COLORADO
Department of Public Health & Environment

COVID-19

Mitigation and outbreak guidelines

Prevention and control in assisted living residences and group homes for persons with intellectual and developmental disabilities

April 24, 2025

What's new:

- Updated broken links throughout the document

Scope

This guidance is for assisted living residences and group homes for people with intellectual and developmental disabilities that are not regulated by the Centers for Medicare and Medicaid Services. Facilities are required to follow this guidance as outlined in 6 CCR 1011-1, Chapter 2, General Licensure Standards. Additionally, Colorado Revised Statute §25-1.5-102 grants CDPHE the authority to investigate and control the causes of epidemic and communicable diseases affecting public health. Colorado Revised Statute §25-1-506 grants local public health agencies this authority for their jurisdiction. Per regulation 5 within 6 CCR 1009-1, the "Epidemic and Communicable Disease Control" rule, public health has the authority to conduct investigations to evaluate exposures to reportable diseases/conditions, including outbreaks, for purposes of case identification and prevention.

Assisted living residences and group homes whose staff* provide non-skilled personal care similar to that provided by family members in the home should follow this CDPHE guidance to respond to cases of COVID-19 identified in the facility. Non-skilled personal care consists of any non-medical care that can reasonably and safely be provided by non-licensed caregivers, such as help with daily activities like bathing and dressing. It may also include the kind of health-related care that most people do themselves, like taking oral

medications. In some cases where care is received at home or in a residential setting, care can also include help with household duties, such as cooking and laundry.

Visiting or shared health care personnel who enter the setting to provide health care to one or more residents (e.g., physical therapy, wound care, intravenous injections, catheter care provided by home health agency nurses) should follow CDC's Infection Control Guidance for SARS-CoV-2.

Independent living communities may consider these guidelines to be applicable if there is an occurrence of illness among residents that share common areas for dining and social activities.

*In this document, “staff” and “health care personnel” include both paid and unpaid (volunteer) personnel.

About COVID-19

Pathogen: COVID-19 is the disease caused by the 2019 novel coronavirus, SARS-CoV-2. The virus can be very contagious and spreads quickly. Over time, mutations (changes) in SARS-CoV-2 can lead to new variants of the virus, which may allow the virus to spread more easily.

Incubation period (time from exposure to the virus to illness onset): 2-14 days, with a median of about 3-5 days. Some virus variants may have a shorter incubation period.

Symptoms: Infection with SARS-CoV-2 can cause a broad spectrum of illness, ranging from asymptomatic infection to critical disease. Symptoms may include but are not limited to: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and/or diarrhea. Symptoms may change with new variants and can vary by person. Although anyone can have severe COVID-19, severe illness is more likely among people who are older, are immunocompromised (have a weakened immune system), have certain disabilities, have underlying health conditions, or are unvaccinated or not up to date on COVID-19 vaccinations. Some people with COVID-19, including those with minor or no symptoms, will develop Long COVID.

Transmission and communicability: COVID-19 spreads when a person who is infected breathes out droplets and very small particles (aerosols) that contain the SARS-CoV-2 virus. These droplets and aerosols are then breathed in by another person or land on the person’s eyes, nose, or mouth. Transmission through contaminated objects or surfaces is a possible but less likely route of transmission. People can be reinfected with SARS-CoV-2 multiple times. Certain variants may have characteristics that allow transmission to occur more rapidly and efficiently.

Anyone infected with SARS-CoV-2 can spread the virus, even if they have no symptoms. People who are infected are considered to be contagious from two days prior to symptom onset to 10 days after. If a person tests positive for COVID-19 but never develops symptoms, they are considered to be contagious from two days prior to the date of their first positive

viral test (the date that the test was performed) to 10 days after. People with severe COVID-19 and or a weakened immune system may be contagious for longer periods.

Vaccination: Getting vaccinated against COVID-19 is the safest, easiest way to lower the risk of serious illness and Long COVID. Everyone aged 6 months and older should get a 2024-2025 COVID-19 vaccine. Most people only need one dose of the 2024-2025 vaccine. Some people may need more than one dose, including people aged 65 years and older, people with weakened immune systems, and children aged 6 months through 4 years (depending on their vaccination history). More information on COVID-19 vaccination is available at CDC's Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States, CDC's Staying Up to Date with COVID-19 Vaccines, and CDPHE's COVID-19 vaccine clinic toolkit for long-term care facilities.

Facilities should follow any applicable state and federal requirements regarding immunization of residents and/or staff. CDPHE's COVID-19 vaccine clinic toolkit for long-term care facilities provides resources, including vaccination guidance, vaccination safety monitoring and reporting information, and links to printable materials. After COVID-19 vaccination, residents and staff might have some side effects. It is normal for these to occur. CDC's Getting Your COVID-19 Vaccine provides information about what to expect before, during, and after vaccination.

Treatment and pre-exposure prophylaxis: Outpatient COVID-19 treatments can help prevent severe illness for some people who get infected with COVID-19, are not hospitalized, and have one or more risk factors for progression to severe disease. A health care provider should promptly (within 24 hours of a positive test) evaluate all residents who have COVID-19 and are not hospitalized to determine if they are eligible for COVID-19 treatment. Early COVID-19 testing and evaluation by a health care provider is important because treatment must be started as soon as possible and within 5-7 days of symptom onset. Pre-exposure prophylaxis (prevention) medication is available for some people who are moderately or severely immunocompromised for additional protection against COVID-19. For more details, see CDC's COVID-19 Treatment Clinical Care for Outpatients and CDPHE's accessing antiviral medications for COVID-19 webpage.

COVID-19 outbreak definitions for residential and long-term care facilities

Facilities should have a plan to investigate and respond to COVID-19 and undiagnosed respiratory illness* in the facility.

Threshold for additional investigation by the facility:

- At least one resident or staff with a positive COVID-19 test result

  or
- Two or more residents with onset of undiagnosed respiratory illness occurring within a three-day period

Suspected COVID-19 outbreak (must be reported to public health):

- At least one resident with a positive COVID-19 test result **and** at least one resident with onset of undiagnosed respiratory illness occurring within a seven-day period,

or

- Three or more residents with onset of undiagnosed respiratory illness occurring within a three-day period

Confirmed COVID-19 outbreak (must be reported to public health):

- Two or more residents with a positive COVID-19 test result occurring within a seven-day period

*The occurrence of respiratory illness among residents should first be considered suspect for COVID-19. If influenza or other respiratory illnesses, such as RSV, are circulating locally, these pathogens should also be considered suspect until testing proves otherwise. Co-infections of SARS-CoV-2 and other viral respiratory pathogens can and do occur.

Reporting an outbreak

Facilities must report known or suspected outbreaks immediately (within four hours of detection) to the local public health agency or to CDPHE by completing the online outbreak report form, calling 303-692-2700, or emailing cdphe_covid_infection_prevention@state.co.us.

COVID-19 and other viral respiratory infections

In addition to the virus that causes COVID-19, there are many other types of respiratory viruses, including influenza (flu) and respiratory syncytial virus (RSV). These viruses can circulate in a community at the same time, and a facility can experience outbreaks of multiple viruses at once. Additionally, it is possible for individuals to be infected with multiple respiratory viruses at the same time (called "co-infection"). Symptoms of COVID-19, influenza, and RSV can be very similar, and these infections may be impossible to distinguish based on symptoms alone. Specific testing is needed to confirm a diagnosis and inform treatment decisions.

Facilities should have a plan to respond to cases and outbreaks of respiratory illness, including COVID-19. The plan should consider the residents' unique needs, such as disabilities and cognitive decline. To protect residents and staff, facilities should use a multi-faceted approach to decrease the risk of transmission of COVID-19 and other respiratory viruses. This document describes general respiratory virus prevention strategies and specific guidance for COVID-19 response.

General respiratory virus prevention strategies

The following general prevention strategies are recommended at all times, even before a case or outbreak is identified. Several strategies to prevent the spread of respiratory viruses are listed below. Facilities should stay informed about respiratory virus disease levels and trends in the community (see CDC's respiratory illnesses data channel and the Colorado viral respiratory diseases data dashboard) and consider implementing additional or more intensive strategies in response to high levels and/or increasing trends. CDC also lists special considerations for people with certain risk factors for severe illness from respiratory viruses, including older adults, young children, people with weakened immune systems, people with disabilities, and those who are pregnant.

Immunization: 6 CCR 1011-1 Chapter 2 part 12 requires residential and long-term care facilities to establish, maintain, and implement an infectious disease mitigation, vaccine, and treatment plan. The plan must demonstrate prevention of and responsiveness to communicable diseases that are or may become present in the individual facility setting. CDPHE has a tool that can be downloaded and modified to meet this requirement. 6 CCR 1011-1 Chapter 2 part 12 also requires facilities to notify residents, designated representatives, and staff of updated CDC vaccination recommendations and ensure recommended vaccines for infectious diseases are available to staff and residents inside their facility on an annual basis. Facilities are encouraged to provide information (e.g., posted materials, letters) to families and other visitors to encourage them to get vaccinated. Facilities should follow any other applicable state and federal requirements regarding immunization of residents and/or staff.

Testing: Testing should be conducted to confirm a diagnosis and inform clinical management if a resident has respiratory illness symptoms. Testing for SARS-CoV-2, influenza, and RSV is recommended when these viruses are circulating in the community (see CDC's respiratory illnesses data channel and the Colorado viral respiratory diseases data dashboard). In general, molecular testing (e.g., PCR) is preferred. However, antigen testing may also be used for immediate response. Confirmatory testing with a molecular test may be recommended in certain situations. Until testing results in a diagnosis, facilities should follow COVID-19 guidelines for infection prevention and control recommendations. Once a pathogen is confirmed, immediately implement disease-specific control measures.

Hand and respiratory hygiene: Post visual alerts and ensure availability of supplies for respiratory hygiene and cough etiquette. Ensure that alcohol-based hand sanitizer containing at least 60% alcohol is available for use in resident care and communal areas within the facility (e.g., resident rooms, dining areas, activity rooms).

Cleaning and disinfection: Use EPA-registered hospital-grade disinfectant for disinfection of environmental surfaces and equipment.

Taking steps for cleaner air: Improve ventilation in buildings (air flow, filtration, and treatment) to help maintain a healthy indoor environment and protect building occupants from respiratory infections.

Masks: Masks should be of high quality and should fit well, covering both the nose and mouth. When worn by a person with an infection ("source control"), masks reduce the spread of the virus to others. Masks can also protect wearers from breathing in infectious particles from people around them. Provide appropriate masks to residents, staff, and visitors. Strongly consider requiring source control for all residents, staff, and visitors when respiratory virus disease levels and trends in the community are high or increasing (see CDC's respiratory illnesses data channel and the Colorado viral respiratory diseases data dashboard). Counsel residents about strategies to protect themselves and others, including recommendations for source control if they are immunocompromised or at high risk for severe disease. Even when a facility does not require source control, residents and staff should be allowed to use a mask or respirator based on personal preference. Other sections

of this document provide guidance for source control and personal protective equipment in response to COVID-19.

Physical distancing: Increase the physical distance between people to help lower the risk of spreading respiratory viruses.

Adherence to infection control practices: Implement CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, including standard precautions for all patient care activities and additional transmission-based precautions for residents with known or suspected infections. This includes proper selection and use of PPE based on the nature of the patient interaction and potential for exposure to blood, body fluids, and/or infectious material. Have supplies of PPE, and make necessary PPE available in areas where resident care is provided. Designate a staff member responsible for stewarding supplies, monitoring and providing timely feedback, and promoting appropriate use by staff. Have plans in place for supply shortages.

Appropriate management of ill residents, staff, and visitors: Residents and staff who are suspected or confirmed to have a viral respiratory infection should be isolated (residents) or excluded from work (staff) for the appropriate length of time, based on the illness. See specific guidance for COVID-19, influenza, and RSV. For the safety of the residents, advise visitors to limit in-person visitation if the visitor is symptomatic and/or infectious. However, facilities should adhere to local, territorial, Tribal, state, and federal regulations related to visitation.

Education: Ensure that residents, staff, and visitors know about current precautions being taken in the facility for infectious diseases and the prevention of their spread. Educate staff, residents, and visitors about actions they should take to protect themselves and others. Remind staff not to report to work when ill.

Interfacility communication: Ensure that transfers to/from other facilities include information about the resident's infection status, so that appropriate infection control precautions can be implemented immediately upon arrival.

Additionally, 6 CCR 1011-1, Chapter 2, General Licensure Standards includes requirements for infectious disease mitigation and control. Some requirements are summarized here, but facilities should refer to the licensure standards for full details. Requirements include:

- Establishing, maintaining, and implementing an infectious disease mitigation, vaccine, and treatment plan.
- Assigning at least one staff member responsible for management of the facility's Infection Prevention and Control Program and training. This infection control officer has several responsibilities, including training and education, reporting, ensuring proper supply and use of PPE and disinfectants, maintaining a facility respiratory protection program, and ensuring recommended vaccines for infectious diseases are available to staff and residents inside their facility on an annual basis.
    - The infection control officer must complete infection prevention and control training from a nationally recognized provider or the Department's training program within two weeks of the assignment of duties, plus continuing

education on an annual basis. The Colorado RCF Infection Prevention Training or a more comprehensive training or certification can be used to meet these requirements.

Response to COVID-19

These recommendations build upon the general respiratory virus prevention strategies described earlier in this document and should be followed when responding to COVID-19 in the facility. Facilities should investigate and respond to COVID-19 and undiagnosed respiratory illness meeting the threshold for additional investigation by the facility, even when the outbreak definition is not met. Do not delay control measures while waiting for test results or waiting for an outbreak to be confirmed. **Keep precautions in place until the outbreak has resolved.** In residential and long-term care facilities, a COVID-19 outbreak can be considered resolved when recommended testing is continued on the affected area(s) or facility-wide until there are no new cases for 14 days. If using a broad-based testing approach, testing should be completed, at minimum, every seven days if using a molecular test or every three days or bi-weekly if using a point-of-care antigen test.

1. **Until testing proves otherwise:** Treat all cases of undiagnosed respiratory illness as potential COVID-19 cases, and follow COVID-19 mitigation and outbreak guidelines. Once a pathogen is confirmed, immediately implement the appropriate disease-specific control measures. If testing confirms the presence of both COVID-19 and influenza or RSV, guidance measures for influenza and RSV are superseded by those of COVID-19, and the facility should follow the COVID-19 guidelines.

2. **Test people who are symptomatic** as soon as possible**,** even if they have only mild symptoms of COVID-19.
    a. If using a molecular test (e.g., PCR): A positive result indicates COVID-19. A negative result is sufficient to rule out COVID-19 in most circumstances. If a higher level of clinical suspicion for COVID-19 exists, consider confirming with a second molecular test.
    b. If using an antigen test: A positive result indicates COVID-19. If the result is negative, further testing must be done to confirm the negative result using one of the following options:
        i. Test with a molecular test. A positive result indicates COVID-19. A negative result rules out COVID-19.
        or
        ii. Test with a second antigen test 48 hours after the first antigen test. A positive result indicates COVID-19. A negative result (for a total of at least two negative antigen tests) presumptively rules out COVID-19. If there is still concern that the person could have COVID-19, you may choose to test again 48 hours after the second COVID-19 test, consider confirmatory testing with a molecular test, or consult a health care provider. Additionally, consider other illnesses with similar symptoms that may require testing.
    c. Testing for SARS-CoV-2 (COVID-19), influenza, and/or RSV is recommended when simultaneous outbreaks are occurring in the facility or when these viruses are circulating at the same time in the community (see CDC's respiratory illnesses data

channel and the Colorado viral respiratory diseases data dashboard). If a symptomatic resident is only tested for COVID-19 and the initial COVID-19 result is negative, follow-up testing should be done for influenza and/or RSV. Additional testing with a full respiratory viral panel may be recommended by a health care provider or public health when symptomatic residents test negative for COVID-19, influenza, and RSV. For many diseases (including influenza), early diagnosis and prompt treatment are important for preventing severe illness.

3. **Identify and test people who were exposed** using either contact tracing or broad-based testing:
   a. **Contact tracing** is the process of identifying people who have recently been in close contact with someone diagnosed with an infectious disease. For this guidance, close contact is defined as being within six feet of a person with SARS-CoV-2 infection for a total of 15 minutes or more over a 24-hour period **or** having unprotected direct contact with infectious secretions or excretions of the person with SARS-CoV-2 infection.
      i. Regardless of test type (molecular or antigen), test all residents and staff identified as close contacts immediately (but not earlier than 24 hours after the exposure). A positive result indicates COVID-19. If the result is negative, conduct a second test 48 hours after the first test. If the second test result is negative, conduct a third test 48 hours after the second test. This testing will typically be on Day 1, Day 3, and Day 5, where the date of exposure is Day 0. Any positive test result indicates COVID-19.
      ii. If additional cases are identified, strongly consider shifting to the broad-based approach.
   b. **Broad-based testing** is the process of testing everyone on the affected unit(s), floor(s), or other specific area(s) of the facility. This approach is preferred if all potential close contacts cannot be identified and managed with contact tracing or if contact tracing fails to stop transmission.
      i. If using a molecular test (e.g., PCR): Test all residents and staff on the affected area(s) or facility-wide every seven days, at minimum, until there are no new cases for 14 days. Any positive test result confirms COVID-19.
      ii. If using antigen testing: Test all residents and staff on the affected area(s) or facility-wide twice per week (every three days) until there are no new cases for 14 days. Any positive test result indicates COVID-19.
   c. Considerations for testing asymptomatic people who previously tested positive for COVID-19 in the past 90 days:
      i. If the person's initial positive COVID-19 test was within the past 30 days, testing is not recommended unless the person develops symptoms.
      ii. If the person's initial positive COVID-19 test was within the past 31-90 days, test with an antigen test instead of a molecular test. Some people may continue to have positive molecular test results but will not be infectious during this period.
   d. Staff and residents who were exposed to COVID-19 should watch for symptoms for 10 days following their most recent exposure. If symptoms develop, the person should isolate immediately and get tested (see "Test people who are symptomatic" above).

4. **Isolate residents who have respiratory symptoms or have tested positive for COVID-19:**
   a. Residents with no symptoms should isolate through Day 5. The day of the person's first positive viral test is Day 0.
      i. If symptoms develop within 10 days of when the resident tested positive, the clock restarts at Day 0 on the day of symptom onset. The resident should then follow the isolation instructions below.
   b. Residents with symptoms should isolate through at least Day 5. The day the person first started experiencing symptoms is Day 0. Isolation can end after Day 5 if the resident is fever-free for 24 hours (without the use of fever-reducing medication) **and** their symptoms are improving.
      i. If symptoms are not improving, isolation should continue until the resident is fever-free for 24 hours (without the use of fever-reducing medication) **and** their symptoms are improving.
      ii. Symptomatic residents who have not yet tested positive for COVID-19 should follow this guidance until COVID-19 has been appropriately ruled out, with continued isolation depending on guidelines for any alternate diagnosis.
   c. People with weakened immune systems (immunocompromise) or severe illness can take longer to recover and may be contagious for a longer period of time. If a resident with suspected or confirmed COVID-19 is immunocompromised or had severe illness, consider consulting the resident's doctor before ending isolation.
   d. **Additional precautions:** After isolation ends, residents should wear a high-quality mask when around others in the facility for the next five days.
   e. Isolation should not impede resident care or the ability to provide social or rehabilitation services in the resident's room as long as infection prevention and control precautions are in place (see below).

5. **Resident placement during isolation:**
   a. Ideally, place the resident in a single-person room. The door should be kept closed, if safe to do so. If possible, the resident should have a dedicated bathroom. If a dedicated bathroom is not available, staff should clean and disinfect the shared bathroom after use by the resident.
   b. If cohorting, only residents with the same respiratory pathogen should be housed in the same room. Multidrug-resistant organism colonization status and/or presence of other communicable diseases should also be taken into consideration during the cohorting process. Refer to Cohorting FAQ's for Long-Term Care Facilities for more information.
   c. Avoid transfer to unaffected areas of the facility. Limit transport and movement of the resident outside of their room to medically essential purposes.
   d. Room placement decisions should balance health risks to other residents. In multiple-resident rooms, at least six feet of spatial separation between beds is advised.
   e. Consider designating entire areas within the facility, with dedicated staff, to care for residents with COVID-19 when the number of residents with COVID-19 is high. Dedicated means that staff are assigned to care only for these residents during their

shifts. Dedicated areas and/or staff might not be feasible due to staffing crises or a small number of residents with COVID-19.

6. **Implement work restrictions for staff who have respiratory symptoms or have tested positive for COVID-19:**
   a. Staff with no symptoms should be excluded from work through Day 5. The day of the person's first positive viral test is Day 0.
      i. If symptoms develop within 10 days of when the person tested positive, the clock restarts at Day 0 on the day of symptom onset. The person should then follow the work exclusion instructions below.
   b. Staff with symptoms should be excluded from work through at least Day 5. The day the person first started experiencing symptoms is Day 0. Staff can return after Day 5 if they are fever-free for 24 hours (without the use of fever-reducing medication) **and** their symptoms are improving.
      i. If symptoms are not improving, work exclusion should continue until the staff is fever-free for 24 hours (without the use of fever-reducing medication) **and** their symptoms are improving.
      ii. Symptomatic staff who have not yet tested positive for COVID-19 should follow this guidance until COVID-19 has been appropriately ruled out, and they can return to work based on guidelines for any alternate diagnosis.
   c. People with weakened immune systems (immunocompromised) or severe illness can take longer to recover and may be contagious for a longer period of time. Staff who are immunocompromised or who had severe illness may need to consult their doctor before returning to work.
   d. **Additional precautions:** After work exclusion ends, staff should wear a high-quality mask when around others in the facility for the next five days.
   e. Visiting or shared health care personnel who enter the facility to provide healthcare to one or more residents should follow CDC's Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.

7. **Restricting staff movement**: Ideally, staff (including health care personnel, as well as dietary, housekeeping, laundry, and therapy staff) working in areas affected by an outbreak should not work in unaffected areas at the same time until the outbreak is over.
   a. If there are simultaneous respiratory disease outbreaks occurring in the facility, such as COVID-19 and influenza, consider cohorting staff by pathogen (i.e., staff that only care for residents with COVID-19 and staff that only care for residents with influenza).

8. **Implement infection prevention and control practices:** In addition to following standard precautions for all patient care activities, staff providing in-person services for a resident in isolation for COVID-19 should should follow recommended IPC practices to protect themselves and others from potential exposures. These measures include hand hygiene, implementation of transmission-based precautions for COVID-19 (with appropriate PPE), and enhanced cleaning and disinfection. The facility should provide necessary supplies to adhere to recommended IPC practices.

a. PPE used for the care of someone suspected or known to have SARS-CoV-2 infection includes: gown, gloves, eye protection (goggles or face shield that covers the front and sides of the face), and NIOSH-approved N95 or higher-level respirator. Make necessary PPE available in areas where resident care is provided. Train staff to properly handle and use PPE. Monitor daily PPE use with CDC's PPE burn rate calculator or other tools. Have plans in place for supply shortages.
b. Clean and disinfect surfaces and equipment more frequently than usual, emphasizing common areas and high-touch surfaces, such as doorknobs and handrails. Clean and disinfect all non-dedicated, non-disposable equipment used for a resident in isolation according to manufacturer's instructions and facility policies before use on another resident. Use EPA List N to identify disinfectants for use against SARS-CoV-2.
c. Manage laundry, food service utensils, and medical waste in accordance with facility policy.
d. In general, **asymptomatic** residents and staff do not require empiric use of transmission-based precautions (quarantine) or work restriction following COVID-19 exposure. However, they should wear source control and be tested as described in this guidance. Facilities may consider or public health may recommend empiric use of transmission-based precautions for residents and work restriction for staff in certain situations, such as when transmission is ongoing despite other interventions.

9. **Source control**: Residents and staff should wear a high-quality, well-fitting mask or respirator for source control in the facility as follows:
   a. Residents who are in isolation for COVID-19 or undiagnosed respiratory illness should wear source control when around others and when leaving their room for medically essential purposes (such as going to a medical appointment).
   b. All staff and residents identified as close contacts to someone with COVID-19 should start wearing source control immediately and continue for 10 days following their last exposure. Everyone being tested for COVID-19 — whether identified through contract tracing or included in broad-based testing — is included in this recommendation.
   c. Source control requirements for new admissions should follow facility policy.
   d. People who are recommended to wear source control should not go places where they are unable to wear a mask.
   e. Visiting or shared health care personnel with higher-risk exposures should follow CDC's Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
   f. Provide appropriate masks and/or respirators to residents, staff, and visitors. Do not place face coverings on anyone who has trouble breathing or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

10. **Group activities and communal dining:** Facilities, in conjunction with the state or local public health agency, should consider pausing group activities and communal dining if a COVID-19 outbreak is not controlled with initial interventions. Residents on transmission-based precautions (i.e., isolation or quarantine) should not participate in

group activities and communal dining until the criteria to discontinue transmission-based precautions have been met.
   a. If limiting group activities and/or communal dining, the facility should communicate these limitations to residents and their representatives and offer alternatives to meet residents' needs.

11. **Visitation:** For the safety of the visitor, residents should be encouraged to limit in-person visitation while in isolation. For the safety of the residents, advise visitors to limit in-person visitation if the visitor is symptomatic and/or infectious. However, facilities should adhere to local, territorial, Tribal, state, and federal regulations related to visitation. Pausing visitation during a COVID-19 outbreak is generally not necessary unless directed by the state or local health department.
   a. Notify visitors that COVID-19 has been identified in the facility, and counsel residents and their visitor(s) about the risks of an in-person visit.
   b. Encourage use of alternative mechanisms for resident and visitor interactions, such as video-call applications on cell phones or tablets, when appropriate.
   c. If indoor visitation is occurring in an area of the facility experiencing COVID-19 transmission, instruct the visitor to only visit the resident's room. Visitors should minimize time spent in other locations in the facility.
   d. Before visitors enter the resident's room, provide instruction on IPC measures the resident and visitor should follow while in the facility, including performing hand hygiene, wearing well-fitting source control (if tolerated), physically distancing during the visit (if possible), and using PPE according to current facility policy.

12. **New admissions**:
   a. Facilities, in conjunction with the state or local public health agency, should consider pausing new admissions if a COVID-19 outbreak is not controlled with initial interventions. If the outbreak is severe enough to warrant pausing visitation (see above), it would also warrant a pause on accepting new admissions.
   b. Newly admitted residents should be housed in unaffected rooms or areas.
   c. Admission testing is at the discretion of the facility.

13. **Treatment:** A health care provider should promptly (within 24 hours of a positive test) evaluate all residents who have COVID-19 and are not hospitalized to determine if they are eligible for COVID-19 treatment. Early COVID-19 testing and evaluation by a health care provider is important because treatment must be started as soon as possible and within 5-7 days of symptom onset.

14. **Notification:**
   a. Notify staff, residents, residents' representatives, and visitors that COVID-19 has been identified in the facility, and communicate the mitigation actions that are being taken. Maintain communication with ongoing, frequent situational updates.
   b. Inform residents, staff, and visitors about IPC practices they should follow while in the facility.
   c. During transfers, notify the receiving facility that the resident is coming from a facility experiencing a COVID-19 outbreak. Include information about transmission-based precautions that are in place for the resident, if applicable.

15. **Outbreak tracking and documentation:**
    a. Report known or suspected outbreaks immediately (within four hours of detection) to the local public health agency or to CDPHE by completing the online outbreak report form, calling 303-692-2700, or emailing cdphe_covid_infection_prevention@state.co.us.
        i. A COVID-19 outbreak report form is included in this document, but the online report form is preferred.
    b. Track residents and staff who have symptoms of (or have tested positive for) COVID-19, and monitor the progression of the outbreak until it has resolved. This line list template can be used to track outbreaks of respiratory pathogens, including COVID-19, influenza, and RSV. At minimum, the facility should collect and document the following information for each person:
        i. Person's name and date of birth
        ii. Location within the facility (room/unit/area)
        iii. Illness onset date
        iv. Symptoms
        v. Hospitalization/death
        vi. Testing information, including date collected, test type, and results
        vii. Vaccination information
        viii. Therapeutics or prophylaxis received
    c. When the outbreak has resolved, submit a final outbreak report form and any other documentation requested by public health, such as a line list. The outbreak can be considered resolved when recommended testing is continued on the affected area(s) or facility-wide until there are no new cases for 14 days.

Additional resources

- CDPHE: COVID-19 resources for long-term and residential care facilities (includes a link to this guidance)
- CDPHE: Infection risk assessment and infection prevention annual plan
- CDPHE: Respiratory outbreak notification signage
- CDPHE: Respiratory Protection Program webpage
- CDPHE: Accessing antiviral medications for COVID-19
- CDC: COVID-19 Treatment Clinical Care for Outpatients
- CDC: Interim Clinical Considerations for Use of COVID-19 Vaccines in the United States
- CDC: Staying Up to Date with COVID-19 Vaccines
- CDPHE: COVID-19 vaccine clinic toolkit for long-term care facilities
- CDC: Viral Respiratory Pathogens Toolkit for Nursing Homes
- CDPHE: Infectious disease guidelines for health care settings (includes influenza and RSV guidance)

Stay informed:

- Subscribe to CDPHE's residential and long-term care emails and newsletters.
- Attend CDPHE's residential and long-term care facility webinars.
- Review Colorado Health Facilities Interactive messages from CDPHE.
- Sign up to receive HAN notifications from CDPHE.

Request assistance:

- Request infection prevention assistance for outbreak response: Contact your local public health agency or cdphe_covid_infection_prevention@state.co.us.
- Request assistance with training and education program development: cdphe_project_firstline@state.co.us.

COLORADO
Department of Public Health & Environment

COVID-19
Response checklist

for assisted living residences and group homes for persons with intellectual and developmental disabilities

The following checklist is to be used in conjunction with the latest COVID-19 mitigation and outbreak guidelines for assisted living residences and group homes for persons with intellectual and developmental disabilities from the Colorado Department of Public Health and Environment.

Infection with SARS-CoV-2 (the virus that causes COVID-19) can cause a broad spectrum of illness, ranging from asymptomatic infection to critical disease. Testing should be used to confirm a diagnosis and inform clinical management if a resident has respiratory symptoms. Until testing results in a diagnosis, facilities should follow COVID-19 guidelines. Once a pathogen is confirmed, immediately implement disease-specific control measures.

Response checklist

Facilities should investigate and respond to COVID-19 and undiagnosed respiratory illness that meets the threshold for additional investigation by the facility, even when the outbreak definition is not met. Do not delay control measures while waiting for test results or waiting for an outbreak to be confirmed. **Keep precautions in place until the outbreak has resolved.** In residential and long-term care facilities, a COVID-19 outbreak can be considered resolved when recommended testing is continued on the affected area(s) or facility-wide until there are no new cases for 14 days. If using a broad-based testing approach, testing should be completed, at minimum, every seven days if using a molecular test or every three days or bi-weekly if using a point-of-care antigen test.

Testing

- ☐ Test people who are symptomatic as soon as possible, even if they have only mild symptoms of COVID-19.
  - ☐ If the initial test is negative, follow the repeat COVID-19 testing guidelines described in the CDPHE COVID-19 guidance.
  - ☐ If COVID-19 testing is negative, test for other pathogens, such as influenza and/or RSV, as appropriate.
- ☐ Choose either a contact tracing or broad-based testing approach to identify and test people who were exposed to SARS-CoV-2. Incorporate the considerations for testing asymptomatic people who previously tested positive for COVID-19 in the past 90 days.
- ☐ If contact tracing: Identify and test people who were in close contact with someone with SARS-CoV-2 infection (within six feet for a total of 15 minutes or more over a 24-hour period **or** had unprotected direct contact with infectious secretions or excretions).
  - ☐ If the initial test is negative, follow the repeat COVID-19 testing guidelines described in the CDPHE COVID-19 guidance.

- ☐ If additional cases are identified, strongly consider shifting to the broad-based approach.
- ☐ If broad-based testing: Test everyone on the affected unit(s), floor(s), or other specific area(s) of the facility.
  - ☐ If using molecular tests (e.g., PCR): Test all residents and staff on affected area(s) or facility-wide every seven days, at minimum, until there are no new cases for 14 days.
  - ☐ If using antigen tests: Test all residents and staff on affected area(s) or facility-wide twice per week (every three days) until there are no new cases for 14 days.
- ☐ Staff and residents who were exposed to COVID-19 should watch for symptoms for 10 days following their most recent exposure. If symptoms develop, the person should isolate immediately and get tested.

Resident isolation

- ☐ Isolate residents who have respiratory symptoms or have tested positive for COVID-19.
  - ☐ Continue isolation through at least Day 5. Residents with continued fever, symptoms that are not improving, severe illness, and/or who are immunocompromised may need to isolate longer.
  - ☐ To determine when to end isolation, refer to the isolation guidelines described in the CDPHE COVID-19 guidance.
  - ☐ After isolation ends, residents should wear a high-quality mask when around others in the facility for the next five days.
- ☐ Ideally, place the resident in a single-person room. Keep the door closed, if safe to do so. The resident should have a dedicated bathroom, if possible.
- ☐ If cohorting, only residents with the same respiratory pathogen should be housed in the same room. Multidrug-resistant organism colonization status and/or presence of other communicable diseases should also be taken into consideration.
- ☐ Avoid transfer to unaffected areas of the facility. Limit transport and movement of the resident outside of their room to medically essential purposes. Residents should wear source control when leaving their room.
- ☐ Residents in isolation should not participate in communal activities and dining.
- ☐ If the outbreak is large, consider designating entire areas within the facility, with dedicated staff, to care for residents with COVID-19.
- ☐ Meet the care, social, and rehabilitation needs of residents in isolation.

Staff work exclusion and movement restrictions

- ☐ Implement work restrictions for staff who have respiratory symptoms or have tested positive for COVID-19.
  - ☐ Exclude these staff from work through at least Day 5. Staff with continued fever, symptoms that are not improving, severe illness, and/or immunocompromise may need to be excluded longer.
  - ☐ To determine when to end work exclusion, refer to the work restriction guidelines described in the CDPHE COVID-19 guidance.
  - ☐ After work exclusion ends, staff should wear a high-quality mask when around others in the facility for the next five days.

- ☐ Visiting or shared health care personnel who enter the facility to provide healthcare to one or more residents should follow CDC's Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.

☐ Ideally, restrict staff working in areas affected by an outbreak from working in unaffected areas. Consider cohorting staff by pathogen if the facility has simultaneous respiratory disease outbreaks.

Infection prevention and control practices

☐ Educate staff, residents, and visitors about performing hand hygiene.
☐ Staff caring for residents in isolation should use appropriate PPE for COVID-19: gown, gloves, eye protection (goggles or face shield that covers the front and sides of the face), and NIOSH-approved N95 or higher-level respirator.
☐ Train staff to properly handle and use PPE.
☐ Clean and disinfect surfaces and equipment more often, emphasizing common areas and high-touch surfaces. Use EPA List N to identify disinfectants for use against SARS-CoV-2.
☐ Clean and disinfect all non-dedicated, non-disposable equipment used for a resident in isolation according to manufacturer's instructions and facility policies before use on another resident.
☐ Manage laundry, food service utensils, and medical waste according to facility policy
☐ Provide necessary PPE and other supplies to adhere to recommended IPC practices.
☐ Consider pausing group activities, communal dining, and new admissions if the outbreak is not controlled with initial interventions. Newly admitted residents should be housed in unaffected rooms or areas.
☐ Follow any state or local public health recommendations related to pausing group activities, communal dining, and acceptance of new admissions.

Source control

☐ Residents in isolation for COVID-19 or undiagnosed respiratory illness should wear source control when around others and when leaving the room for medically essential purposes.
☐ All staff and residents identified as close contacts to someone with COVID-19 should wear source control for 10 days following their last exposure. This includes everyone being tested for COVID-19, whether identified through contract tracing or included in broad-based testing.
☐ Visiting or shared health care personnel with higher-risk exposures should follow CDC's Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
☐ Provide appropriate masks and/or respirators to residents, staff, and visitors.
☐ Do not place face coverings on anyone who has trouble breathing or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

Visitation

☐ Adhere to local, territorial, Tribal, state, and federal regulations related to visitation.
☐ Notify visitors that COVID-19 has been identified in the facility.
☐ Encourage residents to limit in-person visitation while in isolation.

- ☐ Advise visitors to limit in-person visitation if symptomatic and/or infectious.
- ☐ Encourage use of alternative mechanisms for resident and visitor interactions, such as video-call applications on cell phones or tablets, when appropriate.
- ☐ If visitation is occurring in an area of the facility experiencing COVID-19 transmission, instruct the visitor to only visit the resident's room. Visitors should minimize time spent in other locations in the facility.
- ☐ Counsel residents and their visitor(s) about the risks of an in-person visit. Before visitors enter the resident's room, provide instruction on IPC measures the resident and visitor should follow in the facility.
- ☐ Follow any state or local public health recommendations related to pausing visitation.

Treatment

- ☐ A health care provider should promptly (within 24 hours of a positive test) evaluate all residents who have COVID-19 and are not hospitalized to determine if they are eligible for COVID-19 treatment.

Notification

- ☐ Notify staff, residents, residents' representatives, and visitors that COVID-19 has been identified in the facility, and communicate the mitigation actions that are being taken. Maintain communication with ongoing, frequent situational updates.
- ☐ Inform residents, staff, and visitors about IPC practices they should follow in the facility.
- ☐ During transfers, notify the receiving facility that the resident is coming from a facility experiencing a COVID-19 outbreak. Include information about transmission-based precautions that are in place for the resident, if applicable.

Outbreak tracking and documentation

- ☐ Report known or suspected outbreaks immediately (within four hours of detection) to the local public health agency or to CDPHE by completing the online outbreak report form, calling 303-692-2700, or emailing cdphe_covid_infection_prevention@state.co.us.
- ☐ Track residents and staff who have symptoms of (or have tested positive for) COVID-19, and monitor the progression of the outbreak until it has resolved (line list template).
- ☐ When the outbreak has resolved, submit a final outbreak report form and any other documentation requested by public health, such as a line list.
- ☐ Contact your local public health agency or CDPHE (cdphe_covid_infection_prevention@state.co.us) for questions or assistance.

COLORADO
Department of Public Health & Environment

COVID-19
Outbreak report form

for assisted living residences and group homes for persons with intellectual and developmental disabilities

To report an outbreak of COVID-19: Complete the online outbreak report form (preferred), or complete the form below and send it to your local public health agency via secure email.

Outbreak definitions

Residential and long-term care facilities (excluding hospitals) must meet the following criteria:

- **Suspected outbreak:**
  - At least one resident with a positive COVID-19 test result **and** at least one resident with onset of undiagnosed respiratory illness occurring within a seven-day period, **or**
  - Three or more residents with onset of undiagnosed respiratory illness occurring within a three-day period
- **Confirmed outbreak**: two or more residents with a positive COVID-19 test result occurring within a seven-day period

Corrections facilities must meet the following criteria:

- **Suspected outbreak:** at least one resident with a positive COVID-19 test result and at least one resident with onset of undiagnosed respiratory illness occurring within a seven-day period
- **Confirmed outbreak**: two or more residents with a positive COVID-19 test result occurring within a seven-day period
- For corrections outbreak response guidance, see COVID-19 guidance and resources for correctional and detention facilities.

There are no defined outbreak thresholds for other settings. Consult with your local public health agency.

When will the outbreak be considered "over"?

- In residential and long-term care facilities, a COVID-19 outbreak can be considered resolved when recommended testing is continued on the affected area(s) or facility-wide until there are no new cases for 14 days. If using a broad-based testing approach, testing should be completed, at minimum, every seven days if using a molecular test or every three days or bi-weekly if using a point-of-care antigen test. For more information, see CDPHE's COVID-19 guidelines for nursing facilities/intermediate care facilities or assisted living residences/group homes.
- For correctional settings, businesses, schools, and other facilities, an outbreak is considered resolved when the setting goes 28 days without detection of a new COVID-19 case among residents.

What method was used to resolve the outbreak?	What is the onset date of the last case (or test date, if asymptomatic)?
Non-test-based (for all facilities except certain residential health care settings)	
Broad-based testing approach: Testing conducted every 3-7 days on the affected area(s)or facility-wide until no new cases are identified for 14 days (antigen testing should occur more frequently/every three days).	
Contact tracing testing: Test all close contacts and/or higher-risk exposures of health care workers using a series of three tests (typically Day 1, 3, 5 when day of exposure is Day 0). When testing is complete and no new cases are identified for 14 days, an outbreak is considered resolved.	

Reporting individual, if different than facility/business contact

Person reporting:	Email:	Date of initial report:
Agency:	Address:	Phone:

Facility or business information

Facility's full name (no abbreviations):		Phone:
Address where outbreak occurred:		County:
Facility contact:	Title:	Email:
Type of facility:	Other:	
This outbreak is currently: ☐ Suspected ☐ Confirmed		

Complete the sections that apply to your facility.

Outbreak information	Residents	Staff	Attendees
Number living, working, or attending location (i.e., census):			
Lab testing			

Date first COVID-19-positive resident/staff/attendee became symptomatic (or tested positive, if asymptomatic):			
Number tested for COVID-19:	molecular:	molecular:	molecular:
	proctored antigen:	proctored antigen:	proctored antigen:
	unproctored antigen:	unproctored antigen:	unproctored antigen:
Number who tested positive (any test type):			

Outbreak information (cont.)	Residents	Staff	Attendees
Outcomes			
Number with respiratory symptoms (with or without COVID-19 testing):			
Number hospitalized:			
Number of deaths:			
Additional outbreak information			
Did the facility close for one or more days due to COVID-19 staffing shortages or concern for spread?			
For residential and long-term care facilities: Is the facility keeping sick, symptomatic, or positive employees out of the workplace for the minimum recommended time period specified in CDPHE's COVID-19 guidelines (assisted living/group home guidance or nursing facility/intermediate care facility guidance)?			
Number of residents who received COVID-19 treatments (therapeutics) during this outbreak:			
Notes (If you can, provide more information regarding illness or facility disease measures):			