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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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:


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

For COVID, N95 respirators or equivalent or higher-level respirators should be used for all aerosol-generating procedures when located in a county with substantial or high transmission or if the patient/resident is suspected or confirmed for a SARS-CoV-2 infection. As part of routine practices, health care personnel (HCP) should be
applying **standard precautions** and **transmission-based precautions**. HCP should always deliberately assess potential risks of exposure to infectious material before engaging in activities and procedures in health care delivery.

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

Per CDC, explore options, in consultation with facility engineers, to improve ventilation delivery and indoor air quality in all shared spaces. 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 health care facilities](#), which also provides [COVID-19 technical resources for health care facilities](#)
- [Ventilation in Buildings](#) resource from CDC, which includes options for non-clinical spaces in health care facilities

HCP should clean and disinfect environmental surfaces and shared equipment before the room is used for another patient.

**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)

Source control and physical distancing (when physical distancing is feasible and will not interfere with the provision of care) are recommended for everyone in a health care setting. Even if the HCP is fully vaccinated, they should wear source control when they are in areas of the health care facility where they could encounter residents (e.g., dining room, common halls/corridors).

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

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.

If self-serve stations are offered, below are some considerations:

- 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.
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. To be compliant with physical distancing, consider two shifts to keep the total number of residents and staff at a minimum.

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.

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 immediately (but not earlier
than 2 days after the exposure) and, if negative, again 5-7 days after the 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 HCP risk assessment guidance, work restriction of asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days and asymptomatic HCP who are fully vaccinated is not necessary unless they develop symptoms, test positive for SARS-CoV-2 infection, or are otherwise directed to do so by the jurisdiction’s public health authority. 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. Having immediate and 5-7 day post-exposure testing may not be enough, consider more frequent testing and have a low threshold for symptom monitoring.

- **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](https://www.cdc.gov/infectioncontrol) applies to all health care settings as indicated above. There are also special setting-specific guidelines for areas like [nursing homes and long-term care facilities](https://www.cdc.gov/longtermcare/) 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](https://www.cdc.gov/longtermcare/index.htm) has a section covering new admissions 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 ideally 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.
Asymptomatic, fully vaccinated residents and residents within 90 days of a SARS-CoV-2 infection 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, even if they have a negative test upon admission.

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 an outbreak. 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 to discontinue transmission-based precautions could be considered for some patients (e.g., those who are moderately to severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the patient being infectious for more than 20 days. The test-based strategy can be used to end isolation early for the positive individual if results are negative from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative PCR specimens). That does not end the outbreak, however, just the positive case’s isolation. Outbreak testing still needs to be completed per CMS guidance. 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.”

Source control and physical distancing (when physical distancing is feasible and will not interfere with the provision of care) are recommended for everyone in a health care setting, including visitors. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission.

Source control options for HCP include:

- A NIOSH-approved N95 or equivalent or higher-level respirator OR
- A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators (note: these should not be used instead of a NIOSH-approved respirator when respiratory protection is indicated) OR
- A well-fitting facemask.

When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH-approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH-approved N95 or equivalent or higher-level respirator during the care of a patient with SARS-CoV-2 infection, facemask during a surgical procedure or during care of a patient on droplet precautions), they should be removed and discarded after the patient care encounter and a new one should be donned.

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.

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.

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.

When should PPE be removed? Should PPE be removed when using the restroom or going on break?

Settings affected: All facility types

Evidence-based best practice recommends removing PPE and performing hand hygiene before leaving the patient/resident care environment. Depending on the care setting, it is ideal to remove PPE at the doorway before leaving a patient/resident room or in an anteroom and perform hand hygiene after removal. Proper removal of PPE is a core principle of Preventing Transmission of Infectious Agents in Healthcare Settings. If HCP accidentally wear PPE in the restroom, they should discard it and don new PPE, including disinfection of any reusable PPE (e.g., eye protection), prior to entering a resident/patient care area again.

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. 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.
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.

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

Eye protection should be removed when leaving the patient/resident care area. As soon as staff re-enter a patient/resident area, they should don their 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.

**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 and PPE use. 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**

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.

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

Source control and physical distancing (when physical distancing is feasible and will not interfere with the provision of care) are recommended for everyone in a health care setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission levels or who have:

- Not been fully vaccinated; or
- Suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
- Had close contact (patients and visitors) or a higher-risk exposure (HCP) with someone with SARS-CoV-2 infection for 14 days after their exposure, including those residing or working in areas of a health care facility experiencing SARS-CoV-2 transmission (i.e., outbreak); or
- Moderate to severe immunocompromise; or
- Otherwise had source control and physical distancing recommended by public health authorities.
While it is generally safest to implement universal use of source control for everyone in a health care setting, the following allowances could be considered for **fully vaccinated individuals** (who do not otherwise meet the criteria described above) in health care facilities **located in counties with low to moderate community transmission**. Fully vaccinated people might choose to continuing using source control if they or someone in their household is immunocompromised or at **increased risk for severe disease**, or if someone in their household is unvaccinated.

- **Fully vaccinated HCP:**
  - Consistent with [guidance for the community](#) could choose not to wear source control or physically distance when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms, kitchen).
  - They **should wear source control** when they are in areas of the health care facility where they could encounter patients/residents (e.g., hospital cafeteria, common halls/corridors).

**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. [CMS notes](#) that EMS personnel do not need to be screened, so they can attend to an emergency without delay.
Do we still need to screen residents daily for all COVID symptoms? *Settings affected: LTC*

CDC’s [LTC infection control guidance](https://www.cdc.gov/coronavirus/2019-ncov/patient/infection-control-guidance.html) 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.

Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to identify and quickly manage serious infection.

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](https://www.cdc.gov/coronavirus/2019-ncov/patient/infection-control-guidance.html) indicates to establish a process to identify anyone entering the facility, regardless of their vaccination status, who has any of the following so that they can be properly managed: 1) a positive viral test for SARS-CoV-2, 2) symptoms of COVID-19, or 3) who meets criteria for [quarantine](https://www.cdc.gov/coronavirus/2019-ncov/patient/quarantine.html) or [exclusion from work](https://www.cdc.gov/coronavirus/2019-ncov/patient/exclusion.html).

- Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which individuals can self-report any of the above before entering the facility.

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*

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. Although no longer updated, CDC previously offered some considerations for [Memory Care Units in LTCFs](https://www.cdc.gov/coronavirus/2019-ncov/patient/long-term-care/long-term-care-units.html):
- Limit the number of residents or space residents at least 6 feet apart as much as feasible when in a common area, and gently redirect residents who are ambulatory and are in close proximity to other residents or personnel.
- Frequently clean often-touched surfaces in the memory care unit, especially in hallways and common areas where residents and staff spend a lot of time.
- If suspected or confirmed to have COVID-19, it may be challenging to restrict residents to their rooms, implement universal use of eye protection and N95 or other respirators (or facemasks if respirators are not available) for all personnel when on the unit to address potential for encountering a wandering resident who might have COVID-19.

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*

While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation.

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*

Visitors meeting any of the three below criteria should generally be restricted from entering the facility until they have met criteria to end isolation or quarantine, respectively.

1) A positive viral test for SARS-CoV-2
2) Symptoms of COVID-19
3) Meets criteria for quarantine or exclusion from work

Additional information about visitation for nursing homes and intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities is available from CMS.