

**EXHIBIT Q**

# KaiVac® 1750

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The KaiVac® 1750 combines high capacity, compact size and a compelling price to deliver the highest value possible in this fast growing category. Designed for total soil removal, No-Touch Cleaning combines an indoor pressure washer, chemical injection and wet vacuum technologies onto a single space-efficient platform. Workers simply spray cleaning solution on fixtures and floors, and then blast the soils to the floor with a high-pressure water spray. Finally, they vacuum the floor dry, completely removing soils and bacteria. The results are sparkling clean restrooms, kitchens, stairwells and more without ever touching a contaminated surface. No more soil, no more odor, no more complaints.

## Multipurpose for Total Building Cleaning

Like all No-Touch Cleaning systems, the versatile KaiVac 1750 accommodates an array of add-on components that instantly transforms it into a truly multipurpose machine.

### Highlights:

- 500 psi pump
- HEPA filtration
- Small footprint and height for easy maneuvering and worker acceptance
- Removable "black box" engine compartment for rapid repair
- CRI Silver-Rated carpet extraction capability
- Perfect for climbing stairs and loading into vehicles
- Breaks apart for maximum portability
- Part of a complete system including a full line of cleaning chemicals

Contact us today for a free on-site demonstration and see the benefits of No-Touch Cleaning for yourself.



Protected by multiple US patents.  
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**EXHIBIT R**



## Coronavirus Disease 2019 (COVID-19)

# Healthcare Infection Prevention and Control FAQs for COVID-19

Updated June 5, 2020

### Page Summary

This page was updated on April 23, 2020 to align with the revised [Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#).

**Who is this for:** Healthcare personnel who may care for patients who are confirmed with or under investigation for COVID-19.

**What is it for:** This creates FAQs to support the existing [Healthcare Infection Prevention and Control Guidance for COVID-19](#).

**How is it used:** To assist healthcare facilities in preventing transmission of COVID-19 in healthcare settings.

### Do CDC's interim infection prevention and control recommendations for COVID-19 apply to psychiatric hospitals or other behavioral health facilities? +



Yes. To keep patients and healthcare personnel (HCP) healthy and safe, CDC's infection prevention and control guidance applies to all settings where healthcare is delivered. However, as with any guidance, facilities can tailor certain recommendations to their setting. For example, inpatient psychiatric care includes communal experiences and group activities that may need to continue. If so, these activities might need to be adapted to align with [social distancing](#) recommendations. Other recommended infection control measures (for example, ensuring access to alcohol-based hand sanitizer, cohorting patients with COVID-19 and assigning dedicated staff, or implementing universal source control measures) might not be safe or appropriate to implement in all locations or for all patients due to security and behavioral concerns.

Challenges and potential solutions specific to behavioral health settings might include:

- Cohorting
  - **Challenge:** To prevent transmission, it is generally recommended that patients with COVID-19 be transferred to a separate area of the facility where they can be cared for by dedicated HCP. Because of security concerns or specialized care needs, it might not be possible to cohort certain patients together or change HCP assigned to their care.
  - **Potential Solutions:** When cohorting is not possible, implement measures to maintain social distancing (at least 6 feet) between patients with COVID-19 and others on the unit. Ideally, this would include a separate bathroom for COVID-19 patients. Ensure HCP wear [all recommended personal protective equipment \(PPE\)](#) when caring for patients with suspected or confirmed COVID-19.
- Group Therapy Sessions
  - **Challenge:** Group counseling, therapy, and discussion sessions are a critical component of psychiatric treatment and care plans, but the traditional set-up for these activities is not compatible with social distancing recommendations.
  - **Potential Solutions:** When possible, use virtual methods, or decrease group size so social distancing can be maintained. In the event that COVID-19 is transmitted in the facility, sessions should stop or move to a video discussion forum until additional infection prevention measures are in place to stop the spread.

- Cloth Face Coverings
  - **Challenge:** For some patients, the use of cloth face coverings or facemasks might pose an additional danger or may cause distress. Some patients may be unable or unwilling to use them as intended. Elastic and cloth straps can be used for strangling oneself or others, and metal nasal bridges can be used for self-harm or as a weapon.
  - **Potential Solutions:** Consider allowing patients at low risk for misuse to wear cloth face coverings or facemasks, with a preference for those with short ear-loops rather than longer ties. Consider use of cloth face coverings or facemasks during supervised group activities. Ensure that HCP interacting with patients who cannot wear a cloth face covering or facemask are wearing eye protection and a facemask (or a respirator if the patient is suspected to have COVID-19 and respirators are available).
- Alcohol-based Hand Sanitizer
  - **Challenge:** While alcohol-based hand sanitizer (ABHS) containing 60-95% alcohol is an important tool to increase adherence to [hand hygiene](#) recommendations, ABHS must be used carefully in psychiatric facilities to ensure it is not ingested by patients.
  - **Potential Solutions:** Consider not placing ABHS in patients' rooms in psychiatric facilities, nor in locations where the patients have unsupervised access. Encourage frequent hand washing with soap and water for patients and HCP. Consider providing personal, pocket-sized ABHS dispensers for HCP.
- Dining
  - **Challenge:** As part of social distancing, communal dining is generally not recommended. However, eating needs to remain supervised due to the potential for self-harm with eating utensils and because commonly used psychiatric medications may cause side effects (e.g., tardive dyskinesia, dysphagia, hypo- and hypersalivation) that increase choking risk for patients.
  - **Potential Solutions:** One option is to position staff in patients' rooms to monitor their dining. Another option is to allow communal dining in shifts so that staff can monitor patients while ensuring they remain at least 6 feet apart. A third option is to have patients sit in appropriately spaced chairs in the hallway outside their rooms so they can be monitored while they eat.
- Smoking
  - **Challenge:** A higher proportion of psychiatric patients smoke cigarettes compared to the general population. Patients might congregate in outdoor smoking spaces without practicing appropriate social distancing.
  - **Potential Solutions:** Limit the number of patients allowed to access smoking spaces at the same time, and position staff to observe and ensure patients are practicing appropriate physical distancing.

**If a long-term care facility has a resident or staff member with suspected or confirmed COVID-19, how and to whom should this be communicated?** +

Facilities should follow the reporting requirements of their state or jurisdiction. Those regulated by the Centers for Medicare and Medicaid Services (CMS) (e.g., nursing homes) should also follow all [CMS requirements](#)  , which are being updated to include new requirements for reporting to CDC and to residents and their representatives.

In addition, [CDC recommends](#) that [health departments](#) be promptly notified about:

- Residents or healthcare personnel (HCP) with suspected or confirmed COVID-19,
- Residents with severe respiratory infection resulting in hospitalization or death, and
- $\geq 3$  residents or HCP with new-onset respiratory symptoms within 72 hours of each other.

These could signal an outbreak of COVID-19 or other respiratory disease in the facility. The health department can provide important guidance to assist with case finding and halting transmission.

The facility should also have a plan and mechanism to regularly communicate with residents, family members, and HCP, including if cases of COVID-19 are identified in the facility. Often, information in nursing homes is communicated through town hall meetings and staff meetings, along with letters or emails. However, during the COVID-19 pandemic, in-person gatherings should not occur. Instead, communication should occur through virtual meetings over phone or web platforms. These should be supplemented with written communications that provide contact information for a staff member who can respond to questions or concerns. Communications should include information describing the current

situation, plans for limiting spread within the facility, and recommended actions they can take to protect themselves and others. Facilities should make this information available in a timely manner and offer periodic updates as the situation develops and more information becomes available.

**Is a negative test for SARS-CoV-2, the virus that causes COVID-19, required before a hospitalized patient can be discharged to a nursing home?** +

**No.** For patients hospitalized with COVID-19, decisions about discharge from the hospital should be based on their **clinical status** and the ability of the accepting facility to meet their care needs and adhere to recommended infection prevention and control practices. Decisions about hospital discharge are distinct from decisions about [discontinuation of Transmission-Based Precautions](#).

For patients with suspected or confirmed COVID-19, decisions about discontinuing Transmission-Based Precautions should be based on the strategies outlined [here](#). The test-based strategy is **NOT REQUIRED** and might not be possible due to limitations on availability of testing.

If a patient with suspected or confirmed COVID-19 **has not** met criteria for discontinuing Transmission-Based Precautions, they should be transferred to a facility with the ability to adhere to [infection prevention and control recommendations](#) for the care of residents with COVID-19, including placement in a unit or area of the facility designated to care for residents with COVID-19 and provision of recommended personal protective equipment to healthcare personnel.

If the patient with suspected or confirmed COVID-19 **has** met the criteria for discontinuing Transmission-Based Precautions but **has** persistent symptoms (e.g., persistent cough), they should ideally be placed in a single room, be restricted to their room to the extent possible, and wear a facemask (if tolerated) during care activities until all symptoms are completely resolved or at baseline. If the patient **has** met the criteria for discontinuing Transmission-Based Precautions and **does not have** persistent symptoms, they do not require additional restrictions.

A patient hospitalized for non-COVID-related illnesses whose COVID-19 status is not known can be transferred to a nursing home without testing. However, to ensure they are not infected, nursing homes should place them in [Transmission-based Precautions](#) in a separate observation area or in a single-person room until 14 days have elapsed since admission.

As part of [universal source control measures](#), all residents (including those described in the scenarios above) should wear a cloth face covering or facemask (if tolerated) whenever they leave their room.

**During the COVID-19 pandemic, are there special considerations for surgical and other procedural care settings, including performance of aerosol-generating procedures (AGPs)?** +

As part of routine practices, healthcare personnel (HCP) should be applying [Standard Precautions](#). HCP should always deliberately assess potential risks of exposure to infectious material before engaging in activities and procedures in healthcare delivery. Based on their risk assessment, safe work practices, including engineering controls that reduce the release of infectious material, administrative controls, and use of personal protective equipment (PPE) should be implemented at the point of care according to CDC guidelines and standards of practice for the activity performed.

To reduce SARS-CoV-2 exposure during the COVID-19 pandemic, CDC recommends that facilities:

- consider nonoperative approaches when feasible;
- minimize the use of procedures or techniques that might produce infectious aerosols when feasible;
- minimize the number of people in the operating or procedure room to reduce exposures;
- use the [extent of community transmission and an assessment of the likelihood for patient harm if care is delayed](#) to make decisions about cancelling or postponing elective surgeries and procedures; and
- implement universal source control measures, which includes having patients wear a cloth face covering (as tolerated) and having HCP wear a facemask at all times while they are in the healthcare facility.

If surgery or procedures cannot be postponed, HCP caring for patients with suspected or confirmed COVID-19 should adhere to all [recommended infection prevention and control practices for COVID-19](#). This includes:

- Using all recommended PPE: an N95 or higher-level respirator (or facemask if respirators are not available), eye protection, gloves, and gown.

protection, gloves, and a gown.

- Respirators with exhalation valves should not be used during surgical procedures as unfiltered exhaled breath would compromise the sterile field.
- If shortages exist, N95 or higher-level respirators should be prioritized for procedures involving higher risk techniques (e.g., that generate potentially infectious aerosols) or that involve anatomic regions where viral loads might be higher (e.g., nose and throat, oropharynx, respiratory tract).
- As part of routine practice, HCP should also be using additional engineering controls for source control, when applicable (e.g., smoke evacuation devices).

Because COVID-19 can be transmitted asymptotically, some infected individuals will not be identified based on clinical signs and symptoms. HCP providing surgical or procedural care to patients not suspected of having COVID-19 should use a tiered approach based on the level of community transmission to inform the need for universal eye protection and respirator use (see FAQ addressing recommended PPE when caring for asymptomatic patients who are not suspected to have COVID-19). HCP should continue to use eye protection or an N95 or higher-level respirator whenever recommended for patient care as a part of Standard or Transmission-Based Precautions.

**Why does CDC continue to recommend respiratory protection equivalent or higher to the level provided by an N95 + disposable filtering facepiece respirator for care of patients with known or suspected COVID-19?**

CDC's guidance to use NIOSH-approved N95 disposable filtering facepiece or higher level respirators when providing care for patients with suspected or known COVID-19 is based on the current understanding of SARS-CoV-2 and related respiratory viruses.

Current data suggest that close-range aerosol transmission by droplet and inhalation, and contact followed by self-delivery to the eyes, nose, or mouth are likely routes of transmission. Long-range aerosol transmission, such as is seen with measles, has not been a feature of SARS-CoV-2.

Potential routes of close-range transmission include splashes and sprays of infectious material onto mucous membranes and inhalation of infectious virions exhaled by an infected person. The relative contribution of each of these is not known for SARS-CoV-2.

Facemasks commonly used during surgical procedures will provide barrier protection against droplet sprays contacting mucous membranes of the nose and mouth, but they are not designed to protect wearers from inhaling small particles. N95 and higher level respirators, such as other disposable filtering facepiece respirators, powered air-purifying respirators (PAPRs), and elastomeric respirators, provide both barrier and respiratory protection because of their tight fit and filtration characteristics.

Respirators should be used as part of a respiratory protection program that provides staff with medical evaluations, training, and fit testing.

Although facemasks are routinely used for the care of patients with common viral respiratory infections, N95 or higher level respirators are routinely recommended for emerging pathogens like SARS CoV-2, which have the potential for transmission via small particles, the ability to cause severe infections, and no specific treatments or vaccines.

CDC recommendations acknowledge the current challenges with limited supplies of N95s and other respirators. Facilities that do not have sufficient supplies of N95s and other respirators for all patient care should prioritize their use for activities and procedures that pose high risks of generating infectious aerosols and use facemasks for care that does not involve those activities or procedures. Detailed [strategies for optimizing the supply of N95 respirators](#) are available on the CDC website. Once availability of supplies is reestablished, the guidance states that the use of N95 and higher level respirators should resume.

**What personal protective equipment (PPE) should be worn by individuals transporting patients who are confirmed with or under investigation for COVID-19 within a healthcare facility? For example, what PPE should be worn when transporting a patient to radiology for imaging that cannot be performed in the patient room?** +

In general, transport and movement of the patient outside of their room should be limited to medically essential purposes. If being transported outside of the room, such as to radiology, healthcare personnel (HCP) in the receiving area should be notified in advance of transporting the patient. For transport, the patient should wear a facemask or cloth face covering to contain secretions and be covered with a clean sheet.

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If transport personnel must prepare the patient for transport (e.g., transfer them to the wheelchair or gurney), transport personnel should wear [all recommended PPE](#) (gloves, a gown, respiratory protection that is at least as protective as a fit tested NIOSH-certified disposable N95 filtering facepiece respirator or facemask—if a respirator is not available—and eye protection [i.e., goggles or disposable face shield that covers the front and sides of the face]). This recommendation is needed because these interactions typically involve close, often face-to-face, contact with the patient in an enclosed space (e.g., patient room). Once the patient has been transferred to the wheelchair or gurney (and prior to exiting the room), transporters should remove their gown, gloves, and eye protection and perform hand hygiene.

If the patient is wearing a facemask or cloth face covering, no recommendation for PPE is made typically for HCP transporting patients with a respiratory infection from the patient's room to the destination. However, given current limitations in knowledge regarding COVID-19 and following the currently cautious approach for [risk stratification and monitoring of healthcare personnel caring for patients with COVID-19](#), use of a facemask by the transporter is recommended for anything more than brief encounters with COVID-19 patients. Additional PPE should not be required unless there is an anticipated need to provide medical assistance during transport (e.g., helping the patient replace a dislodged facemask).

After arrival at their destination, receiving personnel (e.g., in radiology) and the transporter (if assisting with transfer) should perform hand hygiene and wear [all recommended PPE](#). If still wearing their original respirator or facemask, the transporter should take care to avoid self-contamination when donning the remainder of the recommended PPE. This cautious approach will be refined and updated as more information becomes available and as response needs change in the United States.

Interim guidance for EMS personnel transporting patients with confirmed or suspected COVID-19 is [available here](#). EMS personnel should wear all recommended PPE because they are providing direct medical care and in close contact with the patient for longer periods of time.

### **Given the potential for asymptomatic transmission of SARS-CoV-2, what personal protective equipment (PPE) should be worn by healthcare personnel (HCP) providing care to patients who are not suspected to have COVID-19?** +

The potential for asymptomatic SARS-CoV-2 transmission underscores the importance of applying prevention practices to all patients, including social distancing, hand hygiene, surface decontamination, and having patients wear a cloth face covering or facemask (for source control) while in a healthcare facility. To protect patients and co-workers, HCP should wear a facemask at all times while they are in a healthcare facility (i.e., practice source control). Use of a facemask, instead of a cloth face covering, is recommended for HCP, because a facemask offers both source control and protection from exposure to splashes and sprays of infectious material from others.

- HCP caring for patients with suspected or confirmed COVID-19 should continue to wear gloves, a gown, respiratory protection that is at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator (or facemask if respirators are not available), and eye protection (i.e., goggles or disposable face shield that covers the front and sides of the face).
- HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic patients with COVID-19. If COVID-19 is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow [Standard Precautions](#) (and [Transmission-Based Precautions](#) if required based on the suspected diagnosis). They should also:
  - Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from splashes and sprays of infectious material from others.
  - Wear an N95 or higher-level respirator, instead of a facemask, for:
    - Aerosol-generating procedures (See [Which procedures are considered aerosol generating procedures in healthcare settings FAQ](#)) and
    - Surgical procedures that might pose higher risk for transmission if the patient has COVID-19 (e.g., that generate potentially infectious aerosols or involving anatomic regions where viral loads might be higher, such as the nose and throat, oropharynx, respiratory tract) (see [Surgical FAQ](#) below).
  - Respirators with exhalation valves are not recommended for source control and should not be used during surgical procedures as unfiltered exhaled breath would compromise the sterile field



- For HCP working in areas with minimal to no community transmission, the universal eye protection and respirator recommendations (described above) for areas with moderate to substantial community transmission are optional. However, HCP should continue to use eye protection or an N95 or higher-level respirator whenever recommended for patient care as a part of Standard or Transmission-Based Precautions. Universal use of a facemask for source control is recommended for HCP.

Depending on testing availability and how rapidly results are available, facilities can also consider implementing pre-admission or pre-procedure testing for COVID-19. Testing results might inform decisions for universal use of eye protection and respirators as described above, especially if there are PPE shortages. Limitations of using this testing strategy include obtaining negative results in patients during their incubation period who later become infectious and false negative test results, depending on the test method used.

Definitions:

- **Substantial community transmission:** Large scale community transmission, including communal settings (e.g., schools, workplaces)
- **Minimal to moderate community transmission:** Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases
- **No to minimal community transmission:** Evidence of isolated cases or limited community transmission, case investigations underway; no evidence of exposure in large communal setting

#### **What personal protective equipment (PPE) should be worn by environmental services (EVS) personnel who clean and disinfect rooms of hospitalized patients with COVID-19?** +

In general, only essential personnel should enter the room of patients with COVID-19. Healthcare facilities should consider assigning daily cleaning and disinfection of high-touch surfaces to nursing personnel who will already be in the room providing care to the patient. If this responsibility is assigned to EVS personnel, they should wear all [recommended PPE](#) when in the room. PPE should be removed upon leaving the room, immediately followed by performance of hand hygiene.

After discharge, terminal cleaning may be performed by EVS personnel. They should delay entry into the room until a [sufficient time has elapsed](#) for enough air changes to remove potentially infectious particles. We do not yet know how long SARS-CoV-2 remains infectious in the air. Regardless, EVS personnel should refrain from entering the vacated room until sufficient time has elapsed for enough air changes to remove potentially infectious particles (more information on [clearance rates under differing ventilation conditions is available](#)). After this time has elapsed, EVS personnel may enter the room and should wear a gown and gloves when performing terminal cleaning. A facemask (if not already wearing for source control) and eye protection should be added if splashes or sprays during cleaning and disinfection activities are anticipated or otherwise required based on the selected cleaning products. Shoe covers are not recommended at this time for personnel caring for patients with COVID-19.

#### **Which procedures are considered aerosol generating procedures in healthcare settings?** +

Some procedures performed on patients are more likely to generate higher concentrations of infectious respiratory aerosols than coughing, sneezing, talking, or breathing. These aerosol generating procedures (AGPs) potentially put healthcare personnel and others at an increased risk for pathogen exposure and infection.

Development of a comprehensive list of AGPs for healthcare settings has not been possible, due to limitations in available data on which procedures may generate potentially infectious aerosols and the challenges in determining if reported transmissions during AGPs are due to aerosols or other exposures.

There is neither expert consensus, nor sufficient supporting data, to create a definitive and comprehensive list of AGPs for healthcare settings.

Commonly performed medical procedures that are often considered AGPs, or that create uncontrolled respiratory secretions, include:

- open suctioning of airways
- sputum induction
- cardiopulmonary resuscitation
- endotracheal intubation and extubation
- non-invasive ventilation (e.g., BiPAP, CPAP)
- bronchoscopy
- manual ventilation

Based on limited available data, it is uncertain whether aerosols generated from some procedures may be infectious, such as:

- nebulizer administration\*
- high flow O2 delivery

\*Aerosols generated by nebulizers are derived from medication in the nebulizer. It is uncertain whether potential associations between performing this common procedure and increased risk of infection might be due to aerosols generated by the procedure or due to increased contact between those administering the nebulized medication and infected patients.

References related to aerosol generating procedures:

Tran K, Cimon K, Severn M, Pessoa-Silva CL, Conly J (2012) Aerosol Generating Procedures and Risk of Transmission of Acute Respiratory Infections to Healthcare Workers: A Systematic Review. PLoS ONE 7(4); <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3338532/#!po=72.2222> ( ).

#### **Where should nasopharyngeal swabs be performed on a known or suspected COVID-19 patient, and with what PPE? +**

The collection of nasopharyngeal (NP) swabs from patients with known or suspected COVID-19 can be performed in a regular examination room with the door closed. Use of an airborne infection isolation room for nasopharyngeal specimen collection is not required. HCP in the room should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown. If respirators are not readily available, they should be prioritized for other procedures at higher risk for producing infectious aerosols (e.g., intubation), instead of for collecting NP swabs.

#### **Do all patients with confirmed or suspected COVID-19 need to be placed in airborne infection isolation rooms? +**

No. Updated *CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings* recommends placing patients in a regular examination room with the door closed. Airborne infection isolation rooms should be reserved for patients undergoing aerosol generating procedures or for diagnoses such as active tuberculosis.

#### **How long does an examination room need to remain vacant after being occupied by a patient with confirmed or suspected COVID-19? +**

Although spread of SARS-CoV-2 is believed to be primarily via respiratory droplets, the contribution of small respirable particles to close proximity transmission is currently uncertain. Airborne transmission from person-to-person over long distances is unlikely.

The amount of time that the air inside an examination room remains potentially infectious is not known and may depend on a number of factors including the size of the room, the number of air changes per hour, how long the patient was in the room, if the patient was coughing or sneezing, and if an aerosol-generating procedure was performed. Facilities will need to consider these factors when deciding when the vacated room can be entered by someone who is not wearing PPE.

For a patient who was not coughing or sneezing, did not undergo an aerosol-generating procedure, and occupied the room for a short period of time (e.g., a few minutes), any risk to HCP and subsequent patients likely dissipates over a matter of minutes. However, for a patient who was coughing and remained in the room for a longer period of time or

underwent an aerosol-generating procedure, the risk period is likely longer.

For these higher risk scenarios, it is reasonable to apply a similar time period as that used for pathogens spread by the airborne route (e.g., measles, tuberculosis) and to restrict HCP and patients without PPE from entering the room until sufficient time has elapsed for enough air changes to remove potentially infectious particles.

General guidance on [clearance rates under differing ventilation conditions](#) is available.

In addition to ensuring sufficient time for enough air changes to remove potentially infectious particles, HCP should clean and disinfect environmental surfaces and shared equipment before the room is used for another patient.

**My hospital is experiencing a shortage of isolation gowns. To preserve our supply, can we stop using gowns for the care of patients with methicillin-resistant *Staphylococcus aureus* (MRSA) and other endemic multidrug-resistant organisms (MDROs), and *Clostridioides difficile*?** +

CDC has released information about [strategies to optimize the supply of isolation gowns](#). Healthcare facilities should refer to that guidance and implement the recommended strategies to optimize their current supply of gowns. This includes shifting toward the use of washable cloth gowns, if feasible.

The use of gowns as part of Contact Precautions in the context of MDROs has been implemented primarily to reduce the risk of transmission to other patients rather than to protect healthcare personnel (HCP). Facilities with shortages could consider suspending the use of gowns for the care of patients with endemic MDROs, such as MRSA, VRE, and ESBL-producing Gram-negative bacilli except as required for [Standard Precautions](#). Facilities should assess their local epidemiology to determine which MDROs are considered endemic. Regardless of the use of gowns, HCP at facilities should continue to wear gloves for contact with these patients and their environment. Hand hygiene should continue to be emphasized. Facilities should also attempt to place patients colonized or infected with an MDRO in a private room, if available.

- **Caring for patients who have highly resistant Gram-negative organisms (e.g., carbapenem-resistant *Enterobacteriaceae*) and other MDROs (e.g., *Candida auris*) that are not considered endemic:** Rather than gowns being donned for every room entry, they should be reserved for use as part of [Standard Precautions](#) and also prioritized for high-contact patient care activities that pose highest risk for transfer of pathogens from the patient to HCP. Examples of such high-contact care activities include dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator), and wound care. To further preserve gowns, HCP are recommended to bundle high-contact care activities as part of individual care encounters. Regardless of the use of gowns, HCP at facilities should continue to wear gloves for contact with these patients and their environment. Hand hygiene should continue to be emphasized. Facilities should also attempt to place patients colonized or infected with an MDRO in a private room, if available.
- **Caring for patients with *Clostridioides difficile* infections (CDI):** Facilities should continue using Contact Precautions (putting on a gown and gloves upon entry into the patient's room and placing the patient in a private room) for the care of symptomatic patients with CDI. As part of a [supplemental strategy to prevent transmission of CDI](#), some facilities have implemented Contact Precautions for the care of patients at high risk for CDI who have asymptomatic carriage of *Clostridioides difficile*. There are limited data about the role of asymptomatic carriage in transmission of CDI. In this setting of a critical national shortage of gowns, facilities should consider suspending this approach until the shortage is addressed. Gowns should still be used as part of [Standard Precautions](#).

**A healthcare provider at our facility was recently diagnosed with COVID-19. What time period and criteria do we use to determine the patients, visitors, and other healthcare personnel (HCP) who might have been exposed to this individual while he/she was potentially infectious?** +


Anyone who had prolonged close contact (within 6 feet for at least 15 minutes) with the infected healthcare provider might have been exposed.

- **If the provider had COVID-19 symptoms,** the provider is considered potentially infectious beginning 2 days before symptoms first appeared until the provider meets criteria to discontinue [Transmission-Based Precautions](#) or [Home Isolation](#).

- **If the provider did not have symptoms**, collecting information about when the provider may have been exposed could help inform the period when they were infectious.
  - **If an exposure is identified.** The provider should be considered potentially infectious beginning 2 days after the exposure until criteria to discontinue [Transmission-Based Precautions](#) or [Home Isolation](#) are met.
  - **If the date of exposure cannot be determined.** For the purposes of contact tracing, it is reasonable to use a cutoff of 2 days before the specimen testing positive for COVID-19 was collected as the starting point, continuing until the criteria to discontinue [Transmission-Based Precautions](#) or [Home Isolation](#) are met. Although the infectious period is generally accepted to be [10 days after onset of infection](#), eliciting contacts during the entire 10 days before obtaining the specimen that tested positive for COVID-19 is likely inefficient. In most situations an exposed provider cannot recall all contacts over the preceding 10 days. Also, because recent data suggest that asymptomatic persons may have a lower viral burden at diagnosis than symptomatic persons, the additional resources required may divert case investigation and contact tracing resources away from activities most likely to interrupt ongoing transmission.

Contact tracing is generally recommended for anyone who had prolonged close contact with the person with COVID-19 during these time periods. While this question addresses exposure to a potentially infectious provider, the following actions are also recommended if the potentially infectious individual is a patient or visitor.


Recommended actions for HCP, patients, and visitors:

- Perform a risk assessment and apply work restrictions for other HCP who were exposed to the infected provider based on whether these HCP had prolonged, close contact **and** what PPE they were wearing. More detailed information is available in the [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19](#).
- Place exposed patients who are currently admitted to the healthcare facility in appropriate [Transmission-Based Precautions](#) and monitor them for onset of COVID-19 until 14 days after their last exposure.
- Perform contact tracing of exposed patients who are not currently admitted to the healthcare facility and for visitors as described in [Health Departments: Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan](#) 

Healthcare facilities should have a process for notifying the health department about known or suspected cases of COVID-19, and should establish a plan, in consultation with local public health authorities, for how exposures in a healthcare facility will be investigated and how contact tracing will be performed. The plan should address the following:

- Who is responsible for identifying contacts and notifying potentially exposed individuals?
- How will such notifications occur?
- What actions and follow-up are recommended for those who were exposed?

Contact tracing should be carried out in a way that protects the confidentiality of HCP to the extent possible and is consistent with applicable laws and regulations. HCP and patients who are currently admitted to the facility or were transferred to another healthcare facility should be prioritized for notification. These groups, if infected, have the potential to expose a large number of individuals at higher risk for severe disease, or in the situation of admitted patients, be at higher risk for severe illness themselves.

Information for health departments about case investigation and contact tracing is available in the [Health Departments: Interim Guidance on Developing a COVID-19 Case Investigation and Contact Tracing Plan](#) . This guidance could also be helpful to healthcare facilities performing such activities.

## Testing in Nursing Homes

Do residents or healthcare personnel (HCP) who previously had COVID-19 confirmed by viral testing (e.g., reverse-transcriptase polymerase chain reaction, RT-PCR) and who have recently recovered need to be re-tested as part of facility-wide testing? +

Whether residents or HCP who previously had COVID-19 confirmed by viral testing need to be re-tested depends on: 1) how much time has passed since their initial illness; 2) what strategy the facility is using to determine when residents can discontinue isolation and HCP can return to work; and 3) whether the individual has developed symptoms after initial recovery.

- Most individuals who recently recovered from COVID-19 are likely no longer infectious even if they continue to have a positive viral test (e.g., persistently or recurrently detectable viral RNA). When an individual has a positive test result <6 weeks after they met criteria for [discontinuation of Transmission-Based Precautions](#) or [Home Isolation](#), it can be difficult to determine if they have been re-infected or if they still have detectable viral RNA from their previous infection.
- Residents and HCP who had a positive viral test in the past 6–8 weeks and are now asymptomatic may not need to be retested as part of facility-wide testing unless the facility is using a [test-based strategy to determine if residents can discontinue isolation](#) or [HCP can return to work](#). Residents and HCP who had a positive viral test over 8 weeks ago should be retested as part of facility-wide testing, regardless of symptoms.
- Residents and HCP who had a positive viral test at any time and become symptomatic after recovering from the initial illness should be re-tested and placed back on the appropriate [Transmission-Based Precautions](#) or excluded from work, respectively.

This evidence may be updated as more learn more information on viral persistence and risk for reinfection.

#### Should residents or HCP who have a positive antibody test for SARS-CoV-2 be tested as part of facility-wide testing? +

Yes. To determine if residents and HCP have a current infection, they should have a viral test (e.g., reverse-transcriptase polymerase chain reaction [RT-PCR]) regardless of their antibody test result. A positive [antibody test](#) result shows that an individual has antibodies from an infection with the virus that causes COVID-19, or possibly from infection with a related virus from the same family of viruses (called coronavirus), such as one that causes the common cold. We do not know yet if having antibodies to the virus that causes COVID-19 can protect someone from getting infected again or, if they do, how long this protection might last. Therefore, antibody tests should not be used to diagnose COVID-19 and should not be used to inform infection prevention actions.

#### How should facilities approach residents who decline testing? +

Residents, or their medical powers of attorney, have the right to decline testing. Clinical discussions about testing may include alternative [specimen collection sources](#) that may be more acceptable to residents than nasopharyngeal swabs (e.g., anterior nares). Providing information about the method of testing and reason for pursuing testing may facilitate discussions with residents and their medical powers of attorney.

If a resident has [symptoms consistent with COVID-19](#), but declines testing, they should remain on [Transmission-Based Precautions](#) until they meet the symptom-based criteria for discontinuation.

If a resident is asymptomatic and declines testing at the time of facility-wide testing, decisions on placing the resident on Transmission-Based Precautions for COVID-19 or providing usual care should be based on whether the facility has evidence suggesting [SARS-CoV-2 transmission](#) (i.e., confirmed infection in HCP or [nursing-home onset infection in a resident](#)).

Only residents who have a confirmed positive [viral test](#) should be moved to COVID-19-designated units or facilities.

#### How should facilities approach HCP who decline testing? +

If HCP with [symptoms consistent with COVID-19](#) decline testing, they should be presumed to have COVID-19 and excluded from work. Return to work decisions should be based on COVID-19 [return to work guidance](#) at the discretion of the facility's occupational health program.

If asymptomatic HCP decline testing, work restriction, if any, should be determined by the facility's occupational health and local jurisdiction policies. All staff should be trained in proper use of personal protective equipment, including universal facemask policies, hand hygiene, and other measures needed to stop transmission of SARS-CoV-2.

#### If HCP work at multiple facilities, do they need to receive a viral test at each facility? +

No, HCP do not need to be tested at each facility. If documentation of the test result is provided to each facility, the results from one setting are adequate to meet the testing recommendations at any facility. Each facility should maintain appropriate documentation of test results and have a plan to [evaluate and manage HCP](#). HCP should be encouraged to tell facilities if they have had exposures at other facilities with recognized COVID-19 cases.

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**How long should facilities continue serial testing of HCP?**

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Serial testing of HCP in nursing homes is indicated in two situations: when there is a COVID-19 outbreak in the facility and as part of the reopening process. If there is a [COVID-19 outbreak in the facility](#), all previously negative residents and HCP should be serially tested until the testing identifies no new cases of COVID-19 among residents or HCP over at least 14 days since the most recent positive result.

As part of [the reopening process](#) [\[4\]](#), the decision to serially test HCP for SARS-CoV-2 should be made in the context of local incidence. Depending on the level of community transmission, HCP could continue to be at risk for acquiring infection in the community and introducing it to residents of nursing homes.

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**How can public health jurisdictions prioritize testing across nursing homes?**

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Health departments should have a [plan on how to prioritize facilities](#) when testing capacity is limited.

Priority facilities may include those with confirmed cases, those in counties with high incidence, those with the ability to cohort residents who are found to be positive, larger facilities, and facilities with more patients with recent healthcare exposures (e.g., recent hospitalization or outpatient dialysis).

If a facility identifies additional cases through facility-wide testing, then that facility should be prioritized for repeat testing of negative residents.

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**Should asymptomatic HCP who are tested as part of facility-wide testing be excluded from work while waiting for test results?**

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If HCP remain asymptomatic, they may continue working while awaiting test results, unless work restrictions have been implemented by the occupational health program because of an [exposure warranting exclusion from work](#).

**EXHIBIT S**



## **Covid19: Interim Considerations for State Psychiatric Hospitals**

*Updated: May 8, 2020*

Individuals with serious mental illness, particularly those who are older or who have chronic medical conditions, can be at higher risk for illness with Covid-19. It is important that mental health facilities be prepared for Covid-19 to keep both patients as well as healthcare staff safe, and this may include proactive measures to reduce the psychiatric disease burden caused by the COVID-19 pandemic. While SAMHSA has preferentially recommended outpatient treatment during the COVID-19 crisis as telehealth technology and social distancing can be more effectively implemented, inpatient psychiatric care will inevitably be required for a number of patients. Psychiatric care on an inpatient service is typically reserved for the most severe conditions, and inpatient care at state psychiatric hospitals is typically reserved for the most refractory cases.

State psychiatric hospitals have typically developed Disaster Plans that require the establishment of protocols and relationships with other local government and healthcare entities. Each accredited facility should have existing infection control plans that are designed to address scenarios such as for MRSA, HIV, Hepatitis, and infectious diseases. Plans to manage COVID-19 at the facility should now be in place at all of these sites. However, in contrast to general healthcare settings, psychiatric facilities may experience unique challenges in prevention and infection control.

In addition to consideration of infection control guidelines with the goal of minimizing spread, described below, it is also important to be aware of the psychological impact of quarantine and major disruptions to everyday life. Healthcare workers already support the mental health of their patients, but they also need to attend to their own needs and those of their families.<sup>i</sup> It is important to provide access to accurate information sources such as the Centers for Disease Control and Prevention (CDC).<sup>ii</sup> The American Psychiatric Association has resources on the mental health impacts of Covid-19.<sup>iii</sup> Others also have studied and reported on the adverse effects of quarantine on individuals.<sup>iv</sup> Patients at mental health facilities are vulnerable both to the infection itself, but also to worsening anxiety, mood, or psychosis during this time. Given the uncertainty and rapid change associated with the virus, anxiety and distress should be anticipated.<sup>v</sup>

In response to the CDC recommendations for all healthcare facilities, SAMHSA offers further considerations specific to psychiatric hospitals.

- 1) Reduce morbidity and mortality:
  - a. Many patients admitted to state psychiatric facilities have a number of health comorbidities that increase their risk of developing severe symptoms from COVID-19 infection. These include the very high incidence of tobacco use with resultant COPD and lung disease or metabolic syndrome with diabetes, hypertension, and heart disease. In addition to intake screening and testing when appropriate, these patients should be informed of their elevated risk and frequent follow up COVID-19 screening should be performed. These patients should be segregated from new or symptomatic patients due to their higher stratified risk.
  - b. SAMHSA recommends that when possible all new admissions be segregated until COVID-19 testing results are available for review. For new and existing patients, all suspected and



- symptomatic cases should be immediately segregated and transferred, if necessary, to appropriate healthcare facilities with capabilities of treating more severely ill patients. Advanced directives should be updated on all existing patients and should be completed for new patients upon admission. Psychiatric hospitals may not have the capacity to respond to severe respiratory infections.
- c. Symptoms associated with psychotic illness, such as paranoia or anxiety disorders such as OCD may worsen during the COVID-19 crisis, and patients with these conditions may require additional redirection as they are exposed to more negative news about the pandemic.
- 2) Considerations when attempting to minimize disease transmission:
- a. Limit the movement of COVID-19 patients (e.g., have them remain in their room)
    1. Capacity of informed consent may be lacking for those admitted involuntarily. Individuals with serious mental illnesses may have varying degrees of capacity to follow appropriate infection control procedures, therefore it is important to establish the patient's capacity or lack of capacity when developing the modified COVID-19 treatment plan. Those who lack capacity may not fully appreciate the dangers of exposure. The nature of the therapeutic milieu may make minimal contact rules more challenging. Patients without capacity may require more frequent reorientation to the rules, more activities one on one with staff, and an individual room. While restrictions of movement outside of their room will be implemented for some patients, the presence of mental illness does not mean an individual is incapable of practicing safe hygiene and social distancing practices. Staff should make the assessment based on the patient's capacity and behavior and carefully avoid stigmatizing those with mental illness.
    2. Take steps to prevent known or suspected COVID-19 patients from exposing other patients.
      - a. It is advisable when possible to segregate the areas or individual floors as non-COVID-19 and COVID-19. This may require further restrictions in movement and accommodations should be explored. For instance, the dayroom is often the location where patients congregate and receive the therapeutic benefits of the milieu. Having an alternate dayroom location, when possible, could help to reduce a patient's anxiety about exposure and maintain continuity. Also, those patients with severe anxiety disorder or paranoia may feel some relief in segregation as their risk of exposure is reduced.
      - b. Identify dedicated staff to care for COVID-19 patients.
      - c. Psychosocial group treatment sessions may have to be suspended if these sessions cannot be safely modified with fewer individuals reliably practicing social distancing or with video technology available. One on one psychosocial counseling sessions with social distancing can be considered.
  - b. Another important consideration is that most psychiatric facilities have restricted access with limited visitation. This is stigmatizing in itself as these units are locked for the security of the patients and staff. During the COVID-19 crisis, visitation by friends, family, and various stakeholders may be curtailed. This necessary step to reduce exposure risk can leave the patients feeling more isolated. When visitation is restricted staff of all levels should be aware of this and take steps to reach out and check on patients more often.

- c. Often family members and community support are vital components of the patients' recovery. These individuals are heavily involved in the patient's lives and have traditionally participated in family meetings and therapy. When safely implemented, this important part of treatment should continue. Continuing these meetings by confirmed appointment in designated area, frequently sanitized between visits, can facilitate disposition planning, reduce recidivism rates, and improve patient satisfaction. Such dedicated spaces could also be used for visitation with a schedule and protocol for safe interaction including social distancing and sanitizing after each use. Alternative steps depending on resources could include setting up a computer with a webcam and microphone in another area within the facility that can be cleaned between uses. This would allow patients and family members to communicate visually as well as via audio.
  - d. Post visual alerts (signs, posters) at entrances and in strategic places providing instruction on hand hygiene, respiratory hygiene, and cough etiquette. For patients with limited capacity frequent reorientation to these is required.
  - e. Observe newly arriving patients/residents for development of respiratory symptoms in an area designated for new patient evaluation.
  - f. Confirm or obtain psychiatric advance directives to facilitate medication and treatment compliance in the event of change of capacity for informed consent.
- 3) Protect healthcare personnel
- a. Ensure that staff are aware of sick leave policies, and staff should be encouraged to stay home if they are not feeling well.
  - b. Limit visitors to the facility and perform screening on all who enter the facility.
  - c. Ensure cleaning and disinfectant supplies are available as well as tissues, waste receptacles, and alcohol-based hand sanitizer.
  - d. Ensure housekeeping and dietary personnel frequently sanitize and disinfect all areas where staff and patients can be found.
  - e. Healthcare workers may also develop symptoms of anxiety during this crisis, therefore supervisors and managers should perform more frequent meetings and checks with frontline staff. Flexibilities when possible should be accommodated. Occupational health departments should now be actively engaging staff and implementing plans for staff that are experiencing greater stress and anxiety. Resources should be made available for staff experiencing increased stress, depression, or substance use disorder relapse.
- 4) Preserve healthcare system functioning
- a. As staffing shortages may become more common as healthcare workers also become infected and are quarantined, it is important that supervisors and managers establish contact with outside staffing sources to ensure continuity of care. More flexibility in task assignment may be an option, for instance, the ability to "buddy team" with paraprofessional staff if regular staff ratios are limited due to staff illness.
  - b. As the anxiety and fear from COVID-19 can preclude improvement in the patient's psychiatric condition, providers should instruct staff to engage patients in more one to one activities and

should be mindful of this consideration when ordering prn medications to keep the patient as comfortable as possible. It is important to note that these measures should be implemented in conjunction with the utilization of clear clinical indications and, when applicable, validated psychiatric screening instruments. For example increased screening for worsening symptoms may prompt detection earlier and inform changes to the treatment plan. These measures may prevent escalation of symptoms of agitation, psychosis, or loss of control and thereby avoid seclusion and restraints. Additionally staff should be mindful that overcrowding and restrictions can be potential triggers for behavioral instability. These seclusion events are stressful for staff and traumatic for both the patients and to those patients who observe such incidents. The significant negativity following such events can, in some instances, temporarily transform the nature of the psychiatric unit. Therefore, identifying and addressing issues prior to the outburst should be the goal.

- c. Discharge planning may be more difficult. As many step down residential facilities and outpatient facilities are limiting intakes, social workers may find it more difficult to plan disposition of patients. This may result in longer lengths of stay. The treatment team as well as utilization review staff should adjust with this expectation. Also, questions may arise about the risk of the patient's exposure to those at the receiving facility. Repeat testing for COVID-19 should ideally be completed prior to discharge as further reassurance for receiving facilities. More resources from varied sources should be mobilized such as family, friends, assisted living, county resources, and local charity.

There are a number of steps that healthcare facilities can take to be prepared should an individual become infected with Covid-19.<sup>vi</sup> Psychiatric hospitals should follow all infection control guidelines as stipulated by the CDC. For general infection control guidelines, see <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/index.html>.<sup>vii</sup>

During this rapidly changing situation, mental health providers should refer to the CDC website for the most updated information. Individuals with serious mental illness are at particular risk related to co-occurring medical conditions as well as challenges with accessing healthcare. Attention to proper prevention and infection control procedures as well as attention to the psychological impacts of the virus are important in reducing morbidity and mortality for this vulnerable population.

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<sup>i</sup> Sustaining the Well-Being of Healthcare Personnel during Coronavirus and other Infectious Disease Outbreaks

[https://www.cstsonline.org/assets/media/documents/CSTS\\_FS\\_Sustaining\\_Well\\_Being\\_Healthcare\\_Personnel\\_during.pdf](https://www.cstsonline.org/assets/media/documents/CSTS_FS_Sustaining_Well_Being_Healthcare_Personnel_during.pdf) Accessed March 17, 2020

<sup>ii</sup> Centers for Disease Control, Coronavirus [https://www.cdc.gov/coronavirus/2019-ncov/index.html?CDC\\_AA\\_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2Findex.html](https://www.cdc.gov/coronavirus/2019-ncov/index.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2Findex.html) Accessed March 17, 2020

<sup>iii</sup> Covid-19 Mental Health Impacts Resources for Psychiatrist <https://www.psychiatry.org/news-room/apablogs/apa-blog/2020/03/covid-19-mental-health-impacts-resources-for-psychiatrists> Accessed March 17, 2020

<sup>iv</sup> The Psychological Impact of Quarantine and How to Reduce It: Rapid Review of the Evidence. *Lancet* 2020; 395: pgs. 912-20. Brooks, Samantha K. and Webster, Rebecca K. and Smith, Louise E. and Woodland, Lisa and Wessely, Simon and Greenberg, Neil and Rubin, G. James

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<sup>v</sup> Caring for patient mental well-being during coronavirus

[https://www.cstsonline.org/assets/media/documents/CSTS\\_FS\\_Caring\\_for\\_Patients\\_Mental\\_WellBeing\\_during\\_Coronavirus.pdf](https://www.cstsonline.org/assets/media/documents/CSTS_FS_Caring_for_Patients_Mental_WellBeing_during_Coronavirus.pdf) Accessed March 17, 2020

<sup>vi</sup> Ibid

<sup>vii</sup> Infection control guidelines <https://www.cdc.gov/coronavirus/2019-ncov/infection-control/index.html>. Accessed March 17, 2020

**EXHIBIT T**



# Coronavirus Disease 2019 (COVID-19)

## Testing Guidelines for Nursing Homes

### Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents and Healthcare Personnel

Updated July 2, 2020

[Print](#)

#### Summary of Changes:

Revisions were made on June 1, 2020, to reflect the following:

- Focus on testing recommendations for nursing home residents only.
- Create separate guidance for testing healthcare personnel (HCP), which is available in the [Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2](#).

**Note:** This document is intended to provide guidance on the appropriate use of testing among nursing home residents and does not dictate the determination of payment decisions or insurance coverage of such testing, except as may be otherwise referenced (or prescribed) by another entity or federal or state agency.

Nursing home residents are at high risk for infection, serious illness, and death from COVID-19. Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as [viral testing](#)) among residents in nursing homes. Viral testing of residents in nursing homes, with authorized nucleic acid or antigen detection assays, is an important addition to other [infection prevention and control](#) (IPC) recommendations aimed at preventing SARS-CoV-2 from entering nursing homes, detecting cases quickly, and stopping transmission. This guideline is based on currently available information about COVID-19 and will be refined and updated as more information becomes available.

Testing conducted at nursing homes should be implemented *in addition to* [recommended IPC measures](#). Facilities should have a plan for testing residents for SARS-CoV-2. Additional information about the components of the testing plan are available in the CDC guidance titled [Preparing for COVID-19 in Nursing Homes](#).

Testing practices should aim for rapid turnaround times (e.g., less than 24 hours) in order to facilitate effective interventions. Testing the same resident more than once in a 24-hour period is not recommended. Antibody (serologic) test results generally should not be used as the sole basis to diagnose an active SARS-CoV-2 infection and should not be used to inform IPC actions.

While this guidance focuses on testing in nursing homes, several of the recommendations such as testing residents with signs or symptoms of COVID-19 and testing asymptomatic close contacts should also be applied to other long-term care facilities (e.g., assisted living facilities, intermediate care facilities for individuals with intellectual disabilities, institutions for mental disease, and psychiatric residential treatment facilities).

For additional guidance addressing other non-healthcare settings, refer to the CDC guidance addressing [Communities, Schools, Workplaces and Events](#). Guidance for testing healthcare personnel (HCP) is available in the [Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2](#).

## Diagnostic Testing



### Testing residents with signs or symptoms of COVID-19.

- At least daily, take the temperature of all residents and ask them if they have any [COVID-19 symptoms](#). Perform viral testing of any resident who has signs or symptoms of COVID-19.
  - Clinicians should use their judgment to determine if a resident has signs or [symptoms](#) consistent with COVID-19 and whether the resident should be tested. Individuals with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Some may present with only mild symptoms or [other less common symptoms](#).
  - Clinicians are encouraged to consider testing for other causes of respiratory illness, such as influenza, in addition to testing for SARS-CoV-2.

## Testing asymptomatic residents with known or suspected exposure to an individual infected with SARS-CoV-2, including close and expanded contacts (e.g., there is an outbreak in the facility).

- Perform expanded viral testing of **all** residents in the nursing home if there is an outbreak in the facility (i.e., a new SARS-CoV-2 infection in any HCP or any [nursing home-onset](#) SARS-CoV-2 infection in a resident).
  - A single new case of SARS-CoV-2 infection in any HCP or a [nursing home-onset](#) SARS-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected with SARS-CoV-2 who can continue to spread the infection, even if they are asymptomatic. Performing viral testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent SARS-CoV-2 transmission.
  - When undertaking facility-wide viral testing, facility leadership should expect to identify multiple asymptomatic and pre-symptomatic residents with SARS-CoV-2 infection and be prepared to cohort residents. See [Public Health Response to COVID-19 in Nursing Homes](#) for more details.
  - If viral testing capacity is limited, CDC suggests first directing testing to residents who are close contacts (e.g., on the same unit or floor of a new confirmed case or cared for by infected HCP).
  - See [Considerations for Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes](#) for additional details.

## Initial (baseline) testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2 is part of the recommended reopening process.

- Perform initial viral testing of each resident in a nursing home as part of the recommended [reopening process](#)   .
  - Initial viral testing of each resident (who is not known to have previously been diagnosed with COVID-19) is recommended because of the high likelihood of exposure during a pandemic, transmissibility of SARS-CoV-2, and the risk of complications among residents following infection.
  - The results of viral testing inform care decisions, infection control interventions, and placement decisions (e.g., cohorting decisions) relevant to that resident.

## Testing to determine resolution of infection.

- A [test-based strategy](#), which requires serial tests and improvement of symptoms, can be used as an alternative to a [symptom-based or time-based strategy](#), to determine when a resident with SARS-CoV-2 infection no longer requires Transmission-Based Precautions.

## Repeat Testing in Coordination with the Health Department

### Non-diagnostic testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2 (apart from the initial testing referenced above).


- After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below. Repeat testing should be coordinated with the local, territorial, or state health department.
- Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission.
  - If viral test capacity is limited, CDC suggests directing repeat rounds of testing to residents who leave and return to the facility (e.g., for outpatient dialysis) or have known exposure to a case (e.g., roommates of cases or those cared for by a HCP with confirmed SARS-CoV-2 infection). For large facilities with limited viral test capacity, testing only residents on affected units could be considered, especially if facility-wide repeat viral testing demonstrates no transmission beyond a limited number of units.

## Definitions

- **Healthcare personnel (HCP):** HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, feeding assistants, students and trainees, contractual HCP not employed by the healthcare facility, and persons not directly involved in patient care but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). For this guidance, HCP does not include clinical laboratory personnel.
- **Nursing home-onset SARS-CoV-2 infections** refers to SARS-CoV-2 infections that originated in the nursing home. It does not refer to the following:
  - Residents who were known to have COVID-19 on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.
  - Residents who were placed into Transmission-Based Precautions on admission and developed SARS-CoV-2 infection within 14 days after admission.

Page last reviewed: July 2, 2020

## COVID-2019 Menu

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**EXHIBIT U**



# Coronavirus Disease 2019 (COVID-19)

## Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2

Updated July 2, 2020

[Print](#)

**Note:** This document is intended to provide guidance on the appropriate use of testing among healthcare personnel and does not dictate the determination of payment decisions or insurance coverage of such testing, except as may be otherwise referenced (or prescribed) by another entity or federal or state agency.

This document provides a summary of considerations and current Centers for Disease Control and Prevention (CDC) recommendations regarding testing healthcare personnel (HCP) for SARS-CoV-2. This document does not apply to individuals who do not meet the definition of HCP as defined below. The CDC recommendations for SARS-CoV-2 testing have been developed based on what is currently known about COVID-19 and are subject to change as additional information becomes available.

Testing of HCP can be considered in four situations:

1. Testing HCP with [signs or symptoms](#) consistent with COVID-19
2. Testing asymptomatic HCP with known or suspected exposure to SARS-CoV-2
3. Testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 for early identification in [special settings](#) (e.g., nursing homes)
4. Testing HCP who have been diagnosed with SARS-CoV-2 infection to determine when they are no longer infectious

[Viral tests](#) (authorized nucleic acid or antigen detection assays) are recommended to diagnose acute infection. Testing practices should aim for rapid turnaround times (i.e., less than 24 hours) in order to facilitate effective interventions. Testing the same individual more than once in a 24-hour period is not recommended.

HCP undergoing testing should receive clear information on:

- the purpose of the test
- the reliability of the test and any limitations associated with the test
- who will pay for the test and how the test will be performed
- how to interpret results and any next steps related to the results
- who will receive the results
- how the results may be used
- any consequences for declining testing

Recommended practices to prevent occupational exposure to SARS-CoV-2 are described in the [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#). Guidance for assessing HCP exposure risk and determining the need for work restrictions is available in the [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19](#)

## Testing HCP with signs or symptoms consistent with COVID-19

HCP with [signs or symptoms of COVID-19](#) should be prioritized for SARS-CoV-2 testing. Because HCP often have extensive and close contact to [vulnerable populations](#), even mild signs or symptoms (e.g., sore throat) of possible COVID-19 should prompt consideration for testing. Clinicians should use their judgment to determine if HCP have [signs or symptoms](#) compatible with COVID-19 and whether HCP should be tested

computers with COVID-19 and whether they should be tested.

CDC recommends using [authorized nucleic acid or antigen detection assays](#) that have received an FDA Emergency Use Authorization to test persons **with** symptoms when there is a concern of potential COVID-19. Tests should be used in accordance with the authorized labeling. Providers should be familiar with the tests' performance characteristics and limitations.

## Testing asymptomatic HCP with known or suspected exposure to SARS-CoV-2

As part of [community contact tracing](#) efforts, viral testing is recommended for everyone, including HCP, who have had [close contact](#) with persons with SARS-CoV-2 infection in the community (including household contacts).

Exposures encountered by HCP are unlike those that might occur the community, and trained HCP generally use personal protective equipment (PPE) to reduce the risk of transmission. Because of this, assessment of HCP exposures should be performed as described in the [Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19](#). Due to their often extensive and close contact with vulnerable individuals, this guidance recommends managing occupationally exposed HCP conservatively:

- For certain exposures believed to pose a higher risk for transmission, CDC recommends that exposed HCP be excluded from work for 14 days following the exposure.
- For other, lower risk exposures, HCP may continue to work; however, CDC recommends screening for symptoms prior to starting work each day and using source control measures as described in [CDC's infection control recommendations](#).

Should facilities have staffing shortages, they can refer to CDC's staffing [mitigation guidance](#), which includes allowing HCP with higher risk exposures to continue to work during their 14-day post-exposure period. When testing is readily available, performing testing during the 14-day post-exposure period can be considered to more quickly identify pre-symptomatic or asymptomatic HCP who could contribute to SARS-CoV-2 transmission. For HCP with lower risk exposures, CDC continues to recommend symptom screening and source control measures while at work; regular testing, as described below, could also be considered to more rapidly identify infected HCP.

Facilities that elect to perform post-exposure testing of HCP should be aware that testing is logistically challenging and has limitations. For example, testing only identifies the presence of virus at the time of the test. It is possible that HCP can test negative because they are very early in their infection when their sample is collected. In such situations, they could test positive later and transmit the virus to others; for this reason, repeat testing could be considered. Also, when there is SARS-CoV-2 transmission occurring in the community, positive tests in HCP do not necessarily indicate transmission due to exposures in the workplace.

If testing of exposed HCP is instituted, test results should be available rapidly (i.e., within 24 hours), and there should be a clear plan to respond to results. The Occupational Safety and Health Administration's rules for Recording and Reporting Occupational Injuries and Illness ([29 CFR part 1904](#)) should be consulted regarding requirements for certain employers to make and keep records of [work-](#) related cases of COVID-19.

In **nursing homes**, expanded viral testing of all HCP is recommended in response to an outbreak in the facility. Testing of all residents is also recommended in this situation. See the [Interim SARS-CoV-2 Testing Guidelines for Nursing Home Residents](#) for more information. An outbreak is defined as a new SARS-CoV-2 infection in any HCP or any [nursing home-onset](#) SARS-CoV-2 infection in a resident. Expanded viral testing includes initial testing of all HCP followed by repeat testing of all previously negative HCP, generally between every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. Expanded viral testing of HCP could also be considered in other healthcare settings in some situations (e.g., when multiple instances of SARS-CoV-2 transmission are identified among patients or HCP).

## Testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 for early identification in special settings

Currently, testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 is recommended for HCP working in [nursing homes](#) as part of the recommended reopening process.

in nursing homes as part of the recommended reopening process.

In this situation, initial viral testing of all HCP in nursing homes, along with weekly viral testing thereafter is recommended. State and local officials may adjust the recommendation for weekly viral testing of HCP based on the prevalence of the virus in their community; for example, performing weekly testing in areas with moderate-to-substantial community transmission and less frequent testing in areas with minimal-to-no community transmission.

## Testing to determine when HCP with SARS-CoV-2 infection are no longer infectious

A test-based strategy, which requires serial tests and improvement of symptoms, can be used as an alternative to a symptom-based or time-based strategy, to determine when HCP with SARS-CoV-2 infection may [return to work](#).

### Definitions

**Healthcare personnel (HCP):** HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). For this guidance, HCP does not include clinical laboratory personnel.

**Substantial community transmission:** Large-scale community transmission, including in communal settings (e.g., schools, workplaces).

**Minimal-to-moderate community transmission:** Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases.

**No-to-minimal community transmission:** Evidence of isolated cases or limited community transmission; case investigations under way; no evidence of exposure in large communal setting.

Page last reviewed: July 2, 2020

### COVID-2019 Menu

-  Coronavirus Home
-  Your Health
-  Community, Work & School
-  Healthcare Workers
-  Laboratories
-  Health Departments
-  Cases, Data & Surveillance
-  More Resources

**EXHIBIT V**



# *The Commonwealth of Massachusetts*

*Executive Office of Health and Human Services*

*Department of Mental Health*

*25 Staniford Street*

*Boston, Massachusetts 02114-2575*

**CHARLES D. BAKER**  
*Governor*

**KARYN E. POLITO**  
*Lieutenant Governor*

**MARYLOU SUDDERS**  
*Secretary*

**JOAN MIKULA**  
*Commissioner*

(617) 626-8000

[www.mass.gov/dmh](http://www.mass.gov/dmh)

**DEPARTMENT OF MENTAL HEALTH  
DIVISION OF CLINICAL AND PROFESSIONAL SERVICES  
LICENSING DIVISION – BULLETIN #20-04R**

**June 8, 2020**

**COVID-19 EMERGENCY GUIDANCE  
Admission, COVID-19 Testing, and EPIA**

In light of the current COVID-19 pandemic, this bulletin highlights current regulations and policies that support behavioral health patients leaving Emergency Departments as soon as possible once it is determined that a psychiatric inpatient level of care is required. In recognition of the vital role of acute psychiatric facilities in providing safe appropriate care for individuals in psychiatric crisis, DMH is highlighting licensed facilities' obligations to admit and treat patients meeting admission criteria within their license class. The Department of Mental Health (DMH) is also enhancing its capacity to provide assistance through the Expedited Psychiatric Inpatient Admission process (EPIA), so we may all play our role in keeping patients and health care workers safe.

1. No Reject Policy interpreted for COVID-19 Pandemic:
  - a. If a facility has been identified as accepting admissions and a patient has been medically cleared, requires inpatient psychiatric treatment, and otherwise meets admission criteria, they must admit that patient for care. A facility may deny admission to a patient only if such admission would result in a census exceeding the facility's operational capacity or if the admission has been determined by the facility medical director to exceed the facility's capability at the time admission is sought. This determination must be recorded in writing as an admission denial [Bulletin 18-01](#) and shall be subject to review by the Department of Mental Health.
  - b. It is expected that patients will be preferentially re-admitted to the most recent facility where they had been hospitalized. A facility may not deny admission based on circumstances of a patient's previous admission, including those who were discharged to another facility for treatment and are returning to that inpatient psychiatric facility.
  - c. Facilities should make every effort to admit patients who are in EDs that are within the Facility's healthcare system.
  - d. At this time, inpatient psychiatric facilities, identified to DMH as

**DEPARTMENT OF MENTAL HEALTH**

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accepting patients who are confirmed to be infected with COVID-19, must be prepared to admit patients who have tested positive or are suspect for COVID-19 and who do not need medical hospital treatment for COVID-19.

**2. Enhanced Expedited Psychiatric Inpatient Admission (EPIA):**

- a. All individuals who have been screened appropriate for inpatient psychiatric level of care and are in an ED, ESP, home or other boarding setting awaiting placement must be entered into MABHA no later than 24 hours of such screening and before referring to DMH for assistance under EPIA, to initiate a coordinated advocacy response from the State Agencies involved (MassHealth, DMH, DDS, DCF, DYS, etc.).
- b. The insurance carrier must be notified and involved with the ED and/or ESP as soon as hospital level of care is determined for the individual, as provided in current EPIA escalation protocols.
- c. EPIA referral to DMH may be made at 24 hours. Documentation of ED/ESP and insurance carrier advocacy efforts are required.
- d. Should the above steps not be taken at the time of escalation to DMH, there will be a delay in accepting the referral until they are completed.

Any questions regarding this bulletin should be directed to the DMH Licensing Division at 617-626- 8117 or by email to [Teresa.J.Reynolds@massmail.state.ma.us](mailto:Teresa.J.Reynolds@massmail.state.ma.us)

**EXHIBIT W**





**COVID-19 Pandemic Guidance Document**

**Guidance on Admittance, Discharge of Psychiatric Patients  
During COVID-19**

*The findings, opinions, and conclusions of this guidance document do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association.*

*The findings, opinions, and conclusions of this guidance document do not necessarily represent the views of the officers, trustees, or all members of the American Psychiatric Association.*

APA provides the following guidance for psychiatric care during outbreaks of communicable disease:

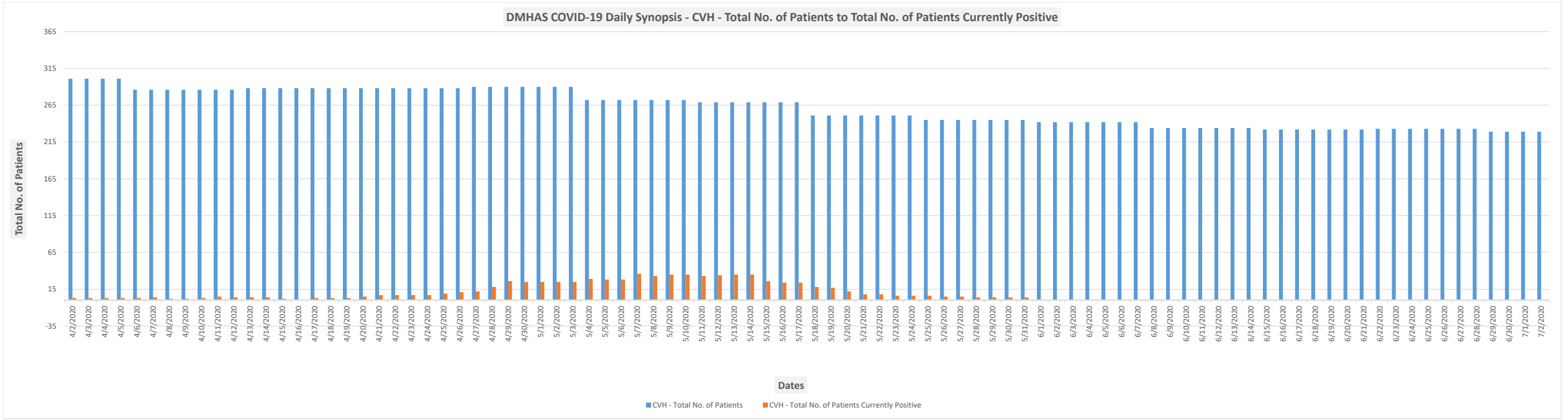
1. Premature discharge of patients from psychiatric hospitals and inpatient psychiatric units is unreasonable as this practice exposes patients, families, and the community at large to the risks of harmful and adverse outcomes irrespective of communicable disease outbreaks.
2. During communicable disease outbreaks, referral of patients to any psychiatric setting should balance efforts to match patients' mental health needs with the appropriate level of care while considering the potential risks of the communicable disease at each level of care.
3. Each level of psychiatric care during such outbreaks should provide safe and appropriate treatment, including adequate protection from the risk of infection from the communicable disease.

**EXHIBIT X**

<b>CVH - Total No. of Patients to Total No. of Patients Currently Positive</b>		
<b>DATE</b>	<b>CVH - Total No. of Patients</b>	<b>CVH - Total No. of Patients Currently Positive</b>
3/27/2020	333	3
3/28/2020	333	1
3/29/2020	333	4
3/30/2020	301	4
3/31/2020	301	4
4/1/2020	301	3
4/2/2020	301	3
4/3/2020	301	3
4/4/2020	301	3
4/5/2020	301	3
4/6/2020	286	3
4/7/2020	286	4
4/8/2020	286	2
4/9/2020	286	2
4/10/2020	286	3
4/11/2020	286	5
4/12/2020	286	4
4/13/2020	288	4
4/14/2020	288	4
4/15/2020	288	2
4/16/2020	288	1
4/17/2020	288	3
4/18/2020	288	3
4/19/2020	288	3
4/20/2020	288	5
4/21/2020	288	7
4/22/2020	288	7
4/23/2020	288	7
4/24/2020	288	7
4/25/2020	288	9
4/26/2020	288	11
4/27/2020	290	12
4/28/2020	290	18
4/29/2020	290	26
4/30/2020	290	25
5/1/2020	290	25
5/2/2020	290	25
5/3/2020	290	25
5/4/2020	272	29
5/5/2020	272	28
5/6/2020	272	28
5/7/2020	272	36
5/8/2020	272	33
5/9/2020	272	35
5/10/2020	272	35

5/11/2020	269	33
5/12/2020	269	34
5/13/2020	269	35
5/14/2020	269	35
5/15/2020	269	26
5/16/2020	269	24
5/17/2020	269	24
5/18/2020	251	18
5/19/2020	251	17
5/20/2020	251	12
5/21/2020	251	8
5/22/2020	251	8
5/23/2020	251	6
5/24/2020	251	6
5/25/2020	245	6
5/26/2020	245	5
5/27/2020	245	5
5/28/2020	245	4
5/29/2020	245	4
5/30/2020	245	4
5/31/2020	245	4
6/1/2020	242	1
6/2/2020	242	1
6/3/2020	242	1
6/4/2020	242	1
6/5/2020	242	1
6/6/2020	242	1
6/7/2020	242	1
6/8/2020	234	1
6/9/2020	234	1
6/10/2020	234	1
6/11/2020	234	1
6/12/2020	234	1
6/13/2020	234	1
6/14/2020	234	1
6/15/2020	232	1
6/16/2020	232	1
6/17/2020	232	1
6/18/2020	232	1
6/19/2020	232	1
6/20/2020	232	1
6/21/2020	232	1
6/22/2020	233	1
6/23/2020	233	1
6/24/2020	233	1
6/25/2020	233	1
6/26/2020	233	1

6/27/2020	233	1
6/28/2020	233	1
6/29/2020	229	1
6/30/2020	229	1
7/1/2020	229	1
7/2/2020	229	1



**EXHIBIT Y**

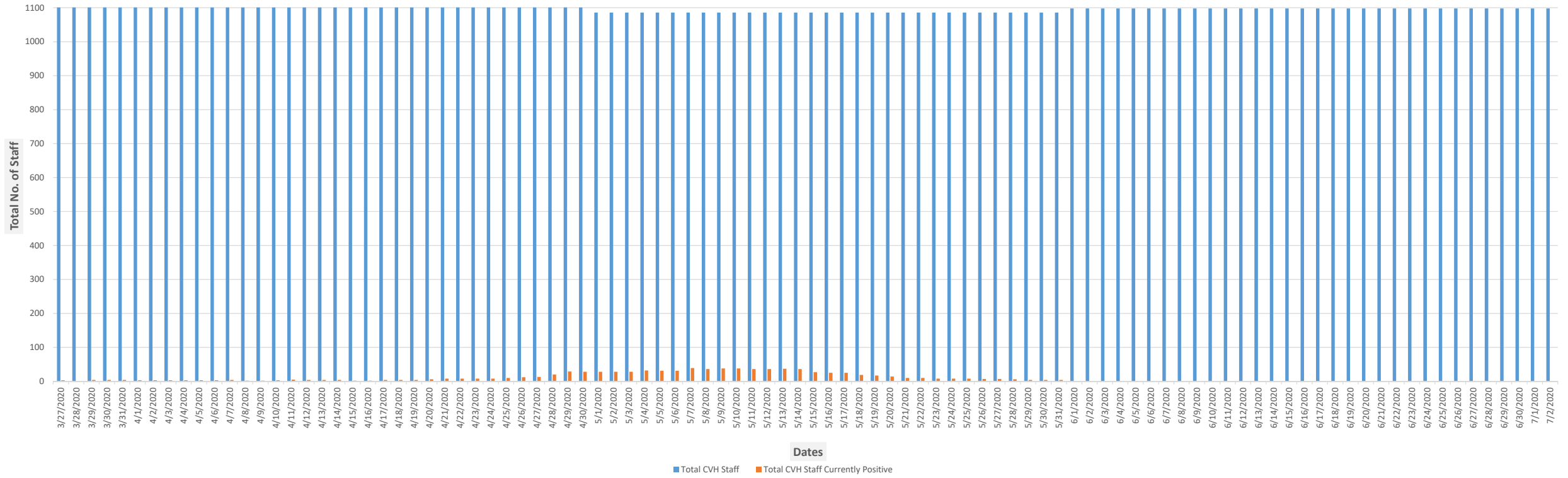


<b>Total All CVH Staff Currently Positive</b>		
<b>DATE</b>	<b>Total CVH Staff</b>	<b>Total CVH Staff Currently Positive</b>
3/27/2020	1101	3
3/28/2020	1101	1
3/29/2020	1101	4
3/30/2020	1101	4
3/31/2020	1101	4
4/1/2020	1101	3
4/2/2020	1101	3
4/3/2020	1101	3
4/4/2020	1101	3
4/5/2020	1101	3
4/6/2020	1101	3
4/7/2020	1101	4
4/8/2020	1101	2
4/9/2020	1101	2
4/10/2020	1101	3
4/11/2020	1101	5
4/12/2020	1101	4
4/13/2020	1101	4
4/14/2020	1101	4
4/15/2020	1101	2
4/16/2020	1101	2
4/17/2020	1101	4
4/18/2020	1101	4
4/19/2020	1101	4
4/20/2020	1101	6
4/21/2020	1101	8
4/22/2020	1101	8
4/23/2020	1101	8
4/24/2020	1101	8
4/25/2020	1101	10
4/26/2020	1101	12
4/27/2020	1101	13
4/28/2020	1101	20
4/29/2020	1101	29
4/30/2020	1101	28
5/1/2020	1086	28
5/2/2020	1086	28
5/3/2020	1086	28
5/4/2020	1086	32
5/5/2020	1086	31
5/6/2020	1086	31
5/7/2020	1086	39
5/8/2020	1086	36
5/9/2020	1086	38
5/10/2020	1086	38

5/11/2020	1086	36
5/12/2020	1086	36
5/13/2020	1086	37
5/14/2020	1086	36
5/15/2020	1086	27
5/16/2020	1086	25
5/17/2020	1086	25
5/18/2020	1086	19
5/19/2020	1086	17
5/20/2020	1086	14
5/21/2020	1086	10
5/22/2020	1086	10
5/23/2020	1086	8
5/24/2020	1086	8
5/25/2020	1086	8
5/26/2020	1086	7
5/27/2020	1086	7
5/28/2020	1086	6
5/29/2020	1086	4
5/30/2020	1086	4
5/31/2020	1086	4
6/1/2020	1098	1
6/2/2020	1098	1
6/3/2020	1098	1
6/4/2020	1098	1
6/5/2020	1098	1
6/6/2020	1098	1
6/7/2020	1098	1
6/8/2020	1098	1
6/9/2020	1098	1
6/10/2020	1098	1
6/11/2020	1098	1
6/12/2020	1098	1
6/13/2020	1098	1
6/14/2020	1098	1
6/15/2020	1098	1
6/16/2020	1098	1
6/17/2020	1098	1
6/18/2020	1098	1
6/19/2020	1098	1
6/20/2020	1098	1
6/21/2020	1098	1
6/22/2020	1098	1
6/23/2020	1098	1
6/24/2020	1098	1
6/25/2020	1098	1
6/26/2020	1098	1

6/27/2020	1098	1
6/28/2020	1098	1
6/29/2020	1098	1
6/30/2020	1098	1
7/1/2020	1098	1
7/2/2020	1098	1

DMHAS COVID-19 Daily Synopsis - Total Comparison of All CVH Staff Currently Positive



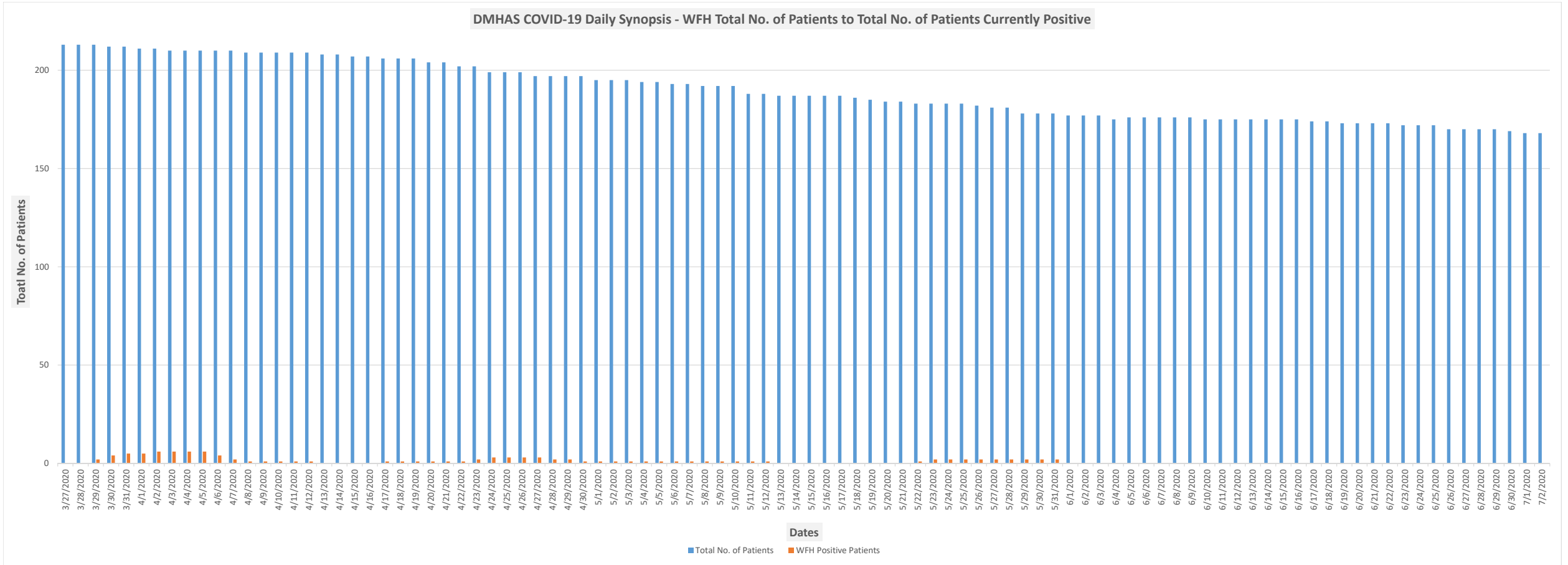
**EXHIBIT –**

WFH Total No. of Patients to Total No. of Patients Currently Positive		
DATE	Total No. of Patients	WFH Positive Patients
3/27/2020	213	0
3/28/2020	213	0
3/29/2020	213	2
3/30/2020	212	4
3/31/2020	212	5
4/1/2020	211	5
4/2/2020	211	6
4/3/2020	210	6
4/4/2020	210	6
4/5/2020	210	6
4/6/2020	210	4
4/7/2020	210	2
4/8/2020	209	1
4/9/2020	209	1
4/10/2020	209	1
4/11/2020	209	1
4/12/2020	209	1
4/13/2020	208	0
4/14/2020	208	0
4/15/2020	207	0
4/16/2020	207	0
4/17/2020	206	1
4/18/2020	206	1
4/19/2020	206	1
4/20/2020	204	1
4/21/2020	204	1
4/22/2020	202	1
4/23/2020	202	2
4/24/2020	199	3
4/25/2020	199	3
4/26/2020	199	3
4/27/2020	197	3
4/28/2020	197	2
4/29/2020	197	2
4/30/2020	197	1
5/1/2020	195	1
5/2/2020	195	1
5/3/2020	195	1
5/4/2020	194	1
5/5/2020	194	1
5/6/2020	193	1
5/7/2020	193	1
5/8/2020	192	1
5/9/2020	192	1

5/10/2020	192	1
5/11/2020	188	1
5/12/2020	188	1
5/13/2020	187	0
5/14/2020	187	0
5/15/2020	187	0
5/16/2020	187	0
5/17/2020	187	0
5/18/2020	186	0
5/19/2020	185	0
5/20/2020	184	0
5/21/2020	184	0
5/22/2020	183	1
5/23/2020	183	2
5/24/2020	183	2
5/25/2020	183	2
5/26/2020	182	2
5/27/2020	181	2
5/28/2020	181	2
5/29/2020	178	2
5/30/2020	178	2
5/31/2020	178	2
6/1/2020	177	0
6/2/2020	177	0
6/3/2020	177	0
6/4/2020	175	0
6/5/2020	176	0
6/6/2020	176	0
6/7/2020	176	0
6/8/2020	176	0
6/9/2020	176	0
6/10/2020	175	0
6/11/2020	175	0
6/12/2020	175	0
6/13/2020	175	0
6/14/2020	175	0
6/15/2020	175	0
6/16/2020	175	0
6/17/2020	174	0
6/18/2020	174	0
6/19/2020	173	0
6/20/2020	173	0
6/21/2020	173	0
6/22/2020	173	0
6/23/2020	172	0
6/24/2020	172	0
6/25/2020	172	0

6/26/2020	170	0
6/27/2020	170	0
6/28/2020	170	0
6/29/2020	170	0
6/30/2020	169	0
7/1/2020	168	0
7/2/2020	168	0





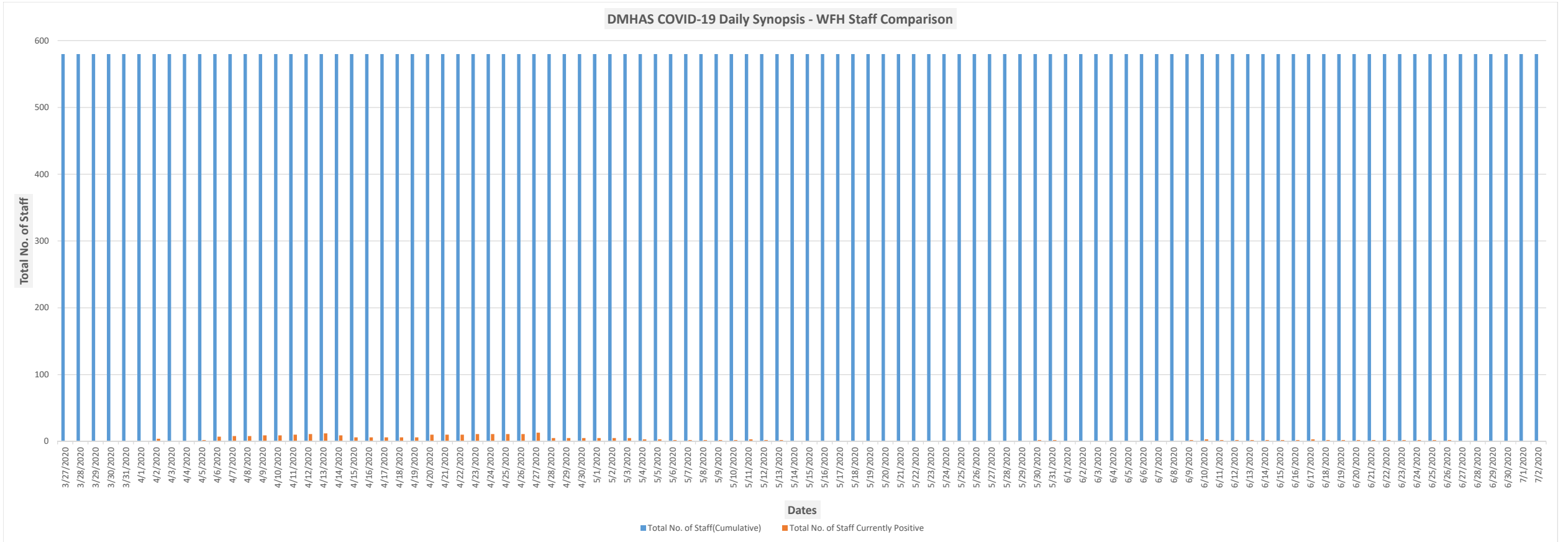
**EXHIBIT ° °**

**WFH Staff - COVID-19 Daily Synopsis**

Date	Total No. of Staff(Cumulative)	Total No. of Staff Currently Positive
3/27/2020	580	0
3/28/2020	580	0
3/29/2020	580	0
3/30/2020	580	0
3/31/2020	580	0
4/1/2020	580	0
4/2/2020	580	4
4/3/2020	580	1
4/4/2020	580	1
4/5/2020	580	2
4/6/2020	580	7
4/7/2020	580	8
4/8/2020	580	8
4/9/2020	580	9
4/10/2020	580	9
4/11/2020	580	10
4/12/2020	580	11
4/13/2020	580	12
4/14/2020	580	9
4/15/2020	580	6
4/16/2020	580	6
4/17/2020	580	6
4/18/2020	580	6
4/19/2020	580	6
4/20/2020	580	10
4/21/2020	580	10
4/22/2020	580	10
4/23/2020	580	11
4/24/2020	580	11
4/25/2020	580	11
4/26/2020	580	11
4/27/2020	580	13
4/28/2020	580	5
4/29/2020	580	5
4/30/2020	580	5
5/1/2020	580	5
5/2/2020	580	5
5/3/2020	580	5
5/4/2020	580	3
5/5/2020	580	3
5/6/2020	580	2
5/7/2020	580	2
5/8/2020	580	2
5/9/2020	580	2
5/10/2020	580	2

5/11/2020	580	3
5/12/2020	580	2
5/13/2020	580	2
5/14/2020	580	1
5/15/2020	580	1
5/16/2020	580	1
5/17/2020	580	1
5/18/2020	580	1
5/19/2020	580	1
5/20/2020	580	1
5/21/2020	580	1
5/22/2020	580	1
5/23/2020	580	1
5/24/2020	580	1
5/25/2020	580	1
5/26/2020	580	0
5/27/2020	580	0
5/28/2020	580	0
5/29/2020	580	0
5/30/2020	580	2
5/31/2020	580	2
6/1/2020	580	0
6/2/2020	580	0
6/3/2020	580	0
6/4/2020	580	1
6/5/2020	580	1
6/6/2020	580	1
6/7/2020	580	1
6/8/2020	580	1
6/9/2020	580	2
6/10/2020	580	3
6/11/2020	580	2
6/12/2020	580	2
6/13/2020	580	2
6/14/2020	580	2
6/15/2020	580	2
6/16/2020	580	2
6/17/2020	580	3
6/18/2020	580	2
6/19/2020	580	2
6/20/2020	580	2
6/21/2020	580	2
6/22/2020	580	2
6/23/2020	580	2
6/24/2020	580	2
6/25/2020	580	2
6/26/2020	580	2

6/27/2020	580	0
6/28/2020	580	0
6/29/2020	580	0
6/30/2020	580	0
7/1/2020	580	0
7/2/2020	580	0



**EXHIBIT BB**

UNITED STATES DISTRICT COURT  
DISTRICT OF CONNECTICUT

THOMAS WILKES,	:	
BARBARA FLOOD,	:	CIVIL NO. 3:20CV594-JCH
VINCENT ARDIZZONE,	:	
GAIL LITSKY,	:	
CARSON MUELLER,	:	
On behalf of themselves and	:	
all other persons similarly	:	
situated,	:	
<i>Plaintiffs</i>	:	
	:	
v.	:	
	:	
NED LAMONT, Governor	:	
MIRIAM E. DELPHIN-RITTMAN,	:	
Commissioner of DMHAS,	:	
HAL SMITH, CEO of Whiting Forensic	:	
Hospital,	:	
LAKISHA HYATT, CEO Connecticut	:	
Valley Hospital,	:	
In their official capacities,	:	
<i>Defendants</i>	:	JULY 8, 2020

**DECLARATION OF HAL SMITH**

The undersigned declarant, Hal Smith, being duly sworn, hereby deposes and declares under the pains and penalties of perjury, pursuant to 28 USC §1746, that:

1. I am employed by the State of Connecticut Department of Mental Health and Addiction Services as the Chief Executive Officer at Whiting Forensic Hospital (“WFH”) in Middletown, CT. I have held this position since June 1, 2018.
2. I make this Declaration based upon personal knowledge, and I understand that it will be submitted to this Court in connection with the above-captioned case in support of the Defendants’ Opposition to the Plaintiffs’ Motion for Preliminary Injunction.



3. WFH is a state-operated inpatient facility providing services to individuals involved in the criminal justice system as well as through the civil commitment process.
4. As part of my job duties, I am responsible for the management and oversight of the daily clinical operations and patient care at WFH.
5. WFH has protocols in place with regard to the testing of staff in response to the COVID-19 pandemic.
6. As of June 22, 2020, testing for COVID-19 is mandatory at for direct care staff and those who regularly interact with patients at WFH.

**DECLARATION**

Pursuant to Conn. Gen. Stat. §§1-24a, 53a-157b, and 28 U.S.C. §1746, I declare under the pains and penalties of perjury that the foregoing statements are true and accurate to the best of my knowledge and belief.

Dated this 8 day of July, 2020.



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Hal Smith, CEO  
Whiting Forensic Hospital