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Updated Interim Guidance for Nursing Homes and Other Long-Term Care Facilities and Programs: Phased Reopening

This interim guidance provides guidelines for nursing homes and other long-term care (LTC) facilities to ease restrictions that were instituted to mitigate the spread of COVID-19. The guidance in this document is specifically intended for facilities as defined in the Nursing Home Care Act (210 ILCS 45), and also applies to Supportive Living Facilities, Assistive Living Facilities, Shared Housing Establishments, Sheltered Care Facilities, Specialized Mental Health Rehabilitation Facilities (SMHRF), Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), State-Operated Developmental Centers (SODC), and Medically Complex/Developmentally Disabled Facilities (MC/DD). Modifications for specific categories of LTC facilities and programs are provided in the Appendix.

Background

The risk of COVID-19 transmission within nursing homes and other LTC facilities is high due to congregate living. In addition, residents of these facilities are highly vulnerable to severe illness from COVID-19 due to advanced age and underlying health conditions. Therefore, decisions to relax restrictions should be undertaken with care and caution. At the same time, Illinois Department of Public Health (IDPH) acknowledges the importance of considering the quality of life of residents.

Early in the pandemic, the Centers for Medicare and Medicaid Services (CMS) mandated the highest level of mitigation for nursing homes (QSO-20-14-NH, revised March 13, 2020). Restrictions included exclusion of all visitors, except in certain compassionate care situations, together with cancellation of communal dining and all group activities. CMS subsequently issued guidance for phased reopening of nursing homes (QSO-20-30-NH, "Nursing Home Reopening Recommendations for State and Local Officials," May 18, 2020; FAQ, June 23, 2020). Phases 1, 2, and 3 in this document correspond to the CMS numbering convention.

This IDPH guidance document draws on currently available best practice recommendations. It is largely based on the CMS sources cited above, together with interim guidelines from the Centers for Disease Control and Prevention (CDC). IDPH will revise and update this document as needed, based on accrued experience, new information, and future guidance from CMS and CDC.

Definitions

Staff – following the definition from CDC: “[Staff] include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).”

Facility-onset case – following the definition from CMS (QSO-20-30-NH): “a COVID-19 case that originated in the facility; not a case where the facility admitted an individual from a hospital with known COVID-19 positive status, or an individual with unknown COVID-19 status that became COVID-19 positive within 14 days after admission.”

State-authorized personnel – Individuals who have a legal duty to provide specified services to residents of long-term care facilities. They include, but are not limited to: representatives of the Office of the State Long-Term Care Ombudsman Program, the Office of State Guardian, and the Legal Advocacy Service; and community-service providers or third parties serving as agents of the State for purposes of providing telemedicine, transitional services to community-based living, and any other supports related to existing consent decrees and court-mandated actions, including, but not limited to the Prime Agencies and sub-contractors of the Comprehensive Program serving the Williams and Colbert Consent Decree Class Members.

Eligibility criteria for advancing to successive CMS phases

Each individual facility must meet specific requirements to advance to each successive CMS phase. Thus, different facilities in the same community may be in different phases of reopening. The eligibility requirements for advancing are as follows:

- **Case status in the community.** The state is divided into eleven geographic Illinois COVID Regions for the purpose of monitoring and mitigating resurgence of COVID-19. Indicators are calculated daily for each region and compared to pre-established threshold values for: (a) test positivity rate; and (b) a composite metric of COVID-19 hospital admissions and hospital resource capacity. Both indicators must have been within their target ranges for at least 14 days before long-term facilities in that region can advance to the next CMS phase.
- **Case status in the facility.** A facility must spend a minimum of 14 days in a given CMS phase, with no new facility-onset COVID-19 cases, before advancing to the next CMS phase.
 - A certified local health department may require an interval longer than 14 days for its jurisdiction.
 - If a resident develops facility-onset COVID-19, the facility must immediately revert to the highest level of mitigation and start the CMS phases over.

- **Staffing level.** The facility has sufficient staffing that it is not operating with a contingency or crisis staffing strategy, as defined by CDC.¹
- **PPE supply and usage; essential cleaning and disinfection supplies** to care for residents. The facility has sufficient personal protective equipment (PPE) that it is not operating at crisis capacity, as defined by CDC.² (The facility may operate at contingency PPE capacity.) All staff must wear appropriate PPE when indicated.
- **Universal screening.** The facility must have a written policy that states where, when, how, and by whom screening will be performed and recorded. The facility must use a checklist-based screening protocol, administered verbally and recorded in written or electronic format, for each person entering the facility, including all staff, visitors, and other persons. The facility must deny access if any findings are positive. The facility must retain screening records according to the facility's record retention policy, but not for less than 30 days. Screening must check for each of these exclusion criteria:
 - measured body temperature of 100.0 degrees or more;³
 - symptoms of COVID-19, as listed by CDC;⁴
 - diagnosis of COVID-19 before completing the appropriate period of isolation;⁵ or
 - prolonged close contact with a person with COVID-19 while not using appropriate PPE during the prior 14 days.⁶

All residents are to be screened for elevated body temperature, pulse oxygen level, and symptoms of COVID-19, as listed by CDC, at least daily.
- **Universal source control and hand hygiene.** All staff are trained in proper hand hygiene.⁷ Everyone entering the facility must perform hand hygiene upon entry. Everyone entering the facility must wear facemasks or respirator, as appropriate, and additional PPE, as appropriate, except during breaks in designated break areas. All residents must wear a cloth face covering or facemask when outside of their rooms and when staff enter their rooms.
 - If, due to a medical condition or a disability, a resident cannot tolerate or would be unable to remove a cloth face covering or facemask, then a face shield may be substituted as a second-best alternative.
 - If, due to a medical condition or a disability, a staff member cannot tolerate a facemask, and the staff member requests a reasonable accommodation under the Americans with Disabilities Act or the Illinois Human Rights Act, then the employer will determine whether such an accommodation can be provided while fully protecting the health and safety of that employee, other staff members, and residents of the facility, and without causing an undue hardship to the employer.
- **Testing plan and response strategy.** A written COVID-19 testing plan and response

¹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>

² <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>

³ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

⁴ <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

⁵ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

⁶ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

⁷ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html>

strategy is in place, based on contingencies informed by the CDC.⁸

- The testing plan specifies the method(s) and locations of testing (laboratory and/or point-of-care);
- *For nursing homes, the testing plan includes:* initial (i.e., baseline) facility-wide testing; routine periodic retesting of staff; testing and repeated retesting of residents and staff in response to an outbreak or a single new, facility-onset COVID-19 case in a resident or a single new case of COVID-19 infection in a staff member; follow-up plans if no new cases are identified on repeated retesting for at least 14 days after a positive test in the facility.
 - Initial testing includes all residents and staff (“facility-wide baseline testing”)
 - In response to an outbreak, or a single facility-onset COVID-19 infection in a resident, or a single new case of COVID-19 infection in a staff member, testing of all previously negative residents and staff occur. Repeated retesting continues, generally every 3 to 7 days, until the testing identifies no new cases of COVID-19 infection among residents or staff for a period of at least 14 days.
 - If a facility has had no new cases within the past 28 days, then retesting of staff occurs as follows:
 - Regular retesting of staff occurs and the default frequency is weekly.
 - However, if the local health department endorses a lower frequency of testing for staff at facilities within its jurisdiction, based on the prevalence of COVID-19 in the county and considering the logistics of repeat large scale testing (for example, weekly testing in areas with moderate to substantial community transmission vs. less frequent testing in areas with minimal to no community transmission),⁹ then facilities in that jurisdiction that have had no new, facility-onset cases within the past 28 days may test staff at the lower frequency.
 - In a facility that has had no cases within the past 28 days, periodic retesting of staff can be done on a fractional basis (for example, 50% of the staff on each testing occasion), provided that all staff are tested at the target frequency. A positive finding still must trigger immediate, facility-wide testing.
- *For LTC facilities other than nursing homes, the testing plan includes:*
 - In response to an outbreak, or a single facility-onset COVID-19 infection in a resident, or a single new case of COVID-19 infection in a staff member, testing of all previously negative residents and staff occurs. Repeated retesting continues, generally every 3 to 7 days, until the testing identifies no new cases of COVID-19 infection among residents or staff for a period of at least 14 days.
 - Optionally, if a facility has had no new cases within the past 28 days, then initial testing of all residents and staff (“facility-wide baseline testing”) occurs, followed optionally by repeated staff testing as for nursing homes.
- Asymptomatic persons with a history of a positive COVID-19 test generally should not be retested

⁸ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

⁹ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html>

- A policy is in place for addressing residents and staff that refuse testing in each of the following situations: (a) symptomatic, or (b) asymptomatic.
- Testing results are reported to IDPH and certified local health department in accordance with applicable regulations; records are retained according to the facility's record retention policy.
- The response plan includes provisions for designating resident care areas with dedicated staff if residents become symptomatic ("PUI unit") or test positive for COVID-19 (COVID-19 unit).^{10,11}
- The long-term care facility, if licensed or regulated by IDPH, submits its testing and response plan on request by IDPH or by the certified local health department.

Procedure for moving between CMS phases or applying tiered mitigation

Advancing to the next CMS phase. A facility must satisfy all the criteria and must spend a minimum of 14 days in a given CMS phase, with no new, facility-onset COVID-19 cases, before advancing to the next CMS phase. The facility's administration performs a self-assessment of the facility's state of readiness for advancing, using the checklist of criteria provided above in the section, "Eligibility criteria." To mark advancement to the next CMS phase, the administrator or designee first attests to the facility's readiness and intent to advance, via the online portal found at <https://redcap.link/LTCreopening>.

The facility then notifies residents, their families or guardians, the Long-Term Care Ombudsman, and the local health department of the new CMS phase and of relevant operational changes. Facilities should meet this requirement by using multiple communication channels, such as email listservs, social media, website postings, recorded telephone messages, and/or paper notification.

Returning to a previous CMS phase. Either of the following criteria trigger regression to an earlier CMS phase:

- If the facility identifies a new, facility-onset COVID-19 case in any phase of reopening, then the facility must revert immediately to the highest level of mitigation and start over in the phases of reopening.
- If any other criterion for the current CMS phase is no longer fulfilled – for example, if staffing or PPE are no longer above threshold levels, or if testing is no longer being performed at appropriate intervals – then the facility must revert to the previous CMS phase until the criterion is fulfilled.

If CMS phase regression occurs, the facility must notify residents, their families or guardians, the Long-Term Care Ombudsman, and the local health department of the new phase and of relevant operational changes. Multiple communication channels should be used, just as for notification of phase advancement.

¹⁰ <https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html>

¹¹ <https://www.cdc.gov/coronavirus/2019-ncov/community/community-mitigation.html>

Tiered mitigation. If health metrics indicate resurgence of COVID-19 within one of the eleven defined Illinois COVID Regions, then IDPH will consider mitigation options for various settings within that region from a tiered menu. If sustained increases in health metrics continue unabated despite initial measures, further mitigations may be added from additional tiers. Actions for long-term care facilities triggered by regional resurgence are shown in the following table:

Mitigation	Tier 1	Tier 2	Tier 3
Visitation	Suspend indoor visits. Continue outdoor visits.	<i>Same as Tier 1</i>	Suspend all visits except for compassionate care
Communal Dining	Continue	Continue	Suspend
Group Activities	Continue, without outside leaders or off-site outings.	Same as Tier 1, plus limit to 10 participants.	Suspend
Barber and Beauty Shop	Suspend	Suspend	Suspend

If resurgence metrics exceed threshold within one of the eleven Illinois COVID Regions and mitigation measures are applied to long-term care facilities in that Region, then LTC facilities must wait at least 14 days after metrics return to their target ranges before reversing tiered mitigation.

Mitigation options from a tiered menu may also be considered under other circumstances:

- A facility may voluntarily apply mitigation measures, if deemed necessary in accordance with the facility’s internal policies for infection control.
- IDPH or the local health department (LHD) may direct a facility to apply temporary mitigation measures pending correction of deficiencies in its infection control program that are identified in a regulatory survey.

If tiered mitigation measures are applied, then the facility must notify residents, their families or guardians, the Long-Term Care Ombudsman, and the local health department of relevant operational changes, as for phase advancement or regression.

Guidance for CMS Phase 1

Virtual visitation. During CMS Phase 1, the facility should make virtual visitation available to all resident through videoconferencing. Virtual visitation should be available at a frequency not less than twice weekly, on a schedule that accommodates residents and their virtual visitors to the greatest extent practicable. The facility should have in place a policy and the requisite technology for virtual visitation. Virtual visitors may include, but are not limited to: family, friends, and clergy.

Compassionate care visitation. In-person visitation is generally prohibited, except in situations of compassionate care.

- Compassionate care visits are considered on a case-by-case basis. Situations warranting consideration are not limited to the end of life. Other cases that may be considered could include a resident whose health status has sharply declined or a resident whose close relative or close friend recently passed away.
- Pre-screen compassionate care visitors by phone using a written, checklist-based screening protocol (see *Universal Screening*, above), required less than 24 hours in advance; re-screen with the same protocol on arrival, as for all other persons entering the facility, including temperature check. (Facilities cannot require viral testing of visitors as part of screening unless they offer point-of-care testing at no charge.)
- Notify all visitors upon arrival that, if they develop symptoms of COVID-19 within 3 days after visiting, they must immediately notify the facility.
- Compassionate care visitors are restricted to the room where the visitation will occur.
- Supervise every visit to ensure infection control practices are used, including that the visitor keeps at least a six-foot separation between themselves and the resident, that the visitor wears a cloth face covering or facemask continuously, and that the visitor practices proper hand hygiene. The facility may determine whether supervision is continuous or intermittent.

State-authorized personnel. The Department grants authorization for entry to state-authorized personnel. They should not be classified as visitors. All such individuals must promptly notify facility staff upon arrival and follow all screening protocols established by the facility. [*For details, see this IDPH guidance document: "Access to Hospital Patients and Residents of Long-Term Care Facilities by Essential State-Authorized Personnel," April 17, 2020.*]

Communal dining. In CMS Phase 1, communal dining is not recommended but may be considered on a limited and modified basis. If it is implemented, then follow guidance for communal dining under CMS Phase 2.

Group activities. Engagement through technology is preferred to minimize opportunity for exposure.

- Facilities are encouraged to offer programming to engage virtually, where possible, in activities that improve quality of life such as worship services, musical events, etc.
- In-person group activities are not recommended in CMS Phase 1 but may be considered. If group activities are implemented, do so on a limited basis and follow guidance for group activities under CMS Phase 2.

Medical Trips. Use telemedicine to the extent practicable. Avoid trips that are not medically necessary. For medically necessary trips away from the facility:

- Share the resident's COVID-19 status with transport staff, any attendant persons, and with the appointment destination.
- Screen the transport staff, patient, and any attendant persons for elevated temperature and COVID-19 symptoms before entry into vehicle.
- Limit occupancy in vehicle based upon ability to maintain 6-foot separation.
- Driver must wear a facemask or cloth face covering and use additional PPE as indicated by CDC guidelines; resident must wear a cloth face covering or facemask.

- Assist resident in performing hand hygiene on departure from facility and upon return to facility.
- Disinfect transport equipment and commonly touched surfaces, including vehicle handles and seatbelts, before and after transport.
- Maintain social distancing, cloth face covering or facemask, and hand hygiene throughout time spent at the destination.
- Upon return of a resident from a trip outside the facility, observe and monitor closely for development of symptoms during the following 14-day period.
 - Some facilities may choose to adopt a policy to manage all residents who go off-site as potentially exposed and use full Transmission-Based Precautions (TBP), and/or cohort these residents, upon return.
 - Other facilities may choose to adopt a policy to make case-by-case decisions on whether to place such residents into TBP, based on an assessment of the potential for exposure while away.

Guidance for CMS Phase 2

All eligibility criteria for phase advancement must be met for a facility to enter CMS Phase 2. This includes the regional resurgence metrics. Thereafter, these conditions must be met continuously for the facility to remain in CMS Phase 2.

- If any resident of the facility develops new, facility-onset COVID-19, then the facility must immediately revert to the highest level of mitigation and start the CMS phases over.
- If the facility no longer meets any other criterion for phase advancement, apart from regional COVID-19 health metrics, then the facility must revert to CMS Phase 1 until the criteria are fulfilled.
- If the facility's Region no longer meets targets for health metrics, then all facilities in the Region are subject to tiered mitigation.

Indoor compassionate care visitation. Indoor visitation is generally prohibited in CMS Phase 2, except in situations of compassionate care when outdoor visitation is not practicable. Indoor compassionate care visits are considered on a case-by-case basis. Situations warranting consideration are not limited to the end of life. Other cases that may be considered could include a resident whose health status has sharply declined or a resident whose close relative or close friend recently passed away. In such cases, proceed as in CMS Phase 1.

State-authorized personnel. Regarding State-authorized personnel, proceed as in CMS Phase 1.

Outdoor visitation. *[This section supersedes a previous IDPH guidance document, "Outdoor Visitation Guidance for Long-Term Care Facilities," June 18, 2020.]*

During CMS Phase 2, all residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure should be allowed to receive outdoor visitors safely, provided facility grounds have suitable space for the requirements described below. Residents in isolation or quarantine cannot receive visitors.

To conduct outdoor visitation, the facility must formulate a written visitation policy. This policy must balance clinical and safety considerations of infection control with the resident's right to receive visitors [42 CFR § 483.10(f)(4)]. The facility should develop a short, easy-to-read fact sheet on visitation policy for residents and visitors, distributed to residents and posted on the facility's website. Visitors are required to comply with the facility's visitation policy. If a visitor refuses to follow the facility's policy during the visit, then staff may end the visit.

The outdoor visitation policy must address the following points:

- Designate outdoor space for visitation.
 - Visits may take place under a canopy or tent without walls.
 - Outdoor space must have separate ingress and egress which do not require visitors to enter the facility's building. Visitors must not enter the facility at any time.
- Measure the designated outdoor space and determine the number of residents and visitors that can be accommodated at one time in that area with at least six-foot separation between residents and their visitors
 - Consider marking the ground to show how visitors can place themselves with at least six-foot separation.
 - Post maximum number of residents and visitors that can occupy the area
 - Post signage to cue six-foot separation, face covering, and hand hygiene;
 - Set up dispensers for alcohol-based hand rub (AHBR)
- Designate outdoor visitation hours when staff for screening and supervision of visitors will be available.
- Limit visitation to two visitors at a time per resident. The visitors, if two, must be from the same household. Specify whether exceptions can be made for compassionate care situations.
- Create an appointment schedule with time slots for each visitation area.
 - Schedule visits by appointment only; specify start, end time, and location for each visit.
 - Limit sign-ups to the allowed number of visitors in each time slot and visitation area.
 - If demand for appointment slots may exceed availability, set limits on the number of slots per week or per day for each resident
- Pre-screen visitors by phone using its checklist-based screening protocol (see section on Universal Screening, above), required less than 24 hours in advance; re-screen with the same protocol on arrival, as for all other persons entering the facility, including temperature check. (Facilities cannot require viral testing of visitors as part of screening unless they offer point-of-care testing at no charge.)
- Maintain a record of all visitors with contact information, for potential contact tracing:
 - Record date and time of visit, name, address, telephone; email address if available;
 - Make records available to state and local health department for inspection and, as needed, for contact tracing; retain at least 30 days.
- Notify all visitors upon arrival that, if they develop symptoms of COVID-19 within 3 days after visiting, they must immediately notify the facility.

- Supervise every visit to ensure infection control practices are utilized, including that visitors keep at least a six-foot separation between themselves and the resident, that the visitor continually wears a cloth face covering or facemask, and that the visitor practices proper hand hygiene. The facility may determine whether supervision is continuous or intermittent.
- If feasible, the facility may construct an outdoor conversation booth for residents unable or unwilling to wear a mask.
 - The conversation booth is constructed as a three-sided box with transparent walls at least three feet higher than the seated height of the occupant and the visitor.
 - The resident sits inside the box and the visitor sits opposite the front wall.
- Clean and disinfect seating and other touched surfaces in the visitation area between visitors.

Modified communal dining. Communal dining may be considered, with a maximum of 25% of seating capacity. To conduct communal dining on a limited basis:

- Allow participation only by residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- Limit number of residents in dining area at a time to the maximum allowed by 6-foot separation; serve diners in shifts as needed.
- Organize residents to enter the dining room one at a time and to take tables starting in the back and then filling in toward the front; after the meal, exit one at a time in reverse order, starting from the front (last in, first out).
- Residents should wear face covering or masks in the dining area when not eating or drinking.
- Maintain at least 6-foot separation between diners.
- Staff must perform hand hygiene and change PPE as appropriate in between assisting residents.
- Clean and disinfect surfaces between shifts of diners.

Small-group activities. Group activities may be considered for activities that improve the quality of life for residents, with a maximum of ten (10) residents at an activity. To conduct activities on a limited basis:

- Allow participation only by residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- Outdoor activities, such as a stroll on facility grounds, are encouraged. Outings beyond the facility grounds are not permitted.
- Provide hand sanitizer stations.
- Use a sign-up process as needed to cap attendance at ten.
- Avoid crowding on ingress and egress.
- Maintain 6-foot separation, mask or face covering, and hand hygiene
- Sanitize items used in activity between users: game pieces, craft tools, etc.
- Avoid activities that involve multiple residents handling the same object (e.g., ball toss).
- For live music, avoid vocal performances and sing-alongs. Limit performances to instruments that can be played while wearing a mask.
- Worship services should avoid singing, chanting, and group recitation.

Medically Necessary Trips. Use telemedicine to the extent practicable. Avoid trips that are not medically necessary. For medically necessary trips away from of the facility, proceed as in CMS Phase 1.

Guidance for CMS Phase 3

All eligibility criteria for phase advancement must be met for a facility to enter CMS Phase 3. This includes the regional resurgence metrics. Thereafter, these conditions must be met continuously for the facility to remain in CMS Phase 3.

- If any resident of the facility develops new, facility-onset COVID-19, then the facility must immediately revert to the highest level of mitigation and start the CMS phases over.
- If the facility no longer meets any other criterion for phase advancement, apart from regional COVID-19 health metrics, then the facility must revert to CMS Phase 2 until the criteria are fulfilled.
- If the facility's Region no longer meets targets for health metrics, then all facilities in the Region are subject to tiered mitigation.

Visitation. *[This section supersedes a previous IDPH guidance document, "Outdoor Visitation Guidance for Long-Term Care Facilities," June 18, 2020.]*

During CMS Phase 3, all residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure should be allowed to receive outdoor or indoor visitors safely. Residents in isolation or quarantine cannot receive visitors.

Outdoor visits are strongly preferable to indoor visits, weather permitting. To conduct outdoor and indoor visitation, the facility must formulate a written visitation policy. This policy must balance clinical and safety considerations of infection control with the resident's right to receive visitors [42 CFR § 483.10(f)(4)].

The facility should develop a short, easy-to-read fact sheet on visitation policy for residents and visitors. This fact sheet should include emphasis that outdoor visits are strongly preferable to indoor visits, weather permitting. The facility should distribute the fact sheet to residents and post it on the facility's website. The facility should also make printed copies available at the visitors' lobby. Visitors are required to comply with the facility's visitation policy. If a visitor refuses to follow the facility's policy during the visit, then staff may end the visit.

The visitation policy must address the following points:

- Designate places for visitation with emphasis on outdoor spaces, weather permitting
 - Outdoor spaces (visits may take place under a canopy or tent without walls)
 - Indoor common areas;
 - In-room visitation is permissible for bedbound patients, provided that:
 - Room layout allows at least six-foot separation from the resident; or

- If six-foot separation is not possible due to room layout, then visitation is only permissible if a transparent room divider is in place between visitors and resident, at least one foot higher than the height of tallest visitor.
 - In-room visitation is also permissible for end-of-life and other compassionate care situations. Examples of other compassionate care situations are given above.
- Measure each visitation space and determine the number of residents and visitors that can be accommodated at one time in that area with at least at least six-foot separation between residents and their visitors.
 - Consider marking the floor or ground to show how visitors can place themselves with at least six-foot separation.
 - Post signage to cue six-foot separation, face covering, and hand hygiene
 - Post maximum number of residents and visitors that can occupy the area
 - Set up dispenser for alcohol-based hand rub (AHBR)
- Designate visitation hours when staff for screening and supervision of visitors will be available.
- Limit visitation to two visitors at a time per resident. The visitors, if two, must be from the same household. Specify whether exceptions can be made for compassionate care situations.
- Create an appointment schedule with time slots for each visitation area.
 - Schedule visits by appointment only; specify start, end time, and location for each visit.
 - Limit sign-ups to the allowed number of visitors in each time slot and visitation area.
 - If demand for appointment slots may exceed availability, set limits on the number of slots per week or per day for each resident
- Pre-screen visitors by phone using its checklist-based screening protocol (see section on Universal Screening, above), required less than 24 hours in advance; re-screen on arrival, as for all other persons entering the facility, including temperature check. (Facilities cannot require viral testing of visitors as part of screening unless they offer point-of-care testing at no charge.)
- Maintain a record of all visitors with contact information, for potential contact tracing:
 - Record date and time of visit, name, address, telephone; email address if available;
 - Make records available to state and local health department for inspection and, as needed, for contact tracing; retain at least 30 days.
- Notify all visitors upon entry that, if they develop symptoms of COVID-19 within 3 days after visiting, they must immediately notify the facility.
- Allow visitors only in locations designated for the visit, not in other areas in the facility.
- Provide PPE to visitors if indicated (indications may include multi-drug resistant organisms such as MRSA, etc.).
- Supervise every visit to ensure infection control practices are utilized, including that visitors keep at least a six-foot separation between themselves and the resident, that the visitor continually wears a cloth face covering or facemask, and that the visitor practices proper hand hygiene. The facility may determine whether supervision is continuous or intermittent.

- Clean and disinfect visitation area between visitors.

State-authorized personnel. Regarding State-authorized personnel, proceed as in CMS Phases 1 and 2.

Modified communal dining. To conduct communal dining, follow the same procedure as in CMS Phase 2, except that the number of diners per sitting may exceed limits set for Phase 2 if space allows six-foot separation.

Group activities. To conduct group activities such as resident council, chapel, game nights, book groups, musical events, etc.:

- Allow participation only by residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- Outdoor activities on facility grounds are encouraged.
- Maintain social distancing, hand hygiene, and masking or face covering
- For indoor activities, post the maximum number of persons that can be accommodated in the designated space while maintaining at least six-foot separation.
- Use a sign-up process as needed to cap attendance.
- Provide hand sanitizer stations.
- Avoid crowding on ingress and egress.
- Sanitize items used in activity between users: game pieces, craft tools, etc.
- Avoid activities that involve multiple residents handling the same object (e.g., ball toss).
- For live music, avoid vocal performances and sing-alongs. Limit performances to instruments that can be played while wearing a mask.
- Worship services should avoid singing, chanting, and group recitation.
- Group outings beyond the facility grounds may be considered, provided all the above precautions are observed, along with precautions listed below for trips that are not medically necessary.
 - Outdoor outings, such as a stroll in the park, are strongly preferable to outings to indoor destinations, weather permitting.
 - Avoid mass events like festivals, fairs, and parades.
 - Avoid other locations where it may be difficult to maintain six-foot separation.

Beauty salons and barber shops. To operate facility-based beauty salons and barber shops in CMS Phase 3:

- Allow services in beauty salons and barber shops only for residents who are not in isolation or quarantine due to known or suspected COVID-19 infection or exposure.
- The beautician or barber is subject to the same infection control requirements as staff, including but not limited to:
 - Testing for COVID-19 with the same frequency as for staff;
 - Screening for elevated temperature and COVID-19 symptoms;
 - Wearing a face mask; performing hand hygiene; and maintaining social distancing, except from a resident receiving service.
- The beautician or barber must remain in the salon area throughout their time in the facility. Services may not be provided in residents' rooms.

- Observe restrictions and precautions in *Personal Care Services Guidelines for Restore Illinois*. <https://dceocovid19resources.com/assets/Restore-Illinois/businessguidelines4/personalcare.pdf>. However, where IDPH guidelines in this document are more stringent, the IDPH guidance applies.
- Do not use hand-held blow dryers.

Medically Necessary Trips. For medically necessary trips away from the facility, proceed as in CMS Phases 1 and 2.

Trips That Are Not Medically Necessary. The decision on making a trip that is not medically necessary should preferably be made collaboratively by the resident, the resident’s family or health care surrogate, a facility representative, and, where appropriate, the resident’s physician. The facility representative should explain the facility’s policy regarding special precautions and/or quarantine that may be applicable following a trip away.

- Residents with symptoms consistent with COVID-19, or a confirmed case, must not make trips that are not medically necessary.
- Residents with high-risk comorbidities should avoid trips that are not medically necessary.
- Avoid use of public transportation or ride-hailing services.
- Observe the same restrictions and precautions as for medically necessary trips.

In the event of a conflict between this guidance document and any previously issued interim guidance from IDPH, this guidance takes precedence.

Questions about reopening may be directed to DPH.LTCreopening@illinois.gov.

Distribution: IL Licensed LTC Facilities, LHD Administrators, LHD Communicable Disease, IDPH Regional Offices

Appendix: Modifications for Other Long-Term Care Facilities and Programs

All categories of long-term care facilities covered by this guidance document should follow the recommendations provided, with modifications for specific categories of facilities and programs as provided below.

Assisted living facilities and other similar arrangements

For Assisted Living Facilities (ALF), Shared Housing Establishments (SHE), Sheltered Care Facilities, and Supportive Living Facilities (SLF), the following modifications are recommended:

Visitation. In CMS Phases 1 and 2, the general visitation rules apply to visitation at these facilities. In CMS Phase 3, facilities should follow these modifications:

- Indoor and outdoor visits do not need to be supervised.
- Visits can be in common areas or in residents' apartments, with six-foot separation and cloth face covering or masking by visitors and residents.

Dining. In all CMS phases, dining in apartments is encouraged. For dining in communal dining room, observe same rules as for other facilities in whatever CMS phase applies.

Facilities for people with developmental disabilities

Facilities for people with developmental disabilities face special challenges in limiting the spread of COVID-19. Residents of these facilities may have difficulty understanding and maintaining social distance, inability to tolerate or safely wear cloth face coverings, and need for assistance with hand hygiene. These factors may compound the risk of COVID-19 transmission in congregate living settings. An individualized approach for COVID-19 may be needed for individuals with physical and intellectual disabilities who have limited mobility and/or difficulty absorbing new information and making changes in their everyday routines.

For Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), State-Operated Developmental Centers (SODC), and Medically Complex/Developmentally Disabled Facilities (MC/DD), modifications to the guidance for nursing homes are recommended, as follows.

Face shields for residents who cannot tolerate masks. Residents in ICF/DD, SODC, and MC/DD facilities who cannot tolerate cloth face coverings or facemasks may be able to tolerate face shields. In such cases the face shield, although less protective than a face covering or mask, may be substituted as a second-best alternative for universal source control.

Community Day Services. Community Day Service (CDS) programs take place in a non-residential setting, separate from the participant's residential living arrangement. Typically, clients from various residential settings mingle in transport vehicles and at the CDS, increasing the risk of transmission among facilities.

A structured instrument, such as the "Illinois COVID-19 Risk Benefit Discussion Tool," will be helpful in weighing the risks and benefits of participation. Such tools are designed to facilitate discussion with the client, their family/guardian, and the service provider:

[https://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD/Illinois Risk Benefit Tool.pdf](https://www.dhs.state.il.us/OneNetLibrary/27897/documents/DD/Illinois_Risk_Benefit_Tool.pdf).

The Department of Human Services approved a very limited opening of CDS programs starting August 1, 2020. Participation is subject to adequate facility preparation and safety precautions as well as individual risk-benefit assessments. A larger opening is planned to start September 1, 2020, still subject to significant capacity restrictions and safety precautions, and contingent on trends in COVID-19 prevalence.

Specialized Mental Health Rehabilitation Facility (SMHRF)

Due to the behavioral health conditions of SMHRF residents, some clients may have difficulty complying with the recommendations for social distancing, hand hygiene, and use of face coverings. In these cases, facilities should consider a harm reduction approach with those residents who have difficulty with these measures. Continued engagement and encouragement will be needed.