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Memorandum

TO: Assisted Living Residences Executive Directors
FROM: Executive Office of Elder Affairs Secretary Elizabeth Chen
SUBJECT: Updated Guidance for Assisted Living Residences (ALRs) during the COVID-19 Public Health Emergency
DATE: March 17, 2021

On March 10, 2020, Governor Baker declared a state of emergency to support the Commonwealth's response during the COVID-19 outbreak. On March 15, 2020, the Department of Public Health (DPH) issued an order requiring Assisted Living Residences (ALRs) to implement visitation restrictions issued by the Executive Office of Elder Affairs (EOEA) to protect the health of residents and staff.

This guidance document is released in accordance with the DPH order, is in effect as of March 17, 2021 and replaces its predecessor issued on January 20, 2021.

This document will be amended and re-released to reflect necessary changes during the state of emergency based on ongoing performance measures (https://www.mass.gov/info-details/reopening-massachusetts).

New content changes from previously issued guidance are reflected in red text.

As of March 12, 2021, 98% of residents and 78% of staff in ALRs have been vaccinated through the Federal Pharmacy Partnership Program that provided on-site vaccinations for ALR residents and staff from January 11, 2021 to March 23, 2021. Overall vaccine uptake may vary by ALR; however, even more individuals will be vaccinated when the remaining clinics are completed in the coming weeks.

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1. General ALR Guidance:

A. Much remains unknown about whether individuals vaccinated against COVID-19 can transmit infectious virus, and place unvaccinated individuals at risk for serious illness.
B. Fully vaccinated individuals are defined as 14 days or more after their final dose. In a 2-dose series, like the Pfizer or Moderna vaccines, the individual is fully vaccinated 14 days or more after their second dose. After a single-dose vaccine, like Johnson & Johnson's Janssen vaccine, the individual is fully vaccinated 14 days or more after the single dose.
C. State and federal guidance about gathering safely will evolve as more of the population becomes fully vaccinated. ALRs should follow CDC and state guidance regarding household gatherings, and Massachusetts sector specific guidance regarding restaurant dining, entertainment, gym, close contact personal services, etc., where applicable.
D. ALR management should foster a supportive environment free from judgment that encourages staff and residents to self-identify as a potential virus carrier due to recent activities that might have placed them at high risk of contracting COVID-19 and to provide these individuals with appropriate tools to mitigate spread as referenced in this memorandum.
E. ALRs are required to submit incident reports for every new COVID-19 case and death for staff and residents within 24 hours.
    1) Critical Incidents must be submitted to EOEA via Dynamics using the flowing link: https://umassmedcwm05.crm.dynamics.com/apps/ui
    2) ALRs are Chapter 93 Elder Facility Reporters and therefore must report on COVID-19 cases and deaths among residents and staff and provide this information to the Department of Public Health within 24 hours of case or death identification. Data is reported through the REDCap system.

2. Additional Considerations During Times of High Community Transmission[1]

A. Strict adherence to infection control practices by all inside the ALR community is paramount to limiting in-house spread during times of high community transmission. ALRs should:
    1) Conduct regular and frequent infection control audits; [2]
    2) Designate infection control personnel to monitor and frequently circulate throughout the ALR to ensure adherence to infection control policies and procedures as referenced in this memorandum and CDC Guidance for Assisted

[1] **High Community Transmission** is defined as cities or towns designated yellow or red on the Weekly COVID-19 Public Health Report.

[2] The MA Department of Public Health has developed an outbreak prevention and management checklist for long-term care settings (see Appendix A). EOEA has adapted this tool to help ALRs mitigate the spread of COVID-19 and ensure the health and safety of residents and staff. This checklist is intended as a reference tool and does not replace DPH and EOEA guidance documents for the full recommendations and requirements for responding to COVID-19.

Living Facilities by residents, staff, and visitors, such as hand hygiene and PPE use. The ALR must implement corrective action immediately when non-adherence or incorrect use is observed. EOEA recommends reaching out to your industry organization (MassALA, LeadingAge) for additional resource recommendations with quality assurance and performance improvement experience.

B. Staff:
   1) Staff should not share assignments as this increases opportunity for virus spread from staff to resident, or resident to staff; and
   2) Staff should not congregate inside or outside the ALR, as this increases opportunity for staff to staff transmission.

C. ALRs with Special Care Units should:
   1) Consider ways to modify the environment to reduce potential for widespread virus spread, such as using temporary zip walls to divide the Residence into smaller sections that still allow for supervision and freedom of movement for residents. Such temporary zip walls can also be used as a tool to cohort positive and negative residents.
   2) Pay special attention to mitigating the potential for virus spread from staff to multiple residents when staff are assisting with medications, feeding, or providing other close contact care. Staff members should not care for both residents who are COVID-19 positive and not known to be infected.

D. Planned Resident Leave of Absences:
   EOEA recommends that residents do not participate in planned leaves of absence during times of high community transmission. If, however, a resident wants to schedule a planned leave of absence from the ALR, the facility clinical leadership should work with the resident and their loved ones to create a plan for a safer leave. This plan should include education for the resident and loved ones about:
   1) Wearing face coverings;
   2) Practicing physical distancing;
   3) Limiting interaction to the fewest number of people possible while the resident is on their planned leave;
   4) Limiting the interaction with loved ones to the fewest number of people possible for two weeks before the resident's planned leave/visit;
   5) Conducting an assessment about the possible exposure risks while the resident is on their planned leave and instructions about how to mitigate them.

3. Screening Non-Residents Before Entry to an ALR:

A. Application
   All non-residents must be screened prior to entry. ALRs should maintain a visitor log of all non-residents in the event contact tracing is required, regardless of the visitor's vaccination status.

B. Screening
Prior to entry, the ALR must screen non-residents for COVID-19 symptoms and exposure within the past 14 days, including:
1) a temperature check to determine whether an individual has a temperature equal to or greater than 100.0 F;
2) questions to determine if the individual has symptoms of an illness consistent with COVID-19 (see the box below) and screen for exposure within the past 14 days.

Symptoms consistent with COVID-19
• Fever (100.0° Fahrenheit or higher), chills, or shaking chills • Cough (not due to other known cause, such as chronic cough) • Difficulty breathing or shortness of breath • New loss of taste or smell • Sore throat • Headache • Muscle aches or body aches • Nausea, vomiting, or diarrhea • Fatigue • Nasal congestion or runny nose

Any individual with a temperature greater than 100.0 F, symptoms consistent with COVID-19 close contact with someone with COVID-19 infection in the prior 14 days must not be allowed to enter the ALR.

In emergency situations, EMS, police, and fire personnel should be permitted to go directly to the resident without undergoing screening or temperature checks.

Any individual who enters an ALR, who subsequently develops COVID-19 symptoms or has a positive test for COVID-19 within 48 hours, should notify the ALR of the date they were in the ALR, the individuals they were in contact with, and the locations within the ALR or the grounds they visited. Please refer to the full list of Covid-19 Symptoms.

4. Testing:

A. Testing of Staff and Residents: EOEA recommends that ALRs follow the latest Long term Care Surveillance testing Guidance issued by DPH; this guidance can be found here under *"For long term care facilities"*

B. Point of Care (POC) rapid diagnostic tests: ALRs should refer to the most up to date EOEA BinaxNow Guidance which can be found here under "*For assisted living residences*"

ALRs may have access to POC rapid diagnostic tests purchased directly or distributed by U.S. Department of Health and Human Services, including BinaxNOW test kits. This guidance applies only to BinaxNOW test kits supplied by DPH and does **not** apply to POC rapid diagnostic tests obtained by LTC Facilities from the federal government.

All positive POC rapid diagnostic tests must be followed up with PCR testing.

C. Testing Visitors:
   1) If an ALR has access to Point of Care (POC) Testing, it may elect to offer such testing to visitors upon arrival. If feasible, ALRs should prioritize POC Testing for visitors who visit regularly (e.g., weekly), though any visitor may be tested. **An ALR cannot require POC testing as a condition of resident visitations.**
   2) If an ALR utilizes onsite POC testing, the ALR must submit both positive and negative test results to the Department of Public Health's Bureau of Infectious Diseases and Laboratory Sciences (BIDLS). The spreadsheet attached to this guidance (Attachment B) includes the required data variables. Please send the completed spreadsheet to ISISImmediateDiseaseReporting@mass.gov along with primary contact details and the BIDLS team will follow up with you.
   3) In the event an ALR offers onsite POC testing as a screening tool for visitors and a visitor tests positive, the visitor must not be allowed to enter the ALR.

D. Surveillance Testing:

It is recommended that ALRs follow the Long-Term care Surveillance testing guidance from DPH. This memorandum applies to all long-term care settings including nursing homes, rest homes and assisted living residences (ALRs) and shall take effect on March 18, 2021. In consideration of decreasing indicators of community transmission and in recognition of the fact that many staff are now fully vaccinated, DPH is updating this surveillance testing memorandum to recommend ALRs to continue to conduct weekly testing of all staff, however staff who are fully vaccinated (14 days or more from receiving the final dose in the series) must only be tested every other week. Compliance with the testing program is recommended in ALRs. The Full guidance can be found here: DPH Guidance, March 12, 2021: Updates to Long-Term care Surveillance Testing

5. In-Person Visits

A. In Person Visits for Service Plans: In-person visits that are required to ensure the delivery of a Resident's service plan must be permitted in accordance with the above Screening protocols. These in-person visits include, but are not limited to persons who are:

   a) health and home care workers (RNs, physical therapists, home care aides, etc.);

b) family members providing or administering necessary medication that ALR staff are not allowed to provide;
c) family members or pharmacy employees dropping off medication for Limited Medication Administration or Self-Administered Medication Management.

d) If services deviate from a resident's service plan for any reason, then ALRs must document such deviation in the resident's progress notes.

B. Compassionate Care Visits: ALRs must accommodate compassionate care visits for residents. Compassionate care situations include end-of-life care as well as certain other situations. Examples of other types of compassionate care situations include, but are not limited to:

1) a resident who is struggling with a lack of physical family support;
2) a resident who is grieving after a friend or family member recently passed away;
3) a resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), and is experiencing weight loss or dehydration; or,
4) a resident, who used to talk and interact with others, is experiencing emotional distress, is seldom speaking, or is crying more frequently (when the resident had rarely cried in the past).

If the resident's unit is shared with an unrelated party, the ALR must safely accommodate the compassionate care visit.

C. Ombudsman Program and Legal Representation: Residents have the right to access the Ombudsman program and to consult with their legal counsel. When in-person access is not available due to infection control concerns, ALRs must take steps to facilitate resident communication by phone or alternate format.

D. Social Visits: A resident who is suspected or confirmed to be infected with COVID-19 and not yet recovered cannot participate in an in-person social visit. ALRs must require visitors to perform hand hygiene and be given a face mask if they do not have one.

1) Virtual Alternatives: ALRs may continue to use alternative electronic methods for virtual communication between residents and visitors, such as Skype, FaceTime, WhatsApp, or Google Duo to augment in-person visitation

2) In-person Social Visits: ALRs shall allow indoor and outdoor visits (weather permitting) with residents to occur in accordance with the CDC guidance regarding masks and safe distancing for small gatherings.

An ALR may allow in-person social visits in a designated outdoor space, designated indoor space, or in the resident's unit, provided that the ALR implements all required screening and infection control measures.

3) In-Unit Visits:
Visits in the resident's unit are allowed. ALRs should educate residents regarding the CDC guidance for masks and safe distancing for small gatherings.

4) Out of State Visitors: ALRs cannot implement policies for out of state visitors travelling to Massachusetts to visit ALR residents that are more restrictive than those put in place by the Commonwealth. Information on the requirements for out of state visitors can be found here. https://www.mass.gov/info-details/covid-19-travel-order

Out-of-state visitors are exempt from the requirements to fill out a travel form, self-quarantine, or obtain a negative COVID-19 test result if their travel is limited to brief trips for purposes that have been designated as Critical Life Activities. This allowance is limited to same-day travel to and from the location where the activity occurs and the time the person engages in the specified activity.

5) Suspending Access to ALR for In-Person Visits: ALRs may suspend in person visits upon identification of a suspected or confirmed COVID-19 Cluster. A COVID-19 Cluster is defined as two or more unrelated cases. Suspension of these services should be limited to the time necessary to determine whether the ALR has a COVID-19 Cluster. If it is determined there is not a COVID-19 Cluster, in person visits should resume following the infectious control procedure outlined above. In the event there is a COVID-19 Cluster, in person visits should resume once there have not been any new cases for 14 days.

If indoor in-person visits are suspended, the ALR must notify residents, their families and/or the legal representatives. The notification must include the reason for suspending indoor visits and the conditions necessary for resuming indoor visits. When it is determined that indoor visits can resume safely, the ALR must notify residents, their families and/or the legal representatives. Additionally, ALRs must designate a specific point of contact at the facility for resident families and/or legal representatives to contact with questions.

ALRs may not suspend compassionate care visits or services that are part of a resident's care plan.

6. Hand Hygiene

A. ALRs should refer to CDC guidance regarding hand hygiene. Staff should practice regular and frequent hand hygiene using an alcohol-based hand rub, including:

1) Immediately before touching a resident
2) Before performing an aseptic task (e.g., placing an indwelling device) or handling invasive medical devices
3) After caring for a person with known or suspected infectious diarrhea
4) Before moving from work on a soiled body site to a clean body site on the same patient
5) After touching a resident or the resident's immediate environment
6) After contact with blood, body fluids or contaminated surfaces
7) Immediately after glove removal

B. ALRs should encourage Residents to practice frequent hand hygiene throughout the day, **including before and after**:

1) Handling face masks;
2) Touching their eyes, nose, or mouth;
3) Dining;
4) Joining a group activity, and throughout the activity if objects are being shared; and,
5) Touching surfaces others have touched, such as elevator buttons, hydration stations, chair backs and arms in common areas, etc.

ALRs should encourage visitors to practice hand hygiene upon entry to the Residence and frequently throughout their visit.

7. Personal Protective Equipment (PPE):

A. Face Shield/Goggles:

- ❑ Staff should wear eye protection such as a face shield/goggles in addition to a facemask covering the nose and mouth when providing care to a resident, regardless of resident COVID-19 status.

- ❑ Staff should wear face shield/goggles throughout the day; face shield/goggles should be dedicated to one staff member and be disinfected after removal and before reusing. Hand hygiene should be performed after touching the face shield/goggles.

B. Face masks:

- ❑ Residents, visitors, and staff should continue to wear face masks in public spaces in the ALR regardless of vaccination status.

C. Gowns and gloves:

Staff should wear gowns and gloves, an N95 respirator or KN95 mask, and a face shield/goggles when caring for Residents who are confirmed or suspected to be COVID-19 positive. An individual exhibiting COVID-19 symptom or following close contact to another individual with COVID-19 and awaiting test results is considered Suspected COVID-19 positive.

Recovered individuals are those who have met the Centers for Disease Control and Prevention's (CDC) criteria for discontinuation of Home Isolation for Persons with COVID-19:.

- At least 10 days* have passed since symptom onset **and**
- At least 24 hours have passed since resolution of fever without the use of fever-reducing medications **and**
- Other symptoms have improved.

The following table summarizes recommended PPE use for both staff and residents:

Table 1 - Summary of Recommended PPE For Staff and Residents	
Staff PPE	**Situation**
Surgical mask	1. At all times in ALR , Governor Baker issued an Order effective November 6, 2020 requiring face masks or cloth face coverings. Read the full DPH Guidance. 2. Commuting to and from work using any shared transportation or carpool.
Surgical mask and face shield/goggles	When providing care to residents who are COVID-19 negative or who have recovered from COVID-19.
N95 respirator or KN95 mask, face shield/googles, gown, and gloves	When providing care to residents suspected or with confirmed COVID-19 infection. Gowns and gloves should be changed in between resident care.
Resident PPE	**Situation**
Face mask covering nose and mouth, as tolerated.	1. Outside resident's unit unless eating or drinking; and 2. Inside resident's unit when a person who does not live in the unit is present.

8. Surface Hygiene:

ALR staff should regularly disinfect surfaces, common areas, and designated visitation sites with a CDC approved disinfectant. Refer to the CDC for more information: https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-building-facility.html

9. Communal Dining and Group Activities:

A. Communal Dining: ALRs may allow communal dining. Dining rooms should follow the Massachusetts sector specific guidance for restaurants. The most up to date guidance can be found here.
EOEA recommends that ALRs encourage residents to have consistent dining partners for meals (similar to cohorting or "pods").

A resident who is suspected or confirmed to be infected with COVID-19 and not yet recovered cannot participate in group dining or activities.

Residents who request or require delivery of meals to their units cannot be refused this service. Given that we are in the midst of a public health emergency, please consider waiving the meal delivery fee if existing contracts charge such a fee.

B. Group Activities: ALRs may provide indoor group entertainment and activities. ALRs must follow Massachusetts sector specific guidance for the respective group activity. This includes but is not limited to.:
1) Theaters and Performance Venues
   Places of Worship
2) Fitness Centers and Health Clubs

Examples of indoor group activities that can be facilitated with appropriate safety, care, and infection control measures include, but are not limited to, book clubs, crafts, movies, exercise, and bingo.

Examples of indoor group activities that should be avoided at this time, include singing or hosting entertainers who might be singing or playing wind instruments.

C. Suspension of Communal Dining and Group Activities: ALRs may suspend Communal Dining and Group activities upon identification of a suspected or confirmed COVID-19 Cluster. A COVID-19 Cluster is defined as two or more unrelated cases. Suspension of these services should be limited to the time necessary to determine whether the ALR has a COVID-19 Cluster. If it is determined there is not a COVID-19 Cluster, Communal Dining and Group activities should resume following the infectious control procedures outlined above. In the event there is a COVID-19 Cluster, Communal Dining and Group activities should resume once there have not been any new cases for 14 days.

10. Close Contact Personal Services:

A. ALRs may offer Close Contact Personal Services (e.g. hair salon, barber shop services.). ALRs must follow Massachusetts sector specific guidance for Close Contact Personal Services. The guidance may be found here.

B. Suspension of Close Contact Personal Services: ALRs may suspend Close Contact Personal Services upon identification of a suspected or confirmed COVID-19 Cluster. A new COVID-19 Cluster is defined as two or more confirmed cases. Suspension of these services should be limited to the time necessary to determine whether the ALR has a COVID-19 Cluster. If it is determined there is not a COVID-19 Cluster, Close Contact Personal Services should resume following the infectious control procedure outlined above. In the event there is a COVID-19 Cluster, Close Contact Personal Services should resume once there have not been any new cases for 14 days.

11. Move-in/Move-out and Resident Re-entry:

A. Move-in/Move-out:
   1) All new resident and family members must be provided in writing the move-in COVID-19 infection control procedures and expectations in advance of the move-in date.
   2) Appropriate precautions should be taken in the event the ALR has identified a COVID-19 Cluster.
   3) ALRs should use their best judgment regarding onsite tours; all infection control measures should be followed for the duration of the tour.

B. Entry/Re-entry: Residents cannot be forced to stay in their homes, nor can they be refused entry even if they fail to meet the screening criteria.

12. Quarantine

ALRs operate under a landlord/tenant relationship and are not allowed to require residents who leave the ALR for visits with family or other activities to quarantine in their units or rooms upon return. Local Boards of Health, however, may impose a quarantine of residents through the issuance of an authorized order.

13. Appendices:

DPH and EOEA strongly encourage all ALRs in Massachusetts to monitor the CMS and CDC website for up-to-date information and resources:

- CMS website: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page
- CDC website: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html

Additionally, please visit DPH's website that provides up-to-date information on COVID-19 in Massachusetts: https://www.mass.gov/2019coronavirus.

Appendix A

Assisted Living Residence Outbreak Prevention and Management Checklist

Purpose: EOEA recommends that ALRs utilize this management checklist to prevent COVID-19 cases and, if any cases are confirmed, to mitigate the spread of COVID-19 within the ALR.

COVID-19 PREVENTION Checklist: ALRs that do not have a COVID-19 positive staff member or a resident within the past 14 days are urged to maintain vigilance and to review and implement the checklist below:

ALR Assessment:

- ❑ Develop an Infection Prevention and Control Assessment Tool with the help of an infection prevention specialist or by using the CDC tool for nursing homes.
    - EOEA recommends reaching out to your industry organization (MassALA, LeadingAge) for resource recommendations with quality assurance and performance improvement experience.
- ❑ Conduct an assessment and then update it at least once per week. Review findings with the ALR's leadership team and make an actionable plan to address any improvement areas that includes a leader responsible for each area identified
- ❑ Identify additional alternate spaces for staff break rooms and limit break room areas to one staff person at a time
    - Post signage in break rooms and consider implementing scheduled breaks
    - Ensure environmental services is cleaning the room frequently throughout the day
- ❑ Post signs in the ALR reminding residents and staff to maintain social distance of 6 feet when possible in common spaces.
    - Post signs about limiting the number of residents and/or staff on the elevator at a single time.
    - Designate a staff to serve as an elevator monitor during high-traffic times of day (e.g., before and after meals and activities).

Testing:

- ❑ Identify a testing provider in advance of needing one to address an outbreak. See DPH's "Testing Options for Entities" search tool.
- ❑ Recommended weekly surveillance testing of 100% of all staff. *See DPH Surveillance Testing Guidance.*

Personal Protective Equipment (PPE) and Hand Hygiene:

- ❑ Perform PPE and hand hygiene audits using a tool, document the findings, review with the ALR's leadership team and provide feedback to staff.
    - Perform hand hygiene audit once per shift in each the traditional assisted living and Special Care Residence (SCR) with a minimum of 10 observations.
    - Perform PPE audit once per shift in each the traditional assisted living and SCR with a minimum of 10 observations.
    - Observe demonstrated understanding and compliance across all staff positions.

- ❑ Ensure that alcohol-based hand-rub (ABHR) stations are available throughout the ALR and that staff has access to handwashing supplies (soap, paper towels) when in individual Resident Units
    - Assign staff to monitor that ABHR stations are sufficiently filled and working correctly train staff to report if handwashing supplies in individual Resident Units need to be re-stocked
    - Exercise caution in placement and use of hand sanitizer in Special Care Residences (SCRs) where Residents may be at risk for toxic ingestion without careful supervision.

- ❑ Ensure all ALR personnel are wearing a facemask while in the ALR and eye protection when in resident care areas.

- ❑ Residents, as they are able to tolerate, should wear a facemask anytime a staff member enters their room and whenever they leave their room or are around others

COVID-19 OUTBREAK Checklist: If the ALR identifies one new resident or staff case then the ALR should take the following steps to mitigate any further transmission:

ALR Assessment:

- ❑ Conduct infection prevention and control assessment using a standardized tool within 24 hours of a new case to identify potential vulnerabilities or deficiencies; conduct an assessment no less than once per week thereafter.
    - Review findings with the ALR's leadership team and make an actionable plan to address any improvement areas that includes a leader responsible for each area identified

Testing:

- ❑ EOEA encourages ALRs to follow DPH's guidance on outbreak testing in response to identification of a new positive case. Outbreak testing should include:
    - Testing all staff and all residents who agree to testing as soon as possible and no later than 48 hours after identification of the positive using laboratory PCR testing.
    - Once the ALR has completed the outbreak testing described above, the ALR should test all staff and residents who agree to testing every three days until the

ALR goes 7 days without a new case or their assigned epidemiologist directs otherwise.

- ❑ Connect with the local Board of health to establish contact with the DPH epidemiologist assigned to the ALR and Local Board of Health once a positive case is identified.
- ❑ Asymptomatic recovered staff and residents can be excluded from outbreak testing unless there is an exposure or they become symptomatic. See DPH's guidance Considerations for Caring for COVID-19 Recovered Residents.
- ❑ EOEA encourages ALRs to follow the DPH Guidance issued March 12: Updates to Long-Term care Surveillance Testing
- ❑ In addition to outbreak testing outlined above, the ALR should immediately test any symptomatic resident or staff member or newly exposed resident or staff member.

Staffing:

- ❑ Dedicate separate staffing teams to residents that are COVID-19-positive.
  - ❑ Take into consideration all staff that potentially interacts with Residents, including but not limited to aides, nurses, housekeeping, dietary, and activities personnel.
- ❑ Maintain consistent assignments of staff to residents to assist in contact tracing and identification of Resident changes; and whenever possible, minimize the number of staff caring for a Resident.
  - ❑ As much as possible, staff, including maintenance, housekeeping and dining staff, should not work across units (traditional assisted living, SCR) or floors.

Personal Protective Equipment (PPE) and Hand Hygiene:

- ❑ Use gowns and gloves in addition to facemasks and eye protection for high contact care activities for COVID-19 negative residents until 14 days with no new COVID-19 positive residents and/or staff.

- ❑ Ensure PPE and Hand Hygiene Compliance.

  - ❑ Train and designate a PPE coach or coaches for each shift who are responsible for performing PPE and hand hygiene audits, correct immediately, and report to leadership if staff need additional training.

- ❑ Perform PPE and hand hygiene audits using a tool, document the findings, share with ALR's leadership team at least daily and provide feedback to frontline staff
  - Perform hand hygiene audits three times per shift on each traditional assisted living and SCR with a minimum of 10 observations
  - Perform PPE audits three times per shift on each the traditional assisted living and SCR with a minimum of 10 observations
  - Establish adherence goals for hand hygiene and PPE audits; if the ALR's performance falls below the goal then identify plan to address any causal factors for non-adherence

- ❑ Ensure that alcohol-based hand-rub (ABHR) stations are available throughout the ALR and that staff has access to handwashing supplies (soap, paper towels) when in individual Resident Units
    - Assign staff to monitor that ABHR stations are sufficiently filled and working correctly.
    - Train staff to report if handwashing supplies in individual Resident Units need to be re-stocked
    - Exercise caution in placement and use of hand sanitizer in Special Care Residences (SCRs) where Residents may be at risk for toxic ingestion without careful supervision. DPH recommends using foaming ABHR.

- ❑ Residents, as they are able to tolerate, should wear a face mask when a staff member enters their room and whenever they leave their room or are around others.