



## INTERIM GUIDANCE ON PROCEDURES TO PREVENT AND RESPOND TO COVID-19 IN SMALL GROUP HOME OR CONGREGATE FACILITY SETTINGS

### INTRODUCTION

This guidance is intended for smaller congregate living facilities such as residential treatment centers and group homes. It provides guidance for the operation of these facilities to prevent transmission of novel coronavirus 2019 (COVID-19). The guidance is based on recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the Maryland Department of Health (MDH). This guidance is not intended for nursing homes or long-term care facilities. For guidance on those or other facilities, visit the [MDH](#) or [CDC](#) websites.

Planning for a COVID-19 epidemic response requires participation and investment by all parties involved in day-to-day operations of congregate settings and the flow of people into and out of the setting. Congregate settings are advised to engage with all of their partners to develop specific protocols and procedures to control impacts from COVID-19 during two phases — when there is community transmission of COVID-19 and when there is widespread transmission in Maryland.

The goals of a facility plan are:

- Prevent the introduction of COVID-19 and other respiratory pathogens into your facility
- Rapidly identify persons with respiratory illnesses that could be COVID-19
- Prevent the spread of COVID-19 and other respiratory pathogens within and among your facility or facilities
- Manage and isolate persons with suspected or confirmed COVID-19
- Be familiar with infection prevention guidance
- Accommodate persons with possible or confirmed COVID-19

The key elements of the plan are:

#### **Protect the workforce, residents and clients**

- Educate the workforce, residents, and clients on steps they can take to prevent the spread of COVID-19, including social distancing, frequent handwashing, covering coughing and sneezing, environmental cleaning, and self-monitoring for symptoms of illness. Avoid groups any larger than 10 in any setting.

- Encourage staff, residents, and clients to wash their hands often with soap and water for at least 20 seconds, especially after interacting with a sick person and before eating. If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol (may not be appropriate in some circumstances). Cover all surfaces of your hands and rub them together until they feel dry.
- Encourage staff, residents, and clients to avoid touching their eyes, noses, and mouths.
- Ensure staff are aware of sick leave policies and are encouraged to stay home if they have symptoms of COVID-19, including: (1) Feeling feverish or having a measured fever (greater than or equal to 100.4 degrees Fahrenheit or 38 degrees Centigrade); (2) A new (within the last seven days) cough; (3) New shortness of breath; or (4) New sore throat.
- Offer leave policies that do not require a health care provider's note for staff to be able to use sick days or for staff to return to work after being sick. Staff should be clearly instructed on the criteria for returning to work after illness:
  - Minimum of 7 days; AND
  - At least 72 hours of those must be fever-free without fever-reducing medication; AND
  - All other symptoms resolved (cough may persist for 1 – 2 weeks).
- Staff should monitor themselves for any signs or symptoms, including checking their temperature before reporting to work each day. Where available, staff temperatures should be taken prior to starting the work shift. Staff should immediately notify their supervisor if they develop any symptoms at work.

**☐ Prevent the Introduction of COVID-19 into the Facility or Group Home**

- Communicate to all visitors and post signs at all entrances instructing visitors not to visit if they are sick. [Sign templates are available for download.](#)
- Except for emergency medical personnel, screen everybody entering the facility or group home prior to entry with questions about symptoms and exposures. It is generally sufficient to ask the following questions:
  - (1) Have you had any of the following new symptoms in the last seven days: fever or chills, cough (either new, or different than your usual cough), sore throat, shortness of breath, or any other flu-like symptoms?
  - (2) In the past week, have you been in close (less than 6 feet), prolonged contact (more than 2-3 minutes) with someone with suspected or confirmed COVID-19 without using infection protection and control precautions?
  - (3) For congregate care facilities that have not prohibited visitors, if measuring temperatures, is the temperature 100.4° F or greater?
- Instruct residents and staff to report COVID-19 symptoms as soon as possible.

- Strongly discourage residents from leaving the facility, except for supervised breaks, as feasible.

#### **□ Environmental Cleaning and Disinfection**

- Clean and disinfect as [recommended](#) by the CDC on a regular basis. The CDC recommendations include guidance for both routine environmental cleaning and specific guidance for when someone is ill.
- Clean frequently touched surfaces, such as doorknobs, door handles, handrails, and telephones, as well as non-porous surfaces in bathrooms, sleeping areas, cafeterias, and offices (e.g., floors), using an hospital disinfectant that is [registered with the Environmental Protection Agency \(EPA\)](#) as active against viruses.
- Place waste baskets in visible locations and empty regularly.
- If feasible, enhance ventilation in common areas such as waiting areas, TV rooms, and reading rooms.
- Linens, eating utensils, and dishes belonging to those who are sick do not need to be cleaned separately, but should be thoroughly washed before sharing. Instruct cleaning staff to avoid “hugging” laundry before washing it to avoid self-contamination. Instruct cleaning staff to wear gloves if available and wash their hands with soap and water or an alcohol-based hand sanitizer immediately after handling infected laundry. [Additional guidance is available from CDC.](#)

#### **□ Detection and Care of People with Suspect or Confirmed COVID-19**

- If suspected or confirmed COVID-19 is detected in your facility or group home, exclude all visitors and cancel group activities in common areas.
- Most people with COVID-19 can be managed without medical intervention using [CDC guidance](#), as long as they are supported with all of their immediate needs. Facilities should be prepared with a supply of basic over-the-counter medications such as acetaminophen, cough drops, and should have the ability to take temperatures.
- Minimize the number of staff members who have face-to-face interactions with clients with respiratory symptoms. Staff and volunteers at high risk of severe COVID-19 (those who are older or have underlying health conditions) should not be designated as caregivers for sick clients.
  - Note: Disposable facemasks should be reserved for use by clients who exhibit respiratory symptoms. Clients who become sick should be given a clean disposable facemask to wear if not in a separate room.
- Employees: Employees with either suspected or confirmed COVID-19 should be sent home for a period of at least 7 days. The employee may return to work after these three things have happened:
  - There has been no fever for at least 72 hours (that is, three full days of no fever without the use of medicine that reduces fevers); AND

- Other symptoms have improved (for example, when cough or shortness of breath have improved); AND
- At least 7 days have passed since symptoms first appeared.
- If residents with suspected COVID-19 develop worsening symptoms (e.g., high fever, rapid breathing), a health care provider should be consulted, and especially for people 50 years old or older, people that have chronic medical conditions (such as chronic lung disease, heart disease, diabetes, or a weakened immune system), or people with disabilities.
- When transport of a client or resident is necessary, implement procedures to ensure notification of all receiving facilities before the transport takes place.

**□ Limiting the Spread of COVID-19 through Social Distancing and Use of Personal Protective Equipment**

- There is a severe shortage of personal protective equipment (PPE) in Maryland. MDH urges providers to implement measures to conserve PPE, such as using social distancing whenever practical and feasible.
- When feasible, MDH recommends that residents with suspected or confirmed COVID-19 be managed in their residence, and preferably isolated in a private bedroom with a private bathroom. If common areas are unavoidable (such as a shared bathroom), clean the area after the individual uses it.
- Avoid sharing personal household items, like dishes, towels, and bedding.
- Staff caring for (including transporting) symptomatic residents should avoid close contact (within 6 feet) if possible, or use appropriate PPE when close contact is unavoidable, including gloves, eye protection (goggles or face shield), and, if available, a face mask.
- When available, symptomatic residents should be provided a face mask to limit the exposure to other residents and staff, especially when in common areas or around other individuals. If the symptomatic resident is unable to wear a face mask, other people in the room should wear face masks, if available, especially if within 6 feet of the ill person.
- If multiple residents of the facility are diagnosed with COVID-19, try to cohort them into a single area, as separated from other residents of the facility as possible. Try to limit the number of staff responsible for interacting with them until their illness has resolved.
- Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. Roommates of symptomatic residents may already be exposed, so if separate rooms are not available it may be acceptable to allow them to remain in the same room.
- Deliver all meals to rooms or apartments, as feasible.
- Suspend all group programs including day programs.

**❑ Special Considerations for People Experiencing Unsheltered Homelessness**

- Congregate homeless shelters will have unique challenges regarding these issues. Depending on how they are configured and the residents they serve, shelter-specific plans may be needed that best limit the potential for COVID-19 transmission through close contact (within 6 feet) in common areas, including hallways if they are used for social interactions. There is [CDC guidance](#) specifically for people experiencing homelessness who are unsheltered.
- Agencies and partner organizations need to implement a plan that can identify suspected COVID-19 in this population and transport affected individuals to a dedicated facility, where they can be housed and supported for the full course of their illness as recommended by MDH.

**❑ Mental Health**

- Some facilities provide mental health services including full on-site services, evaluation of community clients, and referral to off-site providers. Have plans in place for patients who regularly receive mental health services. If possible, do not co-mingle people coming in from the community for day services with the residential population or staff, in order to reduce opportunities for introduction of COVID-19 to the residential population.
- If a client or resident must be isolated because of suspected or confirmed COVID-19, consider alternative arrangements such as video conferencing for continuity of regular services.
- Implement procedures to identify and update at least weekly the mental health resources (e.g., providers, pharmacies) that are available.
- Review and update, as needed, provider contracts and emergency medical protocols and procedures, including transporting persons to inpatient mental health facilities.
- If necessary, evaluate clients and residents for other medical needs.

**☐ Examples of Social Distancing in Congregate Settings**

<p>Sleeping Arrangements</p>	<ul style="list-style-type: none"> <li>• Increase spacing so beds are at least 3 to 6 feet apart.</li> <li>• If space allows, put fewer residents within a dorm/unit.</li> <li>• Arrange beds so that individuals lay head-to-toe (or toe-to-toe), or use neutral barriers (foot lockers, curtains) to create barriers between beds.</li> <li>• Move residents with symptoms into separate rooms with closed doors, and provide a separate bathroom, if possible.</li> <li>• If only shared rooms are available, consider housing the person who is ill in a room with the fewest possible number of other residents.</li> <li>• Avoid housing older adults, people with underlying medical conditions, or people with disabilities in the same room as people with symptoms.</li> </ul>
<p>Mealtimes</p>	<ul style="list-style-type: none"> <li>• Stagger mealtimes to reduce crowding in shared eating facilities.</li> <li>• Stagger the schedule for use of common/shared kitchens.</li> </ul>
<p>Bathrooms and Bathing</p>	<ul style="list-style-type: none"> <li>• Create a staggered bathing schedule to reduce the amount of people using the facilities at the same time.</li> </ul>
<p>Recreation/ Common Areas</p>	<ul style="list-style-type: none"> <li>• Create a schedule for using common spaces.</li> <li>• Reduce activities that congregate many residents at once such as “house meetings” and opt for smaller group activities.</li> </ul>
<p>Transport</p>	<ul style="list-style-type: none"> <li>• Opt for transporting fewer people per trip and ensure that passengers have more space between one another.</li> </ul>
<p>Communication</p>	<ul style="list-style-type: none"> <li>• Reduce the amount of face-to-face interactions with residents for simple informational purposes.</li> <li>• Consider using bulletin boards, signs, posters, brochures, emails, phone, mailbox, or sliding information under someone’s door.</li> </ul>
<p>Staff Activities</p>	<ul style="list-style-type: none"> <li>• Reduce unnecessary assembly of staff (e.g., large meetings when information can be communicated by written guidance instead).</li> </ul>