



COVID-19 Infection Prevention and Control: Frequently Asked Questions



This document is intended to provide answers in a written format for questions commonly asked of the DHS Infection Preventionists related to COVID-19 infection prevention and control issues. While this document will be updated on a regular basis, facilities are encouraged to remain current with the original guidance sources, including the [Centers for Disease Control and Prevention \(CDC\)](#), [Wisconsin Department of Health Services \(DHS\)](#), and others as data and guidance continues to evolve.

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Aerosol-Generating Procedures

What is considered an aerosol-generating procedure (AGP)? *Settings affected: All facility types that perform AGPs*

Per [CDC](#), “Commonly performed medical procedures that are often considered AGPs, or that create uncontrolled respiratory secretions, include:

- Open suctioning of airways
- Sputum induction
- Cardiopulmonary resuscitation
- Endotracheal intubation and extubation
- Non-invasive ventilation (e.g., BiPAP, CPAP)
- Bronchoscopy
- Manual ventilation

Based on limited available data, it is uncertain whether aerosols generated from some procedures may be infectious, such as:

- Nebulizer administration*
- High flow O2 delivery

*Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure and increased risk of infection might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and infected patients.”

References related to aerosol generating procedures:

Tran K, Cimon K, Severn M, Pessoa-Silva CL, Conly J (2012) Aerosol Generating Procedures and Risk of Transmission of Acute Respiratory Infections to Healthcare Workers: A Systematic Review. PLoS ONE 7(4); <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338532/#!po=72.2222>

What are the PPE needs for AGPs? *Settings affected: All facility types that perform AGPs*

Per [CDC](#), “HCP should follow [Standard Precautions](#) (and [Transmission-Based Precautions](#) if required based on the suspected diagnosis; for example, use an N95 respirator or equivalent or higher level respirator if the patient is suspected to have tuberculosis). In

addition, N95 respirators or equivalent or higher-level respirators should be used for all aerosol-generating procedures.

What are other considerations for AGPs (e.g., HEPA filters, gas exchanges, environmental cleaning)? *Settings affected: All facility types that perform AGPs*

Per [CDC](#), “Explore options, in consultation with facility engineers, to improve indoor air quality in all shared spaces.

- Optimize air-handling systems (ensuring appropriate directionality, filtration, exchange rate, proper installation, and up to date maintenance).
- Consider the addition of portable solutions (e.g., portable HEPA filtration units) to augment air quality in areas when permanent air-handling systems are not a feasible option.
- Guidance on ensuring that ventilation systems are operating properly are available in the following resources:
 - [Guidelines for Environmental Infection Control in Health-Care Facilities](#)
 - American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE) resources for healthcare facilities, which also provides [COVID-19 technical resources for healthcare facilities](#)”

Can a resident have a roommate if they need to have an AGP in the room? *Settings affected: All facility types that perform AGPs*

Aerosol-generating procedures potentially put health care personnel (HCP) and others at increased risk for pathogen exposure and infection. It is recommended that the resident has a single occupancy room.

If that is not an option, facilities should develop a plan that includes the roommate not being in the room during the procedure, allowing enough time post-procedure for air changes to eliminate any infectious aerosol particles, and thorough disinfection of the room before the roommate returns. If available, HEPA units also could be used to clean the air. If the resident is able to perform the AGP independently, HCP can set up the equipment and leave during the procedure. The door should be closed during the procedure.

If all residents and staff in a dining room or group activity are fully vaccinated, can the staff member take their mask off? *Settings affected: Long-Term Care (LTC)*

[CDC's guidance for fully vaccinated individuals in health care settings](#) provides for residents to remove their source control masks when all present are vaccinated. This category of "all present" does include staff members, so if the staff assisting with the activity or dining are unvaccinated, residents should continue wearing source control masks when not eating or drinking. The unvaccinated person(s) should physically distance from the others when possible. Obviously, there will need to be some accommodation for this if it's an unvaccinated staff member assisting residents and they need to get within six feet to perform their job duties.

If all the residents AND staff in the activity/room are fully vaccinated, the residents may all remove their source control masks and sit closer than six feet. The fully vaccinated staff member still needs to keep the source control mask on because they are providing resident care as part of their job. Staff are only allowed to remove their source control when they are in staff-only areas (breakrooms, staff meetings) among all fully vaccinated staff members. Eye protection is also be required in this circumstance if the [county transmission levels](#) are moderate to high as part of the universal precautions in areas with higher community transmission levels.

Is it safe to open self-serve food and drink options? *Settings affected: All facility types*

CDC offers a set of [FAQs for institutional food service operators](#) for COVID-19 considerations. Per this guidance, determinations to open self-serve food and drink options are typically made based on local community activity, including factors like the [community levels of COVID-19](#).

"In general, CDC recommends avoiding any self-serve food or drink options, such as hot and cold food bars, salad or condiment bars, and beverage stations. Serve grab-and-go items or individually plated meals, instead.

For individually plated meals, identify one staff member per service station to serve food so that multiple staff are not handling serving utensils. Ensure adequate supplies for staff to minimize sharing of high-touch materials (e.g., serving spoons) to the extent possible; otherwise, limit use of supplies and equipment to one group of workers at a time and clean and disinfect between use or as much as possible.

If self-serve stations are offered:

- Require diners to wear a [mask](#) over the nose and mouth when serving themselves food.

- Provide unpackaged food items behind a barrier and limit diners' bare-hand contact with utensils and/or dispensers by providing deli/wax papers, disposable gloves, and/or disposable serving utensils that are thrown out after each diner uses them.
- Provide handwashing stations or hand sanitizer with at least 60% alcohol and encourage use before and after use of self-service station.
- Encourage diners and food workers to remain at least 6 feet apart in areas that can easily become crowded (e.g., standing in line, dirty dish return) and while eating, by providing physical guidance and visual cues, such as tape or graphics on floors or sidewalks and signs on walls.
- Don't allow diners to grab items from reach-in refrigeration units or cabinets. Instead, serve individual cartons, bottles, and/or condiment packets with meals that diners can pick up without opening a door.
- Do not reuse or allow diners to share items (e.g., paper menus) that are difficult to clean, sanitize, or disinfect. If shared objects (e.g., utensils, tongs) are used, replace at an increased frequency (e.g., every 15 minutes, between cohorts). Ensure shared objects are easy to clean.
- Provide no-touch or foot-pedal trash receptacles.
- Consider assigning staff to monitor service stations to observe diners' behaviors and apply corrective actions to prevent potential contamination and encourage social distancing and hand hygiene. For example: Discard food items if contaminated by diners (e.g., self-service utensil submerged in food; diner sneezes on food)."

Additional guidance that may be helpful from CDC is also available as part of their [restaurant and bar operators guidance](#) and [food service guidance for unvaccinated individuals](#).

What if large group dining is cancelled, but the certified nursing assistants (CNAs) need to feed those who are a choking risk or who can't eat alone (i.e., due to social reasons) at separate tables in a big room? *Settings affected: LTC*

Every facility with staff that help feed residents needs to balance the resident's safety with the distancing risk. They need to have more than six feet of separation in the dining room when everyone present is not fully vaccinated. This is usually being done in two shifts to keep the total number of residents and staff at a minimum. Staff should be using eye protection in this circumstance as well to protect from any unintentional respiratory secretions. Staff should remain aware of the risks in moving among residents to feed multiple people at the same time.

Can I have a pet or therapy dog enter the facility? *Settings affected: All facility types with therapy animals, particularly LTC*

Deciding to allow pets and therapy animals in health care facilities needs to be a facility-based decision on if, when, and how to incorporate this. Allowing animals into any facility does increase risk of transmission for infectious agents. The facility will need to create or modify their policy to address animals in their building(s). To aid in these policies, there is guidance from [CDC for Service and Therapy Animals](#) that can be utilized. The facility may also refer to the [CDC Pets](#) webpage for additional guidance. The Division of Quality Assurance Regional Field Operations Director (RFOD) is an excellent resource for the regulatory perspectives on this issue.

The [CDC animal](#) webpage indicates that dogs and cats can become infected with SARS-CoV-2 and that those suspected or confirmed to have the virus should not interact with animals. The cases of animals contracting COVID seem to be once they have had interaction with known positives. Another consideration for pets in the building is the tendency for residents to group around them and ignore social distancing rules. Private pets should not visit from room-to-room, but instead visit the intended resident and minimize other interactions.

Exposures

CDC references testing for asymptomatic, fully vaccinated HCP with higher-risk exposures in its guidance. What is a higher-risk exposure for HCP? Is it only for workplace exposures? *Settings affected: All facility types*

The [CDC guidance](#) for those fully vaccinated in health care settings states that asymptomatic, fully vaccinated HCP with higher-risk exposures do not need to be restricted from work to quarantine, but they do need to test once aware of the exposure and then 5-7 days after exposure. The only exception to this would be those who are in their 90-day post-infection period.

For more detail on higher-risk exposures, CDC links back to the [HCP risk assessment guidance](#). This means there would be three categories that could be considered higher-risk and require testing without a quarantine for asymptomatic, fully vaccinated HCP:

- **[Workplace Exposure](#)**: HCP who had prolonged close contact* with a patient, visitor, or staff member with confirmed SARS-CoV-2 infection AND the HCP was not wearing a respirator or facemask (AND eye protection if the infected individual was not wearing source control), OR the HCP was not wearing full PPE when participating in an aerosol-generating procedure.
- **[Community Exposure](#)**: Prolonged close contact* to an individual with a SARS-CoV-2 infection. This includes living in the same residence, or one or more known

exposures to respiratory droplets, such being within 6 feet of someone while they are coughing or sneezing while not wearing a face covering.

- Per [HAN 22](#), any asymptomatic HCP can return to work without quarantine using enhanced precautions and serial testing for rapid detection in times when a 14-day quarantine would adversely affect patient/resident care due to staffing shortages. The safest course of action is to complete quarantine when possible.
- Per [CDC's fully vaccinated guidance](#), asymptomatic, fully vaccinated HCP could return to work as deemed necessary to mitigate staffing shortages in consultation with public health. The safest course of action is to complete quarantine when possible. For example, higher-level exposures to consider include household contacts, particularly when the positive is a child or a family member who cannot be isolated from the HCP at home, repeated close contact with a positive community contact, and close contact in a poorly ventilated indoor space. At minimum, asymptomatic, fully vaccinated HCP should test twice in this situation as indicated by CDC or could follow the HAN 22 guidance.
- **[Travel Exposure](#)**: Prolonged close contact* with an individual confirmed to have a SARS-CoV-2 infection during travel. This includes exposure along the lines of the community exposure definition above that occurs in transit or while in a travel destination, as well as those confirmed to have COVID during travel due to the inherently more risky nature of infections acquired abroad (e.g., due to the risk of variants).
 - Some travel destinations may have specific quarantine requirements.
 - Fully vaccinated travelers are advised to test 3-5 days following international travel regardless of vaccination status, but do not need to quarantine.
 - Asymptomatic, fully vaccinated HCP should follow general travel guidance and do not need to automatically test or quarantine due to domestic travel.

Consultation with Occupational Health is advised when possible to categorize the exposure risk.

*Within 6 feet for 15 minutes or more within a 24-hour period

Guidance Sources

To which types of health care facilities does guidance from DHS and CDC cover (e.g., acute care, dentistry, ambulatory)? *Settings affected: All facility types*

Per [CDC](#), “Healthcare settings refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, inpatient rehabilitation facilities, nursing homes and assisted living facilities, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, and others.”

The CDC [general infection control guidance](#) applies to all health care settings as indicated above. There are also special setting-specific guidelines for areas like [LTC](#) and [dialysis](#) that offer additional guidance. DHS follows CDC infection prevention and control guidance.

What is the guidance on LTCFs taking admissions/readmissions from hospitals or other outside entities? *Settings affected: LTC*

CDC’s [LTC-focused infection prevention guidance](#) has a section covering admission and readmission considerations. DPH also offers additional guidance on admissions and readmissions during respiratory outbreaks in its [“Prevention and Control of Acute Respiratory Illness Outbreaks in Long-Term Care Facilities” memo](#).

There are no specific restrictions on taking admissions from certain settings as long as the receiving facility is open to admissions and can accommodate the care needed. For example, COVID positive residents still on transmission-based precautions should be admitted to a LTCF COVID unit. Those who have recovered and are no longer in transmission-based precautions can be admitted to a regular unit since they are in their 90-day post-infection period.

[Fully vaccinated residents](#) being admitted or readmitted without known close contact exposures do not need to be put into a 14-day quarantine. [Unvaccinated residents](#) admitted or readmitted should be in a 14-day quarantine.

Outbreaks

If an asymptomatic, fully vaccinated nursing home resident tests positive 125 days post-infection, do we really need to count that as an outbreak?

Yes. CMS and CDC guidance do not take vaccination status into account when determining outbreak response. Asymptomatic, fully vaccinated individuals can still become infected with COVID-19. This situation could also be related to the prior infection and indicate intermittent or prolonged viral shedding. Regardless, the resident tested

positive and outbreak testing protocols need to be instituted per the [CMS testing memo, QSO-20-38](#).

Testing positive in this situation is not a false positive unless the lab indicates an issue with the testing or processing procedures. Even low levels of virus are still positives and need to be responded to like any other positive. If this is a case of intermittent shedding, the test-based strategy can be used to end isolation early for the positive individual if two negative PCRs are collected more than 24 hours after the positive PCR. That does not end the outbreak, however, just the positive case's isolation. Outbreak testing still needs to be completed per CMS guidance until it has been at least 14 days since the last identified positive. Outbreak guidance is also available as part of the [DHS LTCF Outbreaks Guide](#).

PPE

When is universal source control needed and when is it not? *Settings affected: All facility types*

Per [CDC](#), "Source control refers to use of well-fitting [cloth masks](#), facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. In addition to providing source control, these devices also offer varying levels of protection for the wearer against exposure to infectious droplets and particles produced by infected people. Ensuring a proper fit is important to optimize both the source control and protection offered. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19."

Patients and visitors should wear well-fitting source control masks upon arrival and throughout their stay in a facility. They can be offered source control masks if they do not bring one. Patients do not need to wear source control in their rooms, but should wear it when others enter the room or when leaving their room. Source control should not be put on children under the age of 2 or anyone with a medical condition that makes mask wearing unsafe.

HCP should wear source control at all times when in the health care facility when not eating or drinking. The exception to this is for fully vaccinated HCP who are in staff-only spaces (breakroom, meetings) where all present are fully vaccinated. In those limited circumstances, staff could remove their masks as long as everyone present is fully vaccinated. Staff may want to consider extended use of source control to minimize the number of times they touch the mask and risk self-contamination. Medical-grade PPE

used for source control while on duty should be removed before leaving for the day and replaced with the staff member's community-level source control.

What is the definition of an encounter? What is a resident care area? *Settings affected: All facility types*

An encounter is any time a health care worker has contact with a patient or resident.

The CDC guidance for use of eye protection continues to state that staff should wear eye protection for all patient/resident encounters when in counties where [community transmission data](#) indicate moderate to high levels. As of May 2021, this continues to be all counties in Wisconsin.

In LTCFs, this really means wearing the eye protection in all resident areas because you don't necessarily know when you will have an "encounter." Specific use is also determined by a facility's supply capacity. Most LTCFs use eye protection in extended use and reuse, keeping it on at all times in resident care areas. This also then helps prevent unprotected exposures between staff.

Resident care areas would be any area that is not an office area or staff-only space (break room, bathroom, meeting room). Typically, nurses' stations are still considered resident care areas, since they can have residents in them at times, can be in open hallways, etc. That may vary a bit depending on the physical space in a particular facility though and should be part of the discussion by a facility's leadership team.

Eye Protection

Is eye protection necessary if vaccinated? Do screeners need to wear eye protection?

Settings affected: All facility types

CDC continues to evaluate data surrounding vaccination, disease transmission, and variant activity. While there have been some recent changes to the [community](#) and [health care](#) setting guidance to take vaccination status into account, there have been no changes to the use of PPE in health care settings to date.

CDC's guidance in both the [general infection control](#) and [LTC-specific infection control](#) guidance indicates that eye protection should be used for patient/resident care based on the [community transmission data](#) which, at this point in Wisconsin, means that all facilities should be using eye protection due to at least moderate levels in every county.

Community transmission data is different than the county positivity data ([current, archive](#)) that uses a red/yellow/green color coding system to determine LTCF unvaccinated staff routine testing frequencies.

Even when a county turns “blue”/low on the transmission data set, facilities are strongly encouraged to continue using eye protection until large areas of the state are in sustained low transmission. Staff and visitors are likely coming from surrounding counties that are in moderate to high levels of transmission, even when a facility’s county may be low. The county transmission data are recalculated daily and you will often see counties go between categories from one day to the next. There have been no counties that have maintained a “blue”/low level so far for multiple weeks.

The guidance continues to be that staff should wear eye protection for all patient/resident encounters. In LTCFs, that really means in all resident areas because you don’t necessarily know when you will have an “encounter.” Specific use is also determined by a facility’s supply capacity. Most LTCFs use eye protection in extended use and reuse, keeping it on at all times in resident care areas. This also then helps prevent unprotected exposures between staff.

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The [April 27, 2021, update](#) for fully vaccinated HCP allowed the removal of source control masks when in those specific staff-only areas if all staff present were fully vaccinated. Since these HCP would be in a staff-only space, their eye protection should also be off, disinfected and stored, or discarded. As soon as they re-enter a resident area, they should be in their universal precautions (source control mask and eye protection). This new guidance regarding masks in staff-only spaces should really be fairly limited in practice for most staff who will be in patient/resident care areas for the vast majority of their day.

A [listserv message](#) describing the eye protection guidance was also sent in late-March to remind facilities in all settings of the CDC guidance on universal precautions.

When can HCP take their eye protection off? *Settings affected: All facility types*

The [April 27, 2021, update](#) for fully vaccinated HCP allowed the removal of source control masks when in those specific staff-only areas if all staff present were fully vaccinated. Since these HCP would be in a staff-only space, their eye protection should also be off,

disinfected and stored, or discarded. As soon as they re-enter a resident area, they should be back in their universal precautions (source control mask and eye protection).

The CDC guidance for use of eye protection continues to state that staff should wear eye protection for all patient/resident encounters when in counties where [community transmission data](#) indicate moderate to high levels. As of May 2021, this continues to be all counties in Wisconsin.

Gowns

Can gowns be shared between HCPs? *Settings affected: All facility types*

No, this is not standard infection prevention practice. Sharing PPE with other HCPs can lead to exposures and disease transmission. Reference the [CDC gown optimization guidance](#) when anticipating PPE shortages for safer options. DHS also offers a [PPE optimization handout](#), PPE optimization fact sheets ([PPE overview](#), [optimization](#)), and a [specific FAQ on isolation gowns](#).

Can gowns be worn between patients/residents on an isolation wing? *Settings affected: All facility types*

Consideration can be made to extend the use of isolation gowns (disposable or reusable) such that the same gown is worn by the same staff member when interacting with more than one patient/resident housed in the same location and known to be infected with the same infectious disease (i.e., COVID-19 patients residing in an isolation cohort). However, this can be considered **only** if there are no additional co-infectious diagnoses transmitted by contact (such as *Clostridioides difficile*, *Candida auris*) among patients/residents. CDC offers more information on [optimizing gowns](#) during times of PPE shortages. DHS also offers additional [FAQs specific to isolation gowns](#).

Hand Hygiene

Can alcohol-based hand rub (ABHR) be used to decontaminate gloves? *Settings affected: All facility types*

No, this is not standard infection prevention practice. ABHR can degrade exam gloves and lead to exposures. Reference the [CDC glove optimization guidance](#) when anticipating PPE

shortages for safer options. DHS also offers a [PPE optimization handout](#) and PPE optimization fact sheets ([PPE overview](#), [optimization](#)).

Why should we perform hand hygiene and PPE audits to calculate rates versus just observations of practices? *Settings affected: All facility types*

Performing hand hygiene and PPE audits is important for process improvement. Sharing collected data with frontline staff provides opportunities for education and identifies barriers to hand hygiene. This process also allows frontline HCP the opportunity be part of a solution. Calculating rates also offers for comparison over time as part of the number of observation opportunities, rather than just the certain number performed in a given time period.

Masks

Is universal masking necessary if vaccinated? *Settings affected: All facility types*

[CDC](#) has not changed any of the PPE guidance to take into account vaccination status at this time.

CDC continues to [recommend](#) that all staff should wear a respirator or well-fitting facemask for source control while in the facility and for protection during patient/resident care encounters. “The fit of the medical device used to cover the wearer’s mouth and nose is a critical factor in the level of source control (preventing exposure of others) and level of the wearer’s exposure to infectious particles. Facemasks that conform to the wearer’s face so that more air moves through the material of the facemask rather than through gaps at the edges are more effective for source control than facemasks with gaps and can also reduce the wearer’s exposure to particles in the air. Improving how a facemask fits can increase the facemask’s effectiveness for decreasing particles emitted from the wearer and to which the wearer is exposed.”

Do screeners need to wear a mask? *Settings affected: All facility types*

[CDC](#) has not changed any of the PPE and source control guidance to take into account vaccination status at this time. All staff should be wearing source control masks as described above. All staff in patient or resident care areas should also be wearing eye protection if [county transmission levels](#) are moderate to high as part of the universal precautions in areas with higher community transmission levels.

Are masks necessary behind plexiglass? Is eye protection necessary behind plexiglass?

Settings affected: All facility types

Yes, these barriers do not provide the same protection as a mask or eye protection. Per CDC's field unit support team in 2020: "As to engineering controls such as plexiglass barriers, though this has been used in workplace settings such as retail point of sale and reception desks, there are considerations for installation in residential settings and CDC does not have an official position on this for nursing home or long-term care residential settings.

Important considerations are that barriers do not provide zero risk solution, barriers do not replace the need to maintain 6 feet of separation between individuals, and they do not replace the need to practice good hygiene (washing hands, not touching your face), the need to wear face coverings. Plexiglass barriers are nonporous and should be routinely disinfected.

More information regarding considerations for plexiglass barriers and installation can be found [here](#), though this has not been reviewed by CDC subject matter experts."

When can HCP take their source control mask off? *Settings affected: All facility types*

Per [CDC](#), "In general, fully vaccinated HCP should continue to wear source control while at work. However, fully vaccinated HCP could dine and socialize together in break rooms and conduct in-person meetings without source control or physical distancing. If unvaccinated HCP are present, everyone should wear source control and unvaccinated HCP should physically distance from others."

Unvaccinated HCP should wear source control at all times when not eating or drinking. This new guidance regarding masks in staff-only spaces should really be fairly limited in practice for most staff who will be in patient/resident care areas for the vast majority of their day.

Can staff in facilities without cases wear cloth face masks? *Settings affected: All facility types*

Textile (cloth) face coverings are intended primarily for source control in the community. They are not personal protective equipment (PPE) appropriate for use by health care personnel as the degree to which cloth masks protect the wearer might vary. [HCP](#) should wear medical-grade PPE for source control and PPE purposes while in their workplace.

Screening

If EMS or a medical transporter was screened at the start of a 7 am shift, why should a LTCF also screen them at noon? *Settings affected: LTC*

The LTCF still needs to protect its residents, so if their plans indicate screening transporters, they should do that. Transporters could also develop symptoms after an early morning check. While other organizations are supposed to be symptom monitoring, you don't know how each organization is doing these checks. As long as it is not an emergency situation, all who enter a LTCF should be screened for all COVID symptoms, including staff, visitors, and contractors.

Do we still need to screen residents daily for all COVID symptoms? *Settings affected: LTC*

CDC's [LTC infection control guidance](#) indicates that all residents should be evaluated at least daily, including for fever and all [symptoms consistent with COVID-19](#). This should also ideally include an assessment of oxygen saturation via pulse oximetry.

Residents who are suspected or confirmed to be positive for COVID-19 should have that monitoring increased to at least three times per day, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify changes in condition rapidly.

Do we really need to screen staff still at the start of the shift? *Settings affected: All facility types*

The [CDC general infection control guidance for all settings](#) indicates that facilities should “establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for [symptoms of COVID-19](#), or exposure to others with suspected or confirmed SARS-CoV-2 infection and that they are practicing source control.

- Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, people report absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not been exposed to others with SARS-CoV-2 infection during the prior 14 days.

- Fever can be either measured temperature $\geq 100.0^{\circ}\text{F}$ or subjective fever. People might not notice symptoms of fever at the lower temperature threshold that is used for those entering a healthcare setting, so they should be encouraged to actively take their temperature at home or have their temperature taken upon arrival.”

For nursing homes, [QSO-20-38-NH REVISED](#) indicates “regardless of the frequency of testing being performed or the facility’s COVID-19 status, the facility should continue to screen all staff (each shift), each resident (daily), and all persons entering the facility, such as vendors, volunteers, and visitors, for signs and symptoms of COVID-19.”

The Division of Quality Assurance is also checking on HCP screening practices as part of the survey process due to the CDC guidance language in use as the standard of practice.

Special Populations

What about special populations (e.g., memory care, cognitive disabilities) or those from more community-based facilities who don’t or won’t stay in their rooms or wear masks when advised? What can help with this? *Settings affected: All facility types with special populations, particularly LTC*

CDC offers some considerations for [Memory Care Units in LTCFs](#). Staff should try to provide frequent reminders for residents who can medically wear a mask and offer frequent hand hygiene opportunities. Trying to keep routines and staffing as consistent as possible can help to maintain comfort and offering activities that reinforce physical distancing can help even when residents are unable to keep masks on.

The DHS Division of Quality Assurance also has a [section](#) with tips for residents with dementia, as do organizations like the [Alzheimer’s Association](#).

Visitors

Is proof of visitor vaccination necessary? *Settings affected: All facility types*

Facilities can ask about vaccination status during the screening intake process to inform education for the visit, but they should be taken at their word and do not need to provide proof of visitation. If a visitor refuses to answer the question, they should be given the education for those unvaccinated.

Are fully vaccinated visitors allowed to visit if they have had a COVID-19 exposure but are not experiencing symptoms? *Settings affected: All facility types*

Per [CDC](#), “Visitors should be screened and restricted from visiting, regardless of their vaccination status, if they have: current SARS-CoV-2 infection; symptoms of COVID-19; or prolonged close contact (within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period) with someone with SARS-CoV-2 infection in the prior 14 days or have otherwise met criteria for quarantine.”