Regional Nursing Supervisor and your Medical Director.*

**Guidelines for Re-Use of Standard/Surgical Face Masks**

**Storage for Extended or Re-use**

1. The mask can be stored between uses and/or at the end of the shift in a clean breathable, close-able paper bag (i.e. lunch bag) with the staff members name, date and number of times mask has been used.  
   Example – Mary Smith 4/14/20 – 2nd use.

2. When storing masks, carefully fold so that the outer surface is held inward against itself to reduce contact with the outer surface.

3. Label the bag with the staff members name (DO NOT WRITE ON THE FACE MASK MATERIAL).

4. Bags should be disposed of between uses and clean paper bag used with each use.

5. For reuse masks must be stored in a CLEAN, accessible area close to the entry where staff will be screened at start of shift and where they exit at end of shift.
   a. Place a cart near the screening station. Keep hand sanitizer at the front entry for employees to use when donning and doffing masks.
   **STAFF SHOULD NEVER TAKE PPE HOME TO STORE**
Re-use of Standard/Surgical Face Masks

1. Standard/Surgical Face Masks should be:
   a. Replaced when soiled, damaged, splashed, or sprayed.
   b. Re-used up to 3 shifts
   c. Used only by the same employee
2. Cloth Face Masks ARE NOT an acceptable substitute for a Standard/Surgical Face Mask.

Extended use of Standard/Surgical Face Masks—staff member will wear standard mask for entire shift replacing only when soiled, damaged, splashed, or sprayed. Use only by the same employee.

Guidelines for Re-Use of N-95 Respiratory Masks

Storage for Extended or Re-use

1. Prior to storing, visually inspect the N-95 respirator for contamination, distortion in shape/form. If contaminated/wet, creased or bent, N-95 should be discarded.
2. When the N-95 respirator is being re-used, carefully store between uses:
   a. Label the N-95 respirators on the straps with the user’s name before use to prevent re-use by another individual.
   b. DO NOT WRITE ON THE FACE N-95 RESPIRATOR MASK MATERIAL.
   c. Remove the N-95 mask by only touching the straps or the outmost rim of the N-95 mask.
   d. Avoid touching the inside of the mask
   e. Place the N-95 respirator mask by hanging the mask over the handles of a clean, breathable, paper bag (i.e. paper bag with handles) with user name and date and the number of uses.
   f. Take care not to fold, bend or crush the N-95 respirator inside the bag.
   g. Place the bag containing the N-95 respirator on an isolation cart outside the resident’s room during the user’s shift if using for only one (1) resident.
   h. The bag may be carried by the wearer for use in another room when another resident with COVID-19 requires care. Don the N-95 respirator in that room using the instructions provided above.
i. Paper bags should be disposed of between uses and a clean paper bag used with each storage.

j. Masks must be stored in a CLEAN, accessible area close to the entry where staff will be screened at start of shift and where they exit at end of shift.

k. Place a cart near the screening station. Keep hand sanitizer at the front entry for employees to use when donning and doffing masks.

3. Perform a negative/positive seal check prior to reusing by doing the following:
   a. No air should be felt around the perimeter while blowing out. If you feel air coming out it is not a tight seal.
   b. When taking a small breath in, the mask should pucker in slightly. If it does not, it is not re-usable.
   c. When breathing out you should feel the respirator expand slightly. If it does not, it is not re-usable.
   d. If not a tight seal, the respirator cannot be re-used

Re-use of N-95 Respirator

Extended and Re-use of N-95 Respirator

1. The re-use of N-95 respirators:
   a. Must be replaced when soiled, damaged or moist from sweat or insensible fluid loss through breathing.
   b. Can be extended for 8 hours of continuous use as long as the structural integrity is not compromised.
   c. Should be limited to 5 uses per device as long as able to seal properly and donning and doffing are appropriate per policy to avoid contamination.
   d. Must only be used only by the same employee

Re-use of full-face shields

1. Full face shields are dedicated to individual direct care staff as foam piece and elastic head band cannot be adequately disinfected between personnel.
2. Don gloves and adequately disinfect inside then outside surfaces, avoid using germicidal wipe on foam and elastic band.
3. Store reused full face shield alongside your labeled paper bag containing your re-used N95

Guidelines for Re-Use of Gowns
Gown only re-used between residents if:

- Residents cohorts with same infections disease (COVID+)
- Moving from resident(s) with no symptoms to one resident with symptoms

Storage for reuse procedure:

1. Gown labeled with user name on removable wall hook outside bedroom door for reuse during shift.
2. At end of shift, remove prior to exiting room/apt, bag and secure bag, perform hand hygiene, if reusable put in soiled utility room to have laundered per policy, discard if disposable
3. If Gowns unavailable, ask resident to don standard/surgical mask prior to providing care or service

Prioritizing Gown Use: (when supplies are minimal)

Gowns should be prioritized for the following activities:

- During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures.
- During the following high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of healthcare providers, such as:
  - Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care or use, wound care.


Appendix E: Cohorting Concerns and Caveats to Consider

CONCERN #1 - COHORTING OF SUSPECTED CASES: The reference to “suspected” cases being cohorted prior to receiving test results is problematic. Some will be positive, and some negative. Moving them around the building creates too many opportunities for spreading an outbreak beyond a containable level. Recommend deletion of that word from this guidance. Instead, suspected cases should be separated from asymptomatic roommates when it is possible to do so without moving the suspected case or asymptomatic roommates off the unit or floor. Moving asymptomatic, but already exposed, roommates has been a clear source of spread to other units. We guide our centers to NOT move asymptomatic roommates off the unit until they have negative test results, but do everything possible to find them a private room on the same unit, including temporary use of dining or recreational areas. If this is impossible, we recommend leaving them in place, with curtains drawn and under full contact/droplet precautions. The priority is to protect the naive units.

CONCERN #2 - COHORTING OF CONFIRMED CASES: Cohorting confirmed cases is certainly a goal, but how this is accomplished is important to consider, depending on the volume of confirmed cases. We have seen well-intentioned attempts to move positive cases to a vacant wing of the building, far from the original unit. But the unintended negative result has been that
the number of cases were then insufficient to support dedicated staffing. (The recommendation
to assign dedicated HCPs is the ideal goal, but not possible in many situations.) As a result, a
nearby and previously unaffected/naive unit ended up having to cover the covid+ unit. Not good.
It would have been safer to leave the cases on their original unit, either in private rooms or
cohorted together, as a means of limiting unit-to-unit spread.

CONCERN #3 - COHORTING OF ASYMPTOMATIC PEOPLE: In an outbreak situation, moving
asymptomatic patients around a facility creates significant risk, until facility-wide testing is
performed. Since a significant number of them will be asymptomatic but contagious, movement
across units or to different roommates should be minimized if possible. Therefore, cohorting of
asymptomatic patients should not be encouraged prior to testing, if it involves such
movement. Reducing patient movement unless necessary to separate confirmed cases from
roommates (on the same unit) should be a guiding principle, as should be the pursuit of broad-
based testing to better guide safe cohorting.

CONCERN #4 - MOVEMENT OFF DEMENTIA UNITS: COVID + dementia patients who are
"wanderers" represent a grave risk to an entire center, if a requirement to cohort patients leads
a SNF to move such patients off their locked memory support unit. Moving ambulatory
dementia patients who are COVID+ off such units should be avoided unless absolutely
necessary, and only if the building design allows their safety and the safety of other patients to
be ensured.