



The Commonwealth of Massachusetts  
Executive Office of Elder Affairs  
One Ashburton Place, 5th Floor  
Boston, Massachusetts 02108

**CHARLES D. BAKER**  
Governor

**KARYN E. POLITO**  
Lieutenant Governor

**MARYLOU SUDDERS**  
Secretary, Executive Office of Health  
and Human Services

**ELIZABETH C. CHEN, PhD, MBA, MPH**  
Secretary

Tel: (617) 727-7750  
Fax: (617) 727-9368  
TTY/TTD: 1-800-872-0166  
[www.mass.gov/elders](http://www.mass.gov/elders)

**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  
Outbreak  
**DATE:** January 20 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. The document consolidates and replaces previously issued memoranda and FAQs and is effective as of 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 a reminder, even though ALR staff and residents will be among the earliest recipients of a COVID-19 vaccine, it is still critical that ALRs continue to follow all infection control practices for the foreseeable future. Much remains unknown about duration of immunity and whether a vaccinated individual can still transmit virus.**

## Table of Contents

<a href="#">1. General ALR Guidance:</a>	3
<a href="#">2. Additional Considerations During Times of High Community Transmission</a>	3
<a href="#">3. Screening Non-Residents Before Entry to an ALR:</a>	4
<a href="#">4. Testing:</a>	5
<a href="#">5. In-Person Visits for Service Plans:</a>	6
<a href="#">6. Hand Hygiene</a>	7
<a href="#">7. Safe Spacing and Air Circulation</a>	7
<a href="#">8. Personal Protective Equipment (PPE):</a>	8
<a href="#">9. Surface Hygiene:</a>	9
<a href="#">10. Communal Dining and Group Activities:</a>	9
<a href="#">11. In-Person Social Visits:</a>	11
<a href="#">12. Move-in/Move-out and Resident Re-entry:</a>	13
<a href="#">13. Quarantine</a>	13
<a href="#">14. In-House Salon Services:</a>	13
<a href="#">15. Access for Necessary Repairs or Cosmetic Improvements:</a>	13
<a href="#">16. Ombudsman Program and Legal Representation:</a>	14
<a href="#">17. Appendices:</a>	14
<a href="#">Appendix A</a>	15

## 1. General ALR Guidance:

- A. 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.
- B. 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 following link: <https://umassmedcwm05.crm.dynamics.com/apps/ui>

## 2. Additional Considerations During Times of High Community Transmission<sup>1</sup>

- 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;<sup>2</sup>
  - 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 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

---

<sup>1</sup> **High Community Transmission** is defined as cities or towns designated yellow or red on the [Weekly COVID-19 Public Health Report](#).

<sup>2</sup> 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.

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, including, but not limited to:

- 1) staff
- 2) social visitors
- 3) medical personnel
- 4) private aides
- 5) contractors

B. Screening

Prior to entry, the ALR must screen non-residents for COVID-19 symptoms, 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).

<b><u>Symptoms consistent with COVID-19</u></b>
<ul style="list-style-type: none"><li>• Fever (100.0° Fahrenheit or higher), chills, or shaking chills</li><li>• Cough (not due to other known cause, such as chronic cough)</li><li>• Difficulty breathing or shortness of breath</li><li>• New loss of taste or smell</li></ul>

- 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 or symptoms of COVID-19 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. **ALRs should immediately arrange for staff testing and make efforts to facilitate testing of residents who were in close contact with the individual experiencing COVID-19 symptoms. While awaiting test results and for the 14 day period after the exposure, residents should be considered to be a person under investigation for COVID-19 (Suspected COVID-19) and should not participate in communal dining (subject to the conditions of section 10 below) and group activities. Staff should don appropriate PPE as outlined in Table 1 below when caring for residents who were in close contact.**

#### 4. Testing:

- A. Testing of Staff and Residents: EOEAs recommends that ALRs perform weekly surveillance testing of all staff and outbreak testing of all residents and staff within 48 hours of a newly identified case pursuant to [DPH Guidance: Updates to Long-Term Care Surveillance Testing](#).
- B. As outlined in the [EOEA BinaxNOW guidance](#), ALRs may use state provided BinaxNOW test kits for testing of symptomatic staff and residents at the ALR and/or testing ALR staff and/or residents that came into close contact with an individual who is suspected of being COVID-19 positive or is COVID-19 positive. ALRs may not use BinaxNOW for routine surveillance testing of staff and residents.

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.

### 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 to visit a resident.**
- 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](mailto: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.**

### 5. 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.

In-person visits should be limited to the Resident's unit and only for the time necessary to complete the service.

### 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).

ALRs must limit access of compassionate care visits to the resident's unit or another location designated by the residence. **If the resident's unit is shared with an unrelated party, the ALR must safely accommodate the compassionate care visit.**

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

## 6. Hand Hygiene

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

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

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

- a. Handling face masks;
- b. Touching their eyes, nose, or mouth;
- c. Dining;
- d. Joining a group activity, and throughout the activity if objects are being shared; and,
- e. 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. Safe Spacing and Air Circulation

A minimum of 6 feet of separation should be maintained between individuals at all times, including in staff break rooms, resident activity and dining areas, and while residents are visiting each other in their units. Wearing a mask should not preclude safe distancing.

If brief physical contact is desired by both parties, especially between resident and visitor, they must perform hand hygiene prior to and after touching, hug with their faces in opposite directions, and avoid face-to-face contact even when face masks are used.

Staff and residents should make every effort to ventilate rooms frequently to promote air circulation, and especially when visitation is being conducted.

Appropriate PPE should be used when 6 feet of spacing is not possible, such as when attending to residents' personal care needs.

## 8. Personal Protective Equipment (PPE):

### A. Face masks:

- Staff: Staff must wear a surgical/procedural face mask at all times in the ALR (unless alone in an enclosed office with the door closed). N95 respirator or KN95 masks, if the KN95 has been evaluated to have the same filtration as the N95, should be used when caring for COVID-positive or suspected positive Residents.

Staff should wear a face mask while in transit to and from work if carpooling with individuals outside their household, or while using other shared transportation.

- Residents: Residents who are safely able to wear a face mask or cloth face covering should wear one when:

- outside their unit in the ALR;
- in their unit when receiving services from ALR staff or an outside provider;
- in their unit when socializing with ALR residents from a different unit;
- using ALR or other shared transportation;
- away from the ALR with family or friends.

- Visitors: All visitors to the ALR should wear face masks or cloth face coverings at all times.

### B. 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.
- Face shield/goggles worn throughout the day 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.

### 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:

<b>Table 1 - Summary of Recommended PPE For Staff and Residents</b>	
<b>Staff PPE</b>	<b>Situation</b>
Surgical mask	<ol style="list-style-type: none"> <li>1. At all times in ALR , Governor Baker issued an <a href="#">Order</a> effective November 6, 2020 requiring face masks or cloth face coverings. Read the full <a href="#">DPH Guidance</a>.</li> <li>2. Commuting to and from work using any shared transportation or carpool.</li> </ol>
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/goggles, 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.
<b>Resident PPE</b>	<b>Situation</b>
Face mask covering nose and mouth, as tolerated.	<ol style="list-style-type: none"> <li>1. Outside resident’s unit unless eating or drinking; and</li> <li>2. Inside resident’s unit when a person who does not live in the unit is present.</li> </ol>

## 9. 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>

## 10. Communal Dining and Group Activities:

- A. **Communal Dining:** ALRs may allow communal dining if the residence meets the following conditions:
- 1) the ALR has adequate supplies of PPE and essential cleaning and disinfection supplies to care for residents;
  - 2) the ALR must clean and disinfect the dining area in between meals services; and,
  - 3) the number of residents at each table must be limited, with residents spaced at least 6 feet apart.

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

Communal dining is allowed for Residents who are not able to eat safely alone or who need cueing to eat. 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 in the residence if the residence meets the following conditions:
- 1) the ALR has adequate supplies of PPE and essential cleaning and disinfection supplies to care for residents;
  - 2) participating residents and staff must remain at least six (6) feet apart and residents must wear a face mask, if they are able to do so;
  - 3) staff should perform hand hygiene before and after overseeing any activity, and observe or assist residents in performing hand hygiene before and after they engage in any activity;
  - 4) items used in activities should not be shared between or among residents;
  - 5) the ALR must implement a schedule for frequent cleaning and disinfection of the spaces used for indoor group activities, including cleaning high-touch surfaces using an appropriate EPA-registered disinfectant; and,
  - 6) the ALR must screen any individual entering the facility to provide resident entertainment or activities; any individual that does not pass the screening criteria cannot be permitted to enter the ALR.

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/or group activities upon identification of a suspected or confirmed positive COVID-19 resident and/or staff member. Suspension of these services should be limited to the time necessary to determine whether the ALR has a COVID-19 infection cluster. An ALR should follow the recommendations of its local Board of Health regarding continued suspension and resumption of group dining and/or activities if an infection cluster is detected.

## 11. In-Person 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.

### A. Virtual Alternatives:

To the extent possible, ALRs should facilitate the use of electronic methods for communication and social engagement for residents, such as Zoom, Skype, FaceTime, WhatsApp, or Google Duo, to minimize infection risk.

### B. In-person Social Visits:

ALRs shall allow indoor and outdoor visits (weather permitting) with residents to occur, provided that the requirements described below are followed.

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.

It is within the discretion of the ALR to determine:

- the length each visit, provided that residents are offered the opportunity meet with visitors for no fewer than 45 minutes;
- the days on which visits will be permitted, provided that visits are offered on no fewer than five (5) days each week and that one of the days offered occurs on a weekend;
- the hours during the day when visits will be permitted, provided that at least one day per week visits are offered outside of standard business hours; and,
- the number of visits occurring at the Residence on a given day.

#### 1) Designated Shared Indoor or Outdoor or Space for Social Visits:

- a) Visits with a resident in designated shared indoor or outdoor spaces must be scheduled in advance and are dependent on permissible weather conditions (for outdoor visits), the availability of space, sufficient staffing at the residence to meet resident care needs, and the health and well-being of the resident.
- b) If a designated shared indoor space is used for social visits, ALRs must:
  - i. identify a designated space that is as close to the entrance as possible to minimize visitor impact on other residents in the ALR;
  - ii. Identify a designated space that is large enough so that residents and visitors can be at least 6 feet apart; and,
  - iii. ensure that ventilation systems are operating properly and have been serviced in accordance with manufacturer recommendations and increase circulation of outdoor air as much as possible to designated indoor spaces.
- c) A staff member trained in resident safety and infection control measures must have a line of sight into visits with residents in special care units.
- d) Visitors should perform hand hygiene before and after the visit.

- e) The residence must implement a schedule for frequent cleaning and disinfection of designated shared spaces for social visits, including the cleaning of high-touch surfaces with an appropriate EPA-registered disinfectant.

2) In-Unit Visits:

Visits in the resident's unit are allowed if the unit:

- a) is large enough for at least six (6) feet of distance between visitor and resident;
- b) is not shared between unrelated individuals; and,  
ALRs should ensure that ventilation systems are operating properly and have been serviced in accordance with manufacturer recommendations.

Staff must escort the visitor to and from the resident's unit to ensure that visitors do not stop in common areas or other residents' units.

3) Resident Access:

Whether or not a resident has visitors should not impact their access to fresh air and time outdoors. ALRs are encouraged to offer residents time outdoors (weather permitting), provided that the infection control requirements described above are followed.

D. 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.

E. Suspending Access to ALR for In-Person Social Visits

ALRs may suspend in-person social visits upon the identification of a newly positive COVID-19 resident and/or staff member. 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 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.**

## 12. Move-in/Move-out and Resident Re-entry:

### A. Move-in/Move-out:

- 1) To the extent possible, move-ins should be limited to situations in which an elder faces an increased risk of harm if access to an ALR is not provided.
- 2) Access to the ALR for those assisting with a move-in or move-out should be limited to two persons and standard screening policies apply.
- 3) Move-in and move-out should be scheduled during times when current Residents will not be in the areas accessed by those assisting (perhaps a designated day/time per week).

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.

## 13. 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.

## 14. In-House Salon Services:

ALRs may offer in-house hair salon and barber shop services. Providers must follow the same safety standards and checklists as hair salons and barber shops located outside of ALRs, including but not limited to maintaining social distancing between residents, hygiene protocols, staffing and operations, and cleaning and disinfection. The guidance may be found [here](#).

ALRs should screen all staff and residents seeking hair salon and barber shop services for COVID-19. EOEIA recommends that staff providing in-house hair salon and barber shop services should be included in the “Testing of Staff and Residents” as outlined above in 4.A.

ALRs should **consider suspending** salon services if the ALR has had a new COVID-19 staff or resident case in the last 14 days.

## 15. Access for Necessary Repairs or Cosmetic Improvements:

Contractors may enter the ALR to make repairs deemed necessary to ensure operation of the ALR or provide for the health, safety and well-being of Residents provided that access is limited only to the areas required for such work to be completed.

Cosmetic and/or improvements not deemed necessary to ensure operation of the ALR or provide for the health, safety and well-being of Residents are allowed provided that access is limited only

to the areas required for such work to be completed, and there have been no new COVID-19 positive resident or staff cases identified in the facility in the last 14 days.

The ALR must screen any contractors for risk of COVID-19 in accordance with established procedures prior to entry and ensure appropriate PPE and Infection Control Measures outlined above.

#### 16. 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.

#### 17. Appendices:

DPH and EOEAA 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 December 7: [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.
  
- ❑ 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.