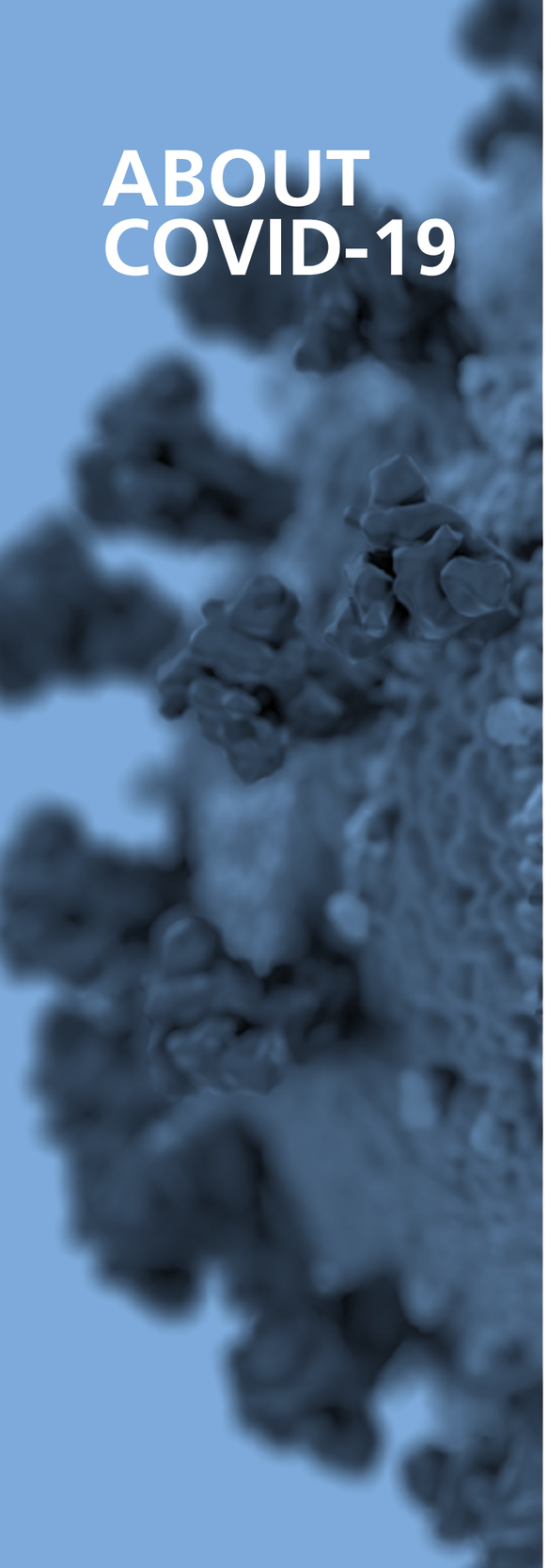
SENIOR LIVING READINESS ASSESSMENT

AMENTA|EMMA

ARCHITECTS

Senior Living communities have remained open and operational on a severely limited basis throughout the COVID-19 Crisis. Outside visitation has been restricted, common areas for dining and other social activities have been closed to resident access, and non-essential staff has been asked to work from home. In the coming weeks and months, these communities will begin to reopen to a “new normal”. Given the uncertainties of these uncharted times, no one can say for certain exactly what should happen or what is the “best” method to accomplish this process. There are many established authorities (e.g. OSHA, Center for Disease Control, Centers for Medicare & Medicaid Services) that have provided recommendations about policies that should be implemented to facilitate reopening Senior Living communities in a safe manner. We have listed below some of the main guidelines shared by many of these experts.

Table of Contents



ABOUT COVID-19

Symptoms & Risks of Covid-19

Infection with SARS-CoV-2, the virus that causes COVID-19, can cause illness ranging from mild to severe and, in some cases, can be fatal. Symptoms typically include fever, cough, and shortness of breath. Some people infected with the virus have reported experiencing other non-respiratory symptoms. Other people, referred to as asymptomatic cases, have experienced no symptoms at all. Note: Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.

According to the CDC, symptoms of COVID-19 may appear in as few as 2 days or as long as 14 days after exposure.

Most persons infected with COVID-19 experience mild symptoms and recover. However, some go on to experience more serious illness and may require hospital care. Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19 and other pathogens, including multidrug-resistant organisms (e.g., Carbapenemase-producing organisms, Candida auris). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP).

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At least half of older adults living in long-term care facilities suffer from cognitive impairment with Alzheimer's disease or other dementias. Infection prevention strategies to prevent the spread of COVID-19 are especially challenging to implement in dedicated memory care units where numerous residents with cognitive impairment reside together. See https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html for further considerations.

How Covid-19 Spreads

Although the first human cases of COVID-19 likely resulted from exposure to infected animals, infected people can spread SARS-CoV-2 to other people. The virus is thought to spread mainly from person-to-person, including:

- Between people who are in close contact with one another (within about 6 feet).
- Through respiratory droplets produced when an infected person coughs or sneezes. These droplets can land in the mouths or noses of people who are nearby or possibly be inhaled into the lungs.

It may be possible that a person can get COVID-19 by touching a surface or object that has SARS-CoV-2 on it and then touching their own mouth, nose, or possibly their eyes, but this is not thought to be the primary way the virus spreads.

People are thought to be most contagious when they are most symptomatic (i.e., experiencing fever, cough, and/or shortness of breath). Some spread might be possible before people show symptoms; there have been reports of this type of asymptomatic transmission with this new coronavirus, but this is also not thought to be the main way the virus spreads.

Although the United States has implemented public health measures to limit the spread of the virus, it is likely that some person-to-person transmission will continue to occur.

The CDC website provides the latest information about COVID-19 transmission: www.cdc.gov/coronavirus/2019-ncov/about/transmission.html.

Basic Infection Prevention Measures

Alcohol-based hand sanitizer (ABHS) is the preferred method of hand hygiene; however, sinks should still be stocked with soap and paper towels. Hand hygiene should be performed in the following situations: before resident contact, even if PPE is worn; after contact with the resident; after contact with blood, body fluids, or contaminated surfaces or equipment; before performing aseptic tasks; and after removing PPE.

Recommended PPE when caring for residents with suspected or confirmed COVID-19 includes gloves, gown, N-95 or higher-level respirator (or facemask if respirators are not available or HCP are not fit-tested), and eye protection (face shield or goggles). PPE should be readily available outside of resident rooms, although the facility should consider assigning a staff member to shepherd supplies and encourage appropriate use.

As appropriate, all building occupants should apply good hygiene and infection control practices, including:

- Frequently washing hands
- Maintain a social distance of 6' (six feet) from others
- If you feel sick, stay at home
- Cover your cough of sneeze
- Avoid using other employees' phones, desk, work tools and equipment when possible.

FACILITY READINESS

Facility Modifications (per OSHA)

Workplace modifications involve isolating employees from work-related hazards. In workplaces where they are appropriate, these types of modifications reduce exposure to hazards without relying on worker behavior and can be the most cost-effective solution to implement. Workplace modifications for COVID-19, in low to medium risk exposure environments include:

- Installing high-efficiency air filters
- Increasing ventilation rates in the work environment
- Installing physical barriers, such as clear plastic sneeze guards
- Installing a drive-thru window for customer service

FACILITY CHECKLISTS

Pre-Assessment Survey

Post-Assessment Summary

HVAC
Supplies
Entrance & Congestion Points
Elevator
Public Restroom
Single-User Restroom
Conference / Meeting / Flex Room
Consultation / Treatment Room
Open Office
Enclosed Office
Nurses' Station / Charting / Work Area
Staff Break Room / Kitchenette
Salon & Personal Services
Rehabilitation / Physical Therapy Area
Multipurpose / Activity Room
Dining Room / Area
Resident Apartments
Resident Units - Memory Care
Private Resident Units
Semi-Private Resident Units
Resident Unit Corridors
Guest / Respite Unit or Suite
Central Bathing
Wellness Center Fitness Equipment Room
Wellness Center Exercise Clasroom
Wellness Center Locker Rooms
Wellness Center Natatorium / Pool
Arts & Crafts Room
Art Gallery
Theater / Auditorium
Main Street Corridor
Central Market
Country Kitchen / Bistro
Lounge / Den / Seating Area
Snoezelen Room
Library
Other

Pre-Assessment Survey

(to establish baseline prior to assessment of facility)

In order to provide a tailored assessment and relevant feedback and recommendations, it is important to understand the status of implementation of preparedness efforts, the challenges and areas of improvement identified through self-evaluation and reporting and the plans for phased reopening or relaxation of preventative meaures. Key assessment tools and checklists are available and can be adapted to meet the specific needs and circumstances of a facility and the stages of combating COVID-19:

Checklists & Assessment Tools

1. **CDC - Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings**

- Facilities are encouraged to adapt this checklist to meet their specific needs and circumstances.
- Checklist identifies key areas facilities should consider in their COVID-19 planning.
- It does not describe mandatory requirements or standards.
- The checklist is formatted for a facility to document *Completed, In Progress* or *Not Started* for each preparedness effort.

COMPLETED BY	
DATE	
PHASE:	

2. **CDC - Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19**

- Referred to as ICAR, Infection Control Assessment and Response Tool
- Geared towards nursing homes but may contain content relevant for assisted living facilities
- Not a regulatory inspection but instead designed to ensure the facility is prepared to identify and prevent spread of COVID-19, promote discussion and offer available resources.
- Format:
  * Assessor / investigator conducts assessment in-person or remotely with a series of prompting questions
  * Elements assessed with Y/N response and notes or areas for improvement
  * Key demographics are collected regarding current COVID-19 status in facility and surrounding community and extent of COVID-19 guidance provided to facility.

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3. **AIA – Re-occupancy Assessment Tool V2.0 (May 28, 2020)**

- Structured on OSHA's Guidance on Preparing Workplaces for COVID-19 (OSHA DOC. 3990-03-2020) & CDC Guidelines
- Base parameters or prerequisites used to determine if a facility is a good candidate for the Assessment Tool.
- Offers general workplace controls in order of CDC priority: Elimination, Substitution, Architectural & Engineering Controls, Administration Controls, Personal Protective Equipment (PPE)
- Some controls are identified for assessment of certain building types: Education, Office, Restaurant, Senior Living, Retail & Housing
- Controls may be further identified as *Essential* or *Desirable* to use as the basis for design considerations.

COMPLETED BY	
DATE	
PHASE:	

Post-Assessment Summary

Facility /. Location _____

Care Setting _____

Summary

Summary

COMPLETED BY	
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PHASE:	

MULTI-PURPOSE / ACTIVITY ROOM

Room name/number _____

ISSUE	DESCRIPTION
	50% Capacity of normal class size with occupancy posted
	Mark areas on floor to allow movement and 6’ distance
	Build cohorts for group classes if possible
	Hand sanitizer available at entry
	Central system ventilation rates increases (fresh air)
	Ceiling fans draw air up
	Window fans (if used) draw air out not in
	Free standing fans that recirculate air not used
	Window A/C units (if used) maximize fresh air with fan set to low speed
	Touchless appliances where possible
	State hotline (2-1-1) for violations posted
	Water fountains for filling only (if available)

Recommendations

COMPLETED BY	
DATE	

DINING ROOM / AREA (INDEPENDENT LIVING)

Room name/number _____

ISSUE	DESCRIPTION
	Entry Separate from exit to allow one way flow
	Signage posted supporting new policies (social distancing, cleaning, PPE, sick policies)
	Indoor waiting areas closed
	Buffet (self serving eliminated)
	Signage posted limiting capacity to 50%
	Customer seating groups minimum 6’ apart
	Customer seating groups closer than 6’ have non porus barriers minimum 30” above table height
	Central system ventilation rates increases (fresh air)
	Ceiling fans draw air up
	Window fan (if used) draw air out not in
	Free standing fans that recirculate air not used
	Window A/C units maximize fresh air with fan set to low speed
	Non essential amenities removed
	Discrete discreet work zones for servers
	Touchless or disposable menus used
	Single packet condiments used
	Silverware rolled and packaged
	Touchless appliances installed (Payment, PT, Soap, Trash)
	Bar Seating open has physical barriers between customers & bar space no active work area behind bar, parties 6’ from other parties
	State hotline (2-1-1) posted for violations
	Hand Sanitizer available at entry points and common areas
	Kitchen (See Kitchen Operations Section)

Recommendations

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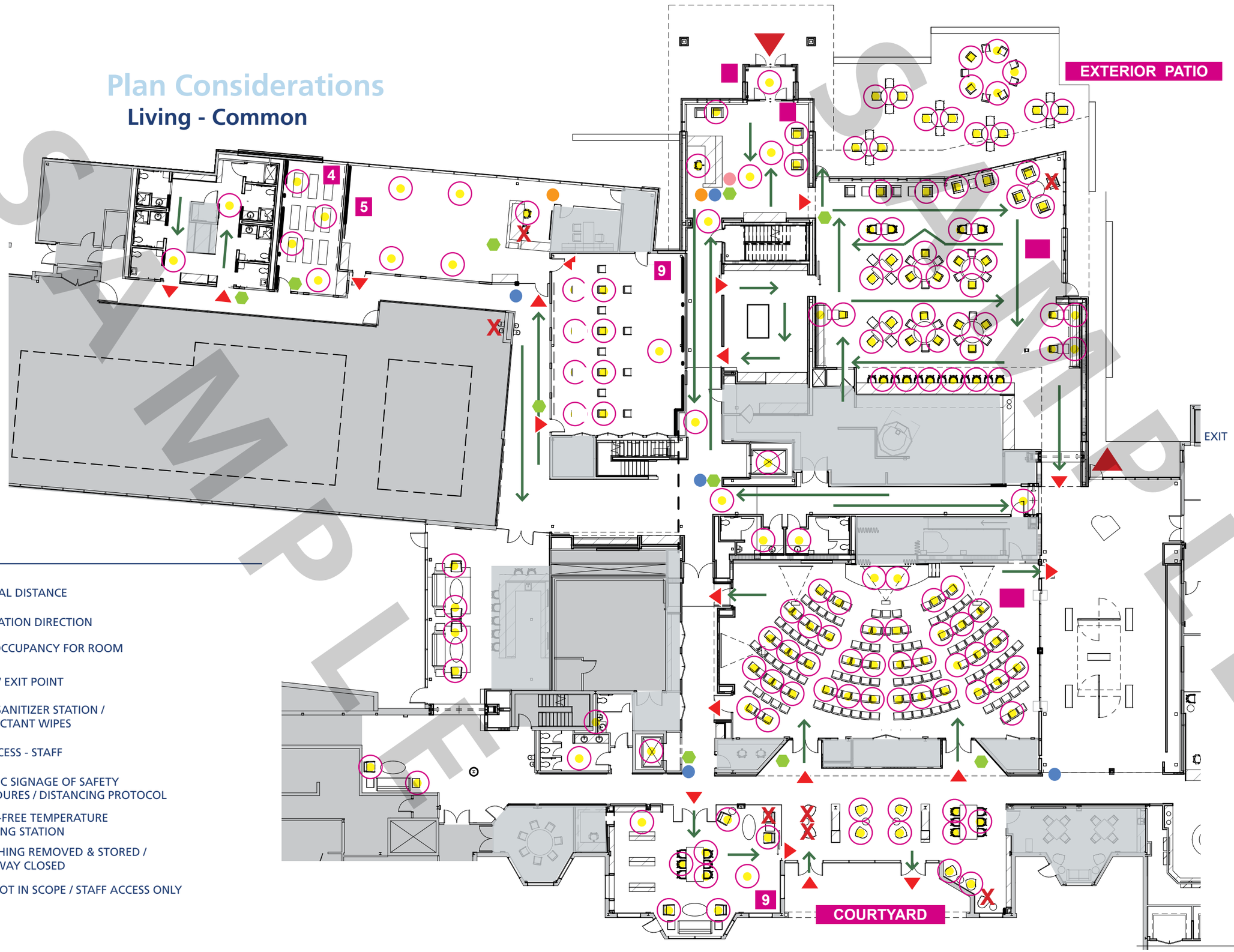
SAMPLE VISITATION & RESIDENT-READY PLANS

Floor Plan Considerations

Senior

Living - Common



LEGEND

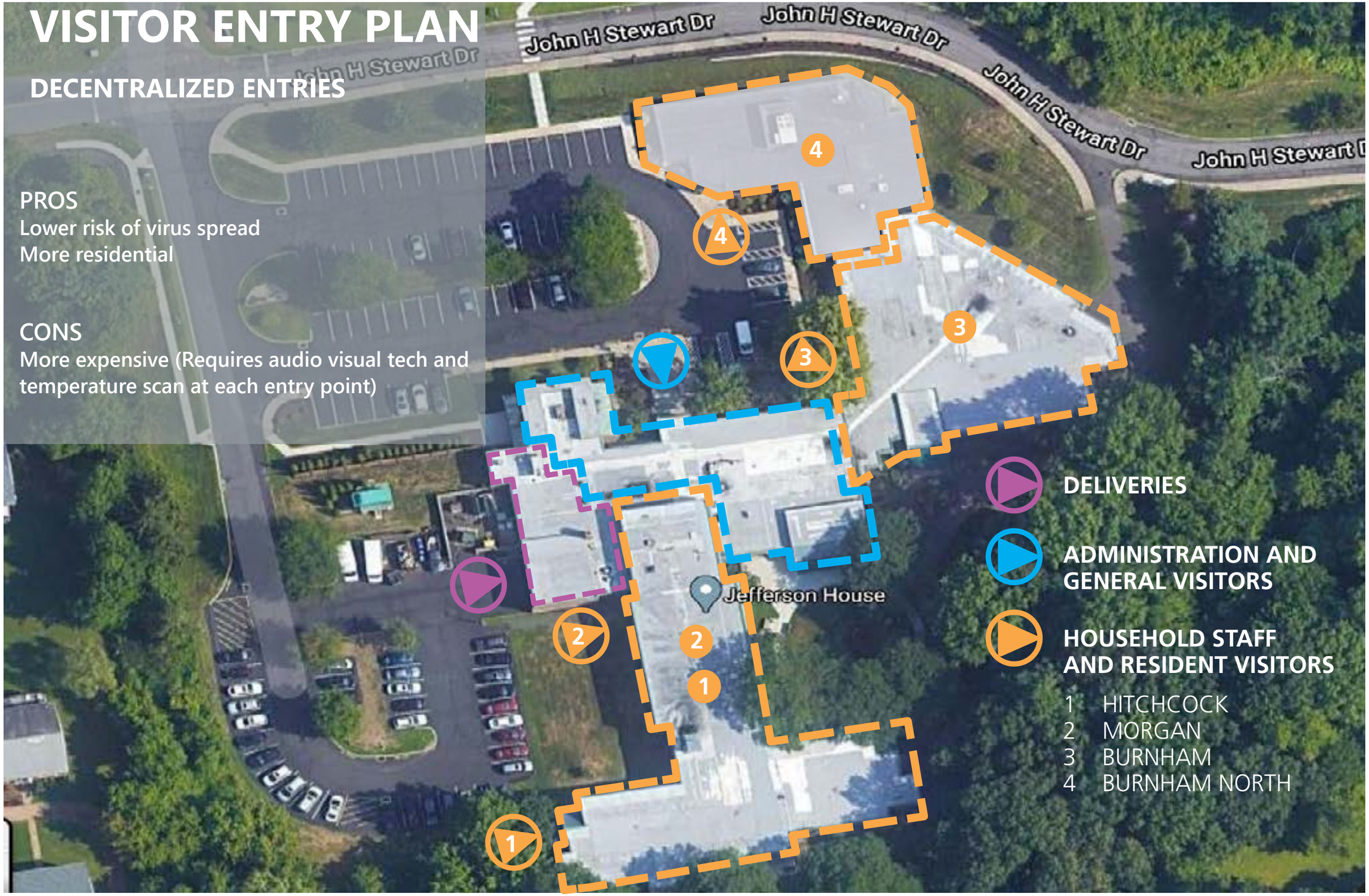
- 6’ SOCIAL DISTANCE
- CIRCULATION DIRECTION
- 2 — MAX. OCCUPANCY FOR ROOM
- ENTRY / EXIT POINT
- HAND SANITIZER STATION / DISINFECTANT WIPES
- PPE ACCESS - STAFF
- GRAPHIC SIGNAGE OF SAFETY PROCEDURES / DISTANCING PROTOCOL
- TOUCH-FREE TEMPERATURE SCANNING STATION
- X — FURNISHING REMOVED & STORED / ENTRYWAY CLOSED
- AREA NOT IN SCOPE / STAFF ACCESS ONLY

VISITOR ENTRY PLAN

DECENTRALIZED ENTRIES

PROS
Lower risk of virus spread
More residential

CONS
More expensive (Requires audio visual tech and temperature scan at each entry point)



OCCUPANT & OPERATIONAL READINESS

Sick Staff Protocol

The identification and isolation of potentially infectious individuals is a critical step in protecting workers, customers, visitors, and others in the workplace. Symptoms may appear 2–14 days after exposure to the virus. People with these symptoms may have COVID-19:

- *Cough*
- *Fever*
- *Shortness Of Breath Or Difficulty Breathing*
- *Chills*
- *Muscle Pain*
- *Sore Throat*
- *New Loss Of Taste Or Smell*

Action Considerations

Implementing procedures for employees to report when they are sick or experiencing symptoms of COVID-19

Implementing policies to immediately isolate employees who have signs and/or symptoms of COVID-19 (e.g., stay home)

Ensure that sick leave policies are flexible and consistent with public health guidance

Establish timeframe for isolation away from office

Implement protocol for identification of other staff members who may have been exposed

Do not require a healthcare provider's note to validate employee's illness or return to work

At-Risk Employees

Certain individuals, or immediate family members, may have underlying health issues that put them at higher risk of complications from COVID-19. Based on current CDC guidance, those at high risk for severe illness due to COVID-19 include:

- *People 65 years and older*
- *People with chronic lung disease or moderate to severe asthma*
- *People who have serious heart conditions*
- *People who are immunocompromised*
- *People with severe obesity (body mass index [BMI] of 40 or higher)*
- *People with diabetes*
- *People with chronic kidney disease undergoing dialysis*
- *People with liver disease*

Action Considerations

Employees who feel they are at-risk for severe illness from COVID-19 should notify employer.

Implementing flexible policies that permit employees to work from home.

Offering flexible at-risk workers duties that minimize their contact with customers or other employees

APPENDIX

Additional Information and resources

Centers for Disease Control and Prevention (CDC)

- Coronavirus Disease 2019 (COVID-19) Symptoms
- Healthcare Facilities: Managing Operations During the COVID-19 Pandemic
- Preparing for COVID-19 in Nursing Homes
- Responding to Coronavirus (COVID-19) in Nursing Homes
- Testing Guidelines for Nursing Homes
- Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes
- Considerations for Memory Care Units in Long-term Care Facilities
- Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities
- Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings
- Guidance for Healthcare Providers about Hand Hygiene and COVID-19
- Recommendations for the Optimization of PPE Supplies
- Using Personal Protective Equipment (PPE) – for Healthcare Professionals
- Use of Cloth Face Coverings to Help Slow the Spread of COVID-19
- Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance)
- *Travel Recommendations

Department of Labor: Occupational Safety & Health Administration (OSHA)

- Alert: COVID-19 Guidance for Nursing Home and Long-Term Care Facility Workers
- COVID-19 Guidance for Healthcare Workers and Employers
- Guidance on Preparing Workplaces for COVID-19 [OSHA 3990-03 2020]

Environmental Protection Agency (EPA)

- List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19)

Center for Medicare and Medicaid Services (CMS)

- Nursing Home Reopening Recommendations for State and Local Officials [QSO-20-30-NH]

State of Connecticut Department of Public Health (DPH)

- Guidelines via Blast Faxes

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