Interagency Memorandum

March 9, 2021

To: Tony Kolbeck
Chief of Staff, Illinois Department of Veterans' Affairs

Major General Peter Nezamis
Interim Director, Illinois Department of Veterans' Affairs

From: Avery Hart, MD FACP /s/ Avery Hart
Medical Consultant, IDPH

Re: **Interagency Infection Prevention Project**

The status report from the Interagency Infection Prevention Project is attached.

Attachment

cc: Karyn Bass Ehler
Justin DeWitt
Ngozi Ezike, MD

Interagency Infection Prevention Project

Status Report: March 9, 2021

This report summarizes the work of the Interagency Infection Prevention Project (IIPP). The IIPP is a collaboration of the Illinois Department of Veterans' Affairs (IDVA), the Illinois Department of Public Health (IDPH), and the Veterans' Integrated Service Network for Region 12 (VISN 12) of the US Department of Veterans' Affairs. The purpose of the IIPP is to support an integrated and comprehensive response to COVID-19 at the Illinois Veterans' Homes.

IDVA reports twice yearly to the legislature about the health and welfare of residents at Illinois Veterans Homes, in accordance with the Department of Veterans' Affairs Act (20 ILCS 2805/2.13). The biannual report, by statute, includes information on any epidemic reported at a Veterans Home and action taken to eradicate the spread of communicable disease during the reporting period. The present document supplements a biannual departmental report previously submitted to the General Assembly for the period from July 1 to December 31, 2020.

Origin and purpose of the IIPP

The IIPP grew out of an interagency site visit to the Illinois Veterans Home in LaSalle. In response to an outbreak of COVID-19 among residents and staff there, the Chief of Staff at IDVA requested assistance from IDPH and from the jurisdictional federal VA Medical Center (Hines VA Hospital).[1] Infection prevention specialists from each agency conferred with the leadership team at LaSalle on November 11 and conducted a site visit together on November 12. Their joint findings and initial recommendations for action steps to limit transmission in the facility have been previously reported, along with findings at the first follow-up visit on November 17.[2,3]

Later that same month, IDVA requested IDPH and the VA Veterans' Integrated Service Network for Region 12 (VISN 12) to assist in a comprehensive, system-wide quality improvement project for COVID-19 response. In response, a project team was convened with the following objectives:

- Review current policies, procedures, and practice relating to COVID-19 response at each facility; identify issues for which corrective action is needed;
- Assist each site with development of a COVID-19 corrective action plan for each action item identified and monitor execution of action plan, including at least one mock inspection;
- Assist in creating a framework of standardized policies to address COVID-19 at IDVA Homes;

[1] State Veterans' Homes must comply with federal requirements set forth in 38 CFR 51. Compliance is subject to certification by the jurisdictional VA Medical Center (VAMC). Hines VA Hospital is the jurisdictional VAMC for Illinois Veterans' Home at LaSalle. In contrast, nursing homes must comply with requirements set forth in 42 CFR 483 and their compliance is subject to certification by the Centers for Medicare and Medicaid Services (CMS).

[2] "Consultative Infection Control Visit Illinois State Veterans Home at LaSalle, 11/12/2020"

[3] "Follow-up Site Visit to VA Home of LaSalle, 11/17/2020"

- Consult as needed with specialists who could identify any engineering controls and/or structural changes needed to reduce potential transmission of SARS-CoV-2 within the facility.

Members and activities of the project team are described in Appendices 1 and 2.

Recommendations of a Health and Safety audit performed in 2019

A previous Health and Safety audit, conducted in 2019, is relevant to the current quality improvement project. Pursuant to Executive Order 2019-04, a consulting firm conducted a comprehensive review of weaknesses, strengths, and opportunities for improvement of policies, protocols, and procedures related to ensuring the health and safety of residents and employees at Illinois Veterans' Homes.[4]

The Health and Safety audit found that "Policies are not standardized between Homes…. A number of reviewed policies appear incomplete; for example, they are possibly outdated (up to five years old) and do not indicate which current regulations or standards of practice they are designed to address. Various infection control policies exist, but it is not clear how they are integrated into an Infection Control Management Program or if they are standalone policies."

The auditor recommended, "Develop 'IDVA System Policies' or standardized policy structure that addresses all Homes. These could be compiled from identified, evidence-based, best practice, and/or National Standards. Additional policies unique to each Home may still be maintained as appropriate….The health and safety team should develop a process to: (1) ensure plans are revised annually, integrating lessons learned and improved approaches and tools; and (2) communicate accurate policy and procedure information to staff."

Following the audit in 2019, the Senior Home Administrator retired. The task of creating an integrated Infection Control Program was deferred while this position remained open. Some of the Veterans' Homes have updated their infection prevention policies, independently of one another, since then.

Recommendations of the interagency project team to IDVA

Standardized policies and procedures, as recommended in the 2019 audit, are needed as one part of an infection prevention program. Based on its review of IDVA's infection prevention program, the IIPP recommends additional enhancements to build an integrated and comprehensive program of infection prevention and control at the Illinois Veterans' Homes, including their response to COVID-19.

Assets. The project team identified multiple strengths at Illinois Veterans' Homes:

- Staff members at all levels of the organization place residents and their family members at the center of care.

[4] Illinois Department of Veterans' Affairs. Health and Safety Audit: Findings and Recommendations. Prepared by Tetra Tech, Inc. May 17, 2019.

- Key resources are available, including sufficient front-line staffing, personal protective equipment (PPE), cleaning and disinfecting products, and point-of-care testing supplies, providing the basics for an effective infection prevention and control response.
- The Veterans' Homes have shown willingness and readiness to engage in an active pandemic response using an interdisciplinary approach that has included administration, nursing, infection preventionists, front line staff, and public health authorities.

Enhancements. The project team recommends these enhancements to build on the assets listed above:

1. Reorganize infection prevention for Veterans' Homes as a coordinated multi-site effort, rather than the independent efforts of individual facilities. Standardize across the organization:
   a. Develop and implement system-wide policies, procedures, and practices for infection prevention. For the recommended framework, see Appendix 3.
   b. Adopt standardized instruments for periodic facility-based self-assessment, such as those developed by the CDC and by the CMS Quality Improvement Organizations.[5]
   c. Utilize standardized tools for Quality Assurance and Performance Improvement (QAPI), such as those developed by the CMS.[6]
   d. Create a position for a Senior Infection Preventionist and establish a new, system-wide Infection Prevention Committee (see next recommendation).
   e. Standardize supplies and equipment for environmental services.
2. Expand system capacity for infection prevention:
   a. Set staffing levels based on CDC recommendations: at least one full-time position for each facility with more than 100 beds.[7]
   b. Create a position for a Senior Infection Preventionist to oversee facility-level infection preventionists, system-wide.
   c. Formalize collaboration of infection preventionists within DVA through a new, system-wide Infection Prevention Committee
   d. Promote regionally based linkages with infection preventionists and communicable disease leads at jurisdictional VA Medical Centers and local health departments.[8]
3. Broaden and deepen the perspective of the infection preventionists, positioning them to be conveners, coordinators, and communicators for Interdisciplinary Team efforts:

[5] CDC, *Infection Control Assessment Tools*, https://www.cdc.gov/hai/prevent/infection-control-assessment-tools.html; CDC, *Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19*. https://www.cdc.gov/coronavirus/2019-ncov/hcp/assessment-tool-for-nursing-homes.html; CMS QIO, *Nursing Home Facility Assessment Tool,* http://qioprogram.org/facility-assessment-tool.

[6] CMS, *QAPI Tools*, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/qapitools; CMS. Nursing Home Resource Center, https://www.cms.gov/nursing-homes.

[7] CDC, *Preparing for COVID-19 in Nursing Homes*. https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html.

[8] Regionally based linkages of the Illinois Veterans' Homes are shown below.

a. Align reporting relationships with their interdisciplinary role and responsibilities.
    i. Facility-level infection preventionists should report to the Senior Infection Preventionist, who in should report directly to the Senior Home Administrator.
    ii. Until the Senior Infection Preventionist is in place, the facility-level infection preventionists should report to their respective Home Administrators.
b. Promote professional development of infection preventionists by strengthening engagement with their discipline's professional society, the Association for Professionals in Infection Control and Epidemiology (APIC).[9] Encourage and support:
    I. Course enrollment and completion;
    II. Participation in national and local chapter events.
c. Consider joining the AHRQ ECHO National Nursing Home COVID-19 Action Network.[10]

4. Strengthen staff-wide training[11]:
    a. Expand structured in-service training: onboarding; annual refreshers; updates for new or substantially revised policies and procedures.
    b. Add a layer of deeper training for managers.
    c. Emphasize competency-based training techniques, such as return demonstration.
5. Monitor adherence to policy and procedure to identify and correct gaps in a timely manner. Active, shared staff participation extends the reach of the infection prevention program and fosters staff ownership of key infection prevention processes:
    a. Direct observation of practice by infection preventionists and supervisory staff;
    b. Interdisciplinary rounds on all shifts[12];
    c. Regular, systematic, participatory audits, sharing results with staff[13]:
        i. Hand hygiene and PPE compliance;

Illinois Veterans' Home	**Regionally based linkages**		
	Local Health Department	Veterans' Integrated Service Network (VISN)	Jurisdictional VA Medical Center
Anna	Southern 7	15	Marion
LaSalle	LaSalle	12	Hines
Manteno	Kankakee	12	Hines
Quincy	Adams	23	Iowa City
Chicago	Chicago	12	Hines

[9] APIC. *Roadmap for the Novice Infection Preventionist*. https://apic.org/professional-practice/roadmap/novice-roadmap-for-the-infection-preventionist/.

[10] Agency for Healthcare Research and Quality. *AHRQ ECHO National Nursing Home COVID-19 Action Network*. https://www.ahrq.gov/nursing-home/index.html.

[11] CMS QSEP. *Targeted COVID-19 Training for Nursing Homes*. https://qsep.cms.gov/COVID-Training-Instructions.aspx. CMS-CDC. *Fundamentals of COVID-19 Prevention for Nursing Home Management*. https://qioprogram.org/cms-cdc-fundamentals-covid-19-prevention-nursing-home-management.

[12] APIC. *Environment of Care Worksheet for Infection Prevention*. https://apic.org/Resource_/TinyMceFileManager/Academy/ASC_101_resources/Assessment_Checklist/Environment_Checklist.doc.

[13] CMS QIO. *Infection Prevention and Control Resources*. https://www.telligenqinqio.com/infection-prevention-and-control-resources/.

ii. Environmental cleaning and disinfecting processes.

6. Engage top management directly with front-line staff through Interdisciplinary Team rounds for infection prevention.[14]
   a. Create a safe space in which to elicit facility-wide and unit-specific concerns from staff; engage in collaborative problem-solving; promote partnerships across disciplines.
   b. Cultivate and inspire a culture of clinical excellence among front-line staff; leverage personal prestige to move initiatives for infection control forward.

Progress to date

Indicators of progress for infection prevention include process measures and outcome measures. Regarding process, IDVA has embraced and adopted numerous recommendations from the interagency project team. Repeated site visits to the Veteran's Homes have documented substantial improvement in infection prevention practices. These visits are described in Appendix 4. Observed progress is summarized in Appendix 5. Regarding resident outcomes, quarterly trends for 2020 and the first ten weeks of 2021 are shown in Table 1.

At the LaSalle Home, the last new resident case associated with the facility's November outbreak tested positive on November 23. The time course of LaSalle's November outbreak is shown in Appendix 6a. There were no further positive tests among LaSalle residents until March 1, when one resident tested positive without symptoms on weekly PCR surveillance. To date, no other residents or staff have tested positive on surveillance testing in association with this one case.

At the Manteno Home, a cluster of newly positive tests among six residents occurred between February 1 and February 13, after an interval of no new cases since December 20. (Four of these residents had already received two doses of COVID-19 vaccine before they tested positive. The other two had declined vaccination.)

At the Quincy Home, the last newly positive resident test occurred on January 3, at the conclusion of a multi-building outbreak there. The distribution of cases at the Quincy Home is shown in Appendix 6b. At the Anna Home, the last newly positive resident test occurred on November 25.

Quarterly trends among staff for 2020 and the first ten weeks of 2021 are shown in Table 2. Newly positive staff tests continue to occur at all four facilities, though at a much lower rate in 2021 than during the last quarter of 2020. Some staff cases will be inevitable while community transmission continues. Pre-shift rapid viral testing has been a useful adjunct for identifying staff cases to limit transmission within the facilities, but it does not detect all cases of infection.[15] Additional cases have been identified through regular PCR testing.

[14] Saint S et al. *Infect Control Hosp Epidemiol* 2010; 31:901-7. Knobloch MJ, et al. *Am J Infect Control.* 2018; 46:303-310.

[15] Pray IW et al, *MMWR Morb Mortal Wkly Rep.* 2021; 69:1642-1647; Prince-Guerra JL et al, *MMWR Morb Mortal Wkly Rep. 2021;* 70:100-105.

Table 1. Residents with Positive COVID-19 Tests During Pandemic										
	Interval Counts of Cases[a] and Deaths[b]								Cumulative Totals	
Facility	2nd Quarter 2020		3rd Quarter 2020		4th Quarter 2020		1/01-3/09/2021			
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
Anna	5	0	1	0	1	0	0	0	7	0
LaSalle	1	0	0	0	107	35	1	0	109	36
Manteno[c]	50	15	12	2	25	2	6	0	93	19
Quincy[d]	0	0	15	1	117	6	2	17	134	24
TOTAL	56	15	28	3	250	43	9	17	343	79

[a] Case counts include all residents with positive COVID-19 tests, with or without symptoms.

[b] Deaths are counted based on IDPH criteria (IDPH, COVID-19 Situational Update, May 27, 2020).

[c] Manteno counts include the co-located Prince Home (3 resident cases).

[d] Deaths at Quincy early in first quarter of 2021 resulted from cases that occurred late in previous quarter.

Table 2. Staff with Positive COVID-19 Tests During Pandemic					
	Interval Case Counts[a,b]				Cumulative Totals
Facility	2nd Quarter 2020	3rd Quarter 2020	4th Quarter 2020	1/01-3/09/2021	
Anna	1	3	10	4	18
LaSalle	0	3	102	11	116
Manteno[c]	30	10	31	15	86
Quincy	0	31	124	13	168
TOTAL	31	47	267	43	388

[a] Case counts include staff with positive COVID-19 tests, with or without symptoms.

[b] No deaths have occurred among staff members.

[b] Manteno counts include Prince Home (4 staff cases).

Immunization, an essential tool in suppressing transmission of COVID-19, became an important focus of the project team's work in December. The Veterans' Homes had enrolled in the federal Pharmacy Partnership for Long-Term Care Program for COVID-19 Vaccination. However, it became apparent that vaccine could be administered sooner if IDVA itself became a vaccine provider. IDPH and local health departments provided vital support for this initiative. Residents and staff at all four Veterans' Homes received their first round of COVID-19 vaccinations during the last week of December.

The status of vaccination among residents is shown in Table 3. The vaccination campaign has been very successful, with 96% of residents having received either one or two doses of vaccine or monoclonal antibody (with vaccination to follow). The vaccine take-up rate among residents at Illinois Veterans' Homes is well above the recent national estimated median vaccination rate of 77.8% among residents at skilled nursing facilities (SNFs) participating in the federal Pharmacy Partnership for Long-Term Care Program.[16] The recent statewide estimated median for residents in Illinois SNFs is 74.8%, similar to the national estimate.[17]

[16] Gharpure R et al. *MMWR Morb Mortal Wkly Rep.* 2021; 70:178-182.

[17] Gharpure R, personal communication, February 12, 2021.

The status of vaccination among staff is shown in Table 4. Challenges remain in this arm of the vaccination campaign, with 50% of staff members having received either one or two doses of vaccine so far. For context, the vaccine take-up rate at Illinois Veterans' Homes is higher than the recent national estimated median vaccination rate of 37.5% among staff members at skilled nursing facilities.[15] The recent statewide estimated median for staff in Illinois SNFs is also 37.5%, the same as the national estimate.[16] Vaccine hesitancy is widespread among staff at long-term care facilities across the country.[18] Efforts build to confidence about COVID-19 vaccination among IDVA staff members are ongoing.

Table 3. Immunization of Current Residents[a]

Facility	Census	Vaccination Status[b]				
		Vaccine doses[c]		Bamlanivimab before vaccine	Declined	Take-up rate[d]
		One	Two			
Anna	36	1	35	0	0	100%
LaSalle	87	1	66	16	4	95.4%
Manteno[e]	158	1	144	0	13	91.7%
Quincy	260	21	214	16	9	96.5%
TOTAL	536	24	459	32	21	96.0%

[a] As of February 11, 2021

[b] Immunized residents include those with active immunization from COVID-19 vaccine and passive immunization from Bamlanivimab. If bamlanivimab has been given to treat active COVID-19, then active immunization is given 90 days later for sustained immunity.

[c] The second dose is due 3 or 4 weeks after first dose, depending on which vaccine is used; it may be delayed if COVID-19 infection occurs between doses.

[d] Take-up rate includes residents who have received two doses, one dose with second dose scheduled, or monoclonal antibody with first dose scheduled, as of February 11, 2021.

[e] Manteno's counts include the co-located Prince Home.

Table 4. Immunization of Current Staff[a]

Facility	Head Count	Vaccination Status			
		Vaccine doses[b]		Declined	Take-up rate
		One	Two		
Anna	78	6	26	46	41.0%
LaSalle	259	19	127	113	56.4%
Manteno[c]	380	11	146	223	41.3%
Quincy	493	48	230	215	56.4%
TOTAL	1210	84	529	597	50.6%

[a] As of February 11, 2021

[b] The second dose is due 3 or 4 weeks after first dose, depending on which vaccine is used; it may be delayed if COVID-19 infection occurs between doses.

[c] Manteno's counts include the co-located Prince Home.

The Chicago Veterans' Home: a new model

[18] NPR. Vaccine Hesitancy Among Long-Term Care Facility Workers. January 31, 2021. Available online at: https://www.npr.org/2021/01/31/962638218/vaccine-hesitancy-among-long-term-care-facility-workers

IDVA is embracing a new concept of long-term care, as evidenced in staff interviews and the design of the soon-to-open Chicago Veterans' Home. All rooms in this new facility are private. Floor plans, staff, and residents are organized in a person-centered, household-and-neighborhood model.[19] Infection prevention is one of the many advantages of this model. Nursing homes with single-occupancy rooms have lower rates of COVID-19 transmission within their facilities.[20] Household-and-neighborhood arrangements may also help to contain infection, reducing the scale and severity of outbreaks.[21]

For the purpose of infection prevention, IDVA should consider the feasibility of converting existing shared rooms to private rooms at its other facilities.

Progressive transition to in-house infection prevention

Throughout this project, IDVA has been highly receptive and responsive to recommendations from the interagency project team. As implementation progresses, the degree of technical assistance needed from the project team is tapering. One or more members of the project team will remain available for timely, day-to-day consultation. Also, the team has encouraged the leadership teams to attend the ongoing Long-Term Care Q&A teleconference series on infection prevention. Two of the IIPP team members are regular panelists at this forum. They will also conduct a follow-up teleconference with each of the four facility leadership teams, to occur about 60 days after the last visit to each site.

After IDVA hires a senior infection preventionist at the system level and further develops its infection prevention workforce at the facility level, staff within the Department will be ready to handle most issues internally. Collegial consultation with infection preventionists at IDPH and at jurisdictional VA medical centers will remain available.

[19] Calkins MP. *Gerontologist.* 2018; 58:S114–S128.

[20] Brown KA et al. *JAMA Intern Med*. 2021; 181:229-236.

[21] Anderson DC et al, *J Am Med Dir Assoc*. 2020; 21: 1519–1524; Zimmerman S et al. *J Am Med Dir Assoc*. 2021, in press; available online at https://www.jamda.com/article/S1525-8610(21)00120-1/fulltext.

Appendix 1. Members of the Project Team

Amelia Bumsted DNP, RN, CIC, FAPIC is Manager of Infection Control at Hines VA Hospital and the VA Great Lakes Health Care System (Veterans' Integrated Service Network, VISN 12). She is board-certified in infection control and she is a Fellow of the Association of Professionals in Infection Control and Epidemiology (APIC). She has served on APIC's Practice Guidance Committee and is a contributing author of the *APIC Text of Infection Control and Epidemiology*, as well as a section editor for its 4th edition.

Deborah Burdsall PhD, RN-BC, CIC, FAPIC is an Infection Prevention Consultant with the Office of Health Protection at the Illinois Department of Public Health. She is board-certified in infection control and in gerontological nursing. She is a Fellow of the Association of Professionals in Infection Control and Epidemiology (APIC). She serves on APIC's Long-Term Care Task Force and on the Long-Term Care Working Group of HICPAC, a federal committee appointed to advise CDC regarding strategies for prevention and control of healthcare-associated infections. She is a contributing author of the textbook *Infection Prevention Guide to Long-Term Care* and a co-author of research studies on COVID-19 published in scientific journals including *Clinical Infectious Disease* and *The Lancet*.

Avery Hart MD, FACP is a practicing physician and a medical consultant with the Illinois Department of Public Health. He is board certified in internal medicine. He is a veteran of the US Air Force and subsequently served 24 years in the Cook County Health & Hospitals System, including twelve years as Division Chief for General Medicine and Primary Care and four years as chief medical officer at the health service for Cook County Jail. His consulting role at IDPH has focused on the COVID-19 response in congregate living settings.

Karen Trimberger BSN, RN, MPH, NE-BC, CIC is an Infection Prevention Consultant with the Office of Health Protection at the Illinois Department of Public Health. She is board-certified in infection control and is a member of the Association of Professionals in Infection Control and Epidemiology (APIC). She is a core member of IDPH's Infection Prevention Liaison Program, which is responsible for implementing the Infection Control Assessment and Response program (ICAR) in the state of Illinois. ICAR is a CDC-sponsored program focused on supporting state-driven efforts to improve infection prevention and control capacity nationally.

The team gratefully acknowledges the assistance of these staff members at IDPH:

Sarah Brister
April Caulk
Heidi Clark
Dr. Catherine Counard
Justin Dammerman
Justin DeWitt
Michelle Ealy
Karyn Bass Ehler
Andrew Friend
Paula Jimenez
Judy Kauerauf
Henry Kowalenko
Aaron Martin
Allison Nickrent
Dennis Schmitt
Heather Stone
Laura Vaught
Lori Weiselberg

Appendix 2. Activities of the Interagency Project Team

- *On-site technical assistance* consisted of 15 in-person site visits. For site visit methodology and schedule, see Appendix 4.
- *Weekly 45-minute videoconferences* brought together leadership from all five sites with the project team at an Infection Prevention Roundtable for policy updates and Q&A.
- *Daily communications* included multichannel contacts with the various IDVA Homes, the IDVA Central Office, the US VA (VISNs 12, 15, and 23), local health departments, and other parties.
- *Coaching on application of CDC and IDPH guidance* to specific real-world scenarios assisted decision-making by staff in a variety of areas such as cohorting, contact tracing, quarantine, tiered mitigation.
- *Strategic consultation* recommended enhancements that will contribute to establishing and maintaining an integrated and comprehensive infection prevention program.
- *Compilation and analysis of epidemiologic data* was conducted to generate epidemic (Epi) curves, monitor trends, and generate hypotheses regarding manner of spread.
- *Assistance with the vaccination campaign* included advising on cold-chain storage equipment and procedures, coaching on administrative and reporting requirements, serving as liaison with IDPH's vaccination task force, and facilitating partnerships with local health departments for vaccination fairs.
- *Policy development* focused on updating and standardizing policies at the system level to form an integrated and comprehensive framework for infection prevention. Policies directly relevant to COVID-19 mitigation were selected for preparation. Policies for other areas of infection prevention were identified and deferred to IDVA for subsequent development.
- *Training* of all frontline and management staff utilized CMS Targeted COVID-19 Training for Nursing Homes.
- *Personnel consultation* yielded workforce recommendations and job descriptions for two levels of infection prevention positions.
- *Support for medical directors* included assistance with allocation and delivery of monoclonal antibody (bamlanivimab) and advice on applying CDC guidance in complex clinical situations.
- *Interface* with a mechanical engineering consultancy created a platform for healthcare-informed dialogue on HVAC questions. (Recommendations from the engineering consultancy on HVAC are presented separately in a report by Thomas Buchheit PE from BRiC Partnership LLC.)

Appendix 3. Framework for Standardization of System-Wide Policies

Current facility-level policies in the areas listed below are being updated and standardized at the system level to form an integrated and comprehensive framework for infection prevention.

	Policy	**High relevance for COVID-19?**	**Status***
1	Infection Control Program	✓	S
2	Health Evaluation of Staff	✓	S
3	COVID-19 Staffing Considerations	✓	S
4	COVID-19 Basic Precautions	✓	S
5	COVID-19 Testing Plan	✓	S
6	COVID-19 Response Strategy	✓	S
7	Vaccine Storage and Handling	✓	S
8	Vaccinations	✓	S
9	Hand Hygiene	✓	S
10	Standard and Transmission-Based Precautions	✓	S
11	Personal Protective Equipment	✓	S
12	Respiratory Protection Program	✓	S
13	Environmental Cleaning and Disinfection	✓	S
14	Laundry and Linen		D
15	Bloodborne Pathogens and Injection Safety		D
16	Surveillance, Outbreak Investigation, and Reporting		D
17	Antibiotic Stewardship Program		D
18	Device-associated Infections		D
19	Tuberculosis Prevention		D
20	Acute Respiratory Infections [other than COVID-19]		D
21	Legionellosis		D
22	Gastroenteritis and C. difficile		D
23	Skin and Soft Tissue Infections		D
24	Varicella Zoster		D
25	Ectoparasites: Scabies, Lice, Bedbugs		D
26-30	Reserved	--	--

* Status codes: S = Submitted to DVA by the IIPP team; D = deferred to DVA for future preparation

Appendix 4. Site Visit Methodology and Schedule

On-site technical assistance consisted of 15 in-person site visits between November 12 and February 11. Infection preventionists from the project team conducted between two and five in-person site visits at each of the four operational State Veterans' Homes. Members of the team also visited the newly constructed Chicago Home once to assist in planning for opening. For the scheduled initial visit and for an unannounced follow-up visit at each operational site, onsite personnel from the project team generally included two infection control consultants, one from the Veterans' Integrated Service Network (VISN 12) and one from the Illinois Department of Public Health.

The primary objectives of these visits were to:

- Identify COVID-related issues for which corrective action is needed at the site;
- assist the site with development of a corrective action plan for each issue identified;
- monitor execution of the action plan.

For the scheduled initial visit and for an unannounced follow-up visit, after December 1 the team used a standardized, structured tool based on the Infection Control Assessment and Response (ICAR) developed by the CDC. ICAR tools are used to assess systematically a long-term care facility's infection prevention and control practices and to guide quality improvement activities by addressing identified gaps based upon current CDC guidance.

The CDC updated the ICAR in late November to focus on infection prevention and control practices specific to COVID-19. In addition, the project team appended two sections to the ICAR tool, one on COVID-19 vaccination and one on the OSHA-mandated respiratory protection program. The sections are:

1: Facility Demographics & Critical Infrastructure
2: Personal Protective Equipment (PPE)
3: Hand Hygiene
4: Environmental Services
5: Infection Prevention and Control Policies
6: Resident Related Infection Prevention & Control Policies
7: SARS-CoV-2 Testing
8: Vaccination Plan [added]
9: Respiratory Protection [added]

The ICAR tool and accompanying guide for facilitators are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/assessment-tool-for-nursing-homes.html.

The scheduled initial visit and an unannounced follow-up visit to each facility typically included: a tour of the facility with special attention to the screening area, the designated COVID-19 care area, and staff break rooms; interviews with frontline healthcare personnel, with managers, and with the infection preventionist; direct observation of PPE use and hand hygiene, and review of selected infection prevention and control policies. At the conclusion of the scheduled initial visit and the unannounced follow-up visit, the team conducted a detailed outbrief with facility staff. This session typically included the Home Administrator, Director of Nursing and/or Assistant Director of Nursing, Infection

Preventionist, housekeeping director, and sometimes other staff. The initial visit was scheduled in advance, whereas one follow-up visit was unannounced. At the two facilities with larger outbreaks (LaSalle and Quincy), the team conducted multiple interim follow-up visits.

In addition to guiding quality improvement activities based on the ICAR assessment, the infection preventionists modeled and coached a self-monitoring technique, environmental rounds conducted jointly with the leadership team and area supervisors. Environmental rounding by facility leadership is a valuable complement to other self-monitoring techniques, such as audits of infection prevention practices. Environmental rounding was conducted using a standardized checklist developed by the Association for Professionals in Infection Control and Epidemiology (APIC). The checklist, Environmental Rounds Worksheet for Infection Prevention, is available here: https://apic.org/Resource_/TinyMceFileManager/Academy/ASC_101_resources/Assessment_Checklist/Environment_Checklist.doc.

Enhancements suggested at initial site visits and observed at unannounced follow-up site visits are summarized in Appendices 5a through 5d. Site visit dates and personnel are listed below. One team member will also conduct a follow-up teleconference with each of the four facility leadership teams, to occur about 60 days after the last visit to each site.

Site Visit Dates and Personnel[a]			
Facility	**Date**	**Team Members**	**Comment**
LaSalle	Nov 12	Bumsted, Ealy	
	Nov 17	Ealy[b]	unannounced
	Nov 24	Bumsted	
	Dec 14	Bumsted, Burdsall	unannounced
	Jan 4	Bumsted, Burdsall	
Quincy	Dec 9 & 10	Bumsted (9-10), Trimberger (9)	
	Dec 23 & 24	Bumsted (23-24), Burdsall (24)	
	Jan 8	Burdsall	
	Jan 14	Bumsted, Burdsall	unannounced
	Jan 20	Trimberger, Bumsted, Burdsall	virtual Environment of Care rounds
	Jan 26	Trimberger, Burdsall	Virtual Environment of Care rounds
Manteno	Dec 17	Bumsted, Burdsall	
	Jan 27	Burdsall	unannounced
	Feb 11	Burdsall	
Anna	Dec 7	Bumsted, Trimberger	
	Jan 12	Bumsted, Burdsall	unannounced
Chicago	Dec 21	Bumsted, Burdsall	pre-opening visit

[a] Site visits were in person except for the two marked “virtual Environment of Care rounds”

[b] Michelle Ealy retired from IDPH on Dec 1.

Appendix 5a. Summary of Infection Control Assessment & Response - Anna Veterans' Home

ICAR Section	Program Enhancement Suggested, 12/7/2020	Program Enhancement Observed, 1/12/2021
Section 1: Facility Demographics & Critical Infrastructure	• Establish IP position: 0.5-0.8 FTE for IP; direct report to administration. • Collaborate with other larger IDVA sites and local health departments (LHD). • Utilize private quarantine/isolation rooms when space available.	• IP is working directly with administrator and DON. • Collaboration is occurring on a weekly basis with other IDVA sites; also, closer relationship with LHD now since working together on vaccine. • Quarantine rooms have shared bathroom: Using commodes to separate residents.
Section 2: Personal Protective Equipment (PPE)	• Ensure proper storage conditions for PPE (temperature and humidity controlled). • Monitor PPE donning and doffing. • Train and verify competency for PPE use. • Standardize isolation signage.	• PPE stored properly. • Routine checks of PPE use are occurring, and PPE used correctly. • Inservice training with return demonstration completed to validate competency. • Signage standardized.
Section 3: Hand Hygiene (HH)	• Use CDC-recommended alcohol-based hand sanitizer (ABHR). • Educate and competency hand hygiene. • Audit and document hand hygiene observations.	• CDC-recommended ABHR is at point of care and inside resident rooms. • Inservice training with return demonstration is completed to validate competency and practice. • Auditing and documenting HH observations.
Section 4: Environmental Services	• Ensure EPA list N cleaner/disinfectants are at all points of care. • Implement routine environmental rounding of units and buildings. • Monitor and audit processes and supply of product. • Ensure interdisciplinary access to products for cleaning/disinfecting at point of care (not locked away with limited access; consider door keypads).	• EPA List N products available at all points of care. • Active, routine rounding and monitoring of practice with just in time training to ensure correct use, continued supply of products at point of care.
Section 5: Infection Prevention and Control Policies	• Standardize infection prevention policies with a system-wide interdisciplinary committee. • Implement CMS Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP).	• Started to standardize policies and procedures.
Section 6: Resident Related Infection Prevention & Control Policies	• Review resident teaching and education re: Hand hygiene, social distancing, mask use, reporting symptoms, group activities and visitation restrictions, use of isolation and quarantine. • Explore enhancement of PCC EHR to enable documentation of pertinent negatives from COVID-specific symptom screen.	• Residents wearing masks and social distancing, no group activities. • Charting by exception with emphasis on symptoms screening. • Work with PCC EHR to establish prompts and alerts.
Section 7: SARS-CoV-2 Testing	• No further recommendations. • Appropriate testing performed.	• Testing frequency exceeds CDC/CMS/IDPH recommendations.
Section 8: Vaccination Plan	• Coordinate with IDVA and local health department.	• 97.4% vaccinated (all but one resident accepted). • Actively working to vaccinate staff.
Section 9: Respiratory Protection	• Develop Respiratory Protection Program.	• Initial medical evaluations completed and fit testing underway.

Appendix 5b. Summary of Infection Control Assessment & Response - LaSalle Veterans' Home

ICAR Section	Program Enhancement Suggested, 11/12/2020	Program Enhancement Observed, 1/4/2021
Section 1: Facility Demographics & Critical Infrastructure	• Establish IP position: at least one person with 1.0 FTE dedicated IP hours; direct report to administration. • Collaborate with other larger IDVA sites and LHD. • Utilize private quarantine/isolation rooms when space available.	• IP is working directly with administrator and DON. • Collaboration is occurring on a weekly basis with other IDVA sites; also, closer relationship with LHD now since working together on vaccine. • Private quarantine/isolation are being used.
Section 2: Personal Protective Equipment (PPE)	• Ensure availability of PPE at all point of care. • Monitor PPE donning and doffing. • Train and verify competency for PPE use. • Standardize signage.	• PPE readily available and supply monitored. • Routine checks are occurring. • Education and competency completed and ongoing. • Signage standardized.
Section 3: Hand Hygiene (HH)	• Use CDC-recommended alcohol-based hand sanitizer (ABHR). • Educate and competency hand hygiene. • Audit and document hand hygiene observations.	• CDC-recommended ABHR is at point of care including inside resident rooms. • Inservice training with return demonstration is completed to validate competency and practice. • Auditing and documenting HH observations.
Section 4: Environmental Services	• Ensure EPA list N cleaner/disinfectants are at all points of care. • Increase in ready-to-use formulations (e.g., bleach). • Implement routine environmental rounding of units and buildings. • Monitor and audit processes and supply of product. • Ensure interdisciplinary access to products for cleaning/disinfecting at point of care (not locked away with limited access; consider door keypads).	• List N products available at point of care. • Active, routine rounding and monitoring of practice with just in time training to ensure correct use, continued supply of products at point of care.
Section 5: Infection Prevention and Control Policies	• Standardize infection prevention policies with a system-wide interdisciplinary committee. • Implement CMS Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP).	• Started to standardize policies and procedures.
Section 6: Resident Related Infection Prevention & Control Policies	• Review resident teaching and education re: Hand hygiene, social distancing, mask use, reporting symptoms, group activities, visitation restrictions, and use of isolation and quarantine. • Explore enhancement of PCC EHR to enable documentation of pertinent negatives from COVID-specific symptom screening.	• Residents wearing masks and social distancing, no group activities. • Charting by exception with emphasis on symptoms screening. • Work with PCC EHR to establish prompts and alerts.
Section 7: SARS-CoV-2 Testing	• Increase frequency and type of testing. • Include daily antigen POC testing and routine PCR.	• Testing frequency exceeds CDC/CMS/IDPH recommendations.
Section 8: Vaccination Plan	• Work with IDVA and local health department.	• 95% of residents vaccinated. • Actively working to vaccinate staff.
Section 9: Respiratory Protection	• Continue fit testing plan in partnership with LHD.	• Working with local health department to manage fit testing program.

Appendix 5c. Summary of Infection Control Assessment & Response - Manteno Veterans' Home

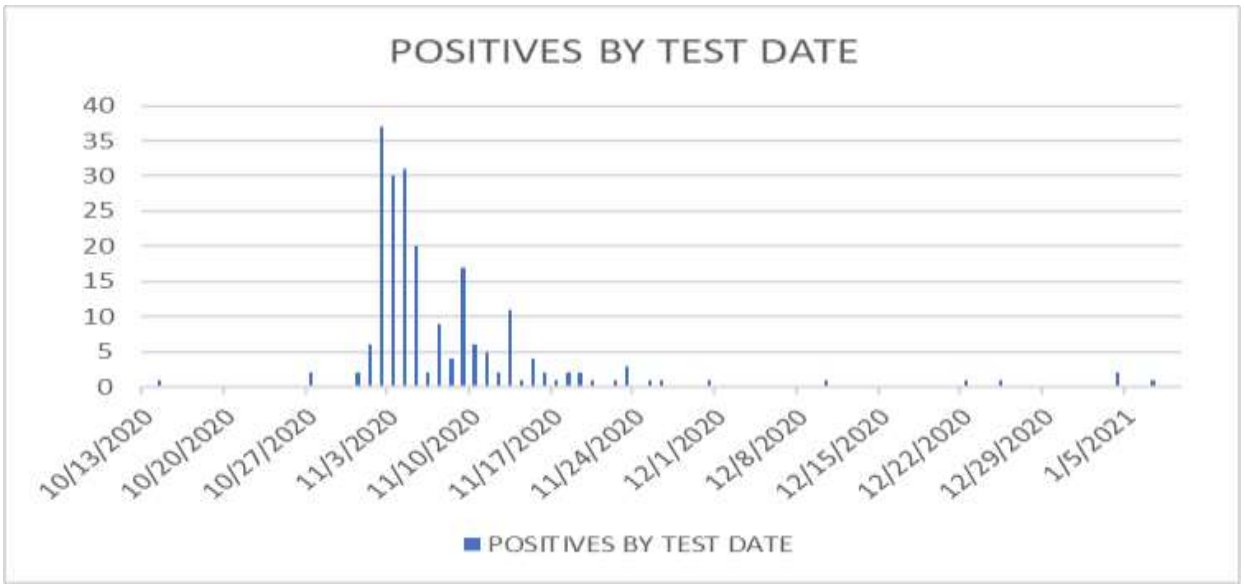
ICAR Section	Suggested Program Enhancement, 12/17/2020	Program Enhancement Observed, 1/27/2021
Section 1: Facility Demographics & Critical Infrastructure	• Establish IP position: at least one person with 1.0 FTE dedicated IP hours; direct report to administration. • Collaborate with other IDVA sites and LHD. • Utilize Private quarantine/isolation rooms when space available.	• IP is working directly with administrator and DON. • Collaboration is occurring on a weekly basis with other IDVA sites; also, closer relationship with LHD now since working together on vaccine.
Section 2: Personal Protective Equipment (PPE)	• Ensure availability of PPE at all point of care. • Monitor PPE donning and doffing. • Train and verify competency for PPE use. • Standardize signage.	• PPE readily available and supply monitored. • Routine checks are occurring. • Education and competency completed and ongoing. • Signage standardized.
Section 3: Hand Hygiene	• Use CDC-recommended alcohol-based hand sanitizer (ABHR). • Educate and competency hand hygiene. • Audit and document hand hygiene observations. • Standardize locations of dispensers.	• Suggest following ADA height for ABHR dispensers. • Inservice training with return demonstration is completed to validate competency and practice. • Auditing and documenting HH observations.
Section 4: Environmental Services	• Ensure EPA list N cleaner/disinfectants are at all points of care. • Implement routine environmental rounding of units and buildings. • Monitor and audit processes and supply of product. • Ensure interdisciplinary access to products for cleaning/disinfecting at point of care (not locked away with limited access; consider door keypads).	• EPA List N products available at point of care. • Active, routine rounding and monitoring of practice with just in time training to ensure correct use, continued supply of products at point of care.
Section 5: Infection Prevention and Control Policies	• Standardize infection prevention policies with a system-wide interdisciplinary committee. • Implement CMS Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP).	• Started to standardize policies and procedures.
Section 6: Resident Related Infection Prevention & Control Policies	• Review resident teaching and education re: Hand hygiene, social distancing, mask use, reporting symptoms, group activities, visitation restrictions, and use of isolation and quarantine. • Explore enhancement of PCC EHR to enable documentation of pertinent negatives from COVID-specific symptom screen.	• Residents wearing masks and social distancing, no group activities. • Charting by exception with emphasis on symptoms screening. • Work with PCC EHR to establish prompts and alerts.
Section 7: SARS-CoV-2 Testing	• No further recommendations. • Appropriate testing performed.	• Testing frequency exceeds CDC/CMS/IDPH recommendations.
Section 8: Vaccination Plan	• Work with IDVA and local health department.	• 98% of residents vaccinated. • Actively working to vaccinate staff.
Section 9: Respiratory Protection	• Continue fit testing plan.	• Train-the-trainer program in place and fit testing completed.

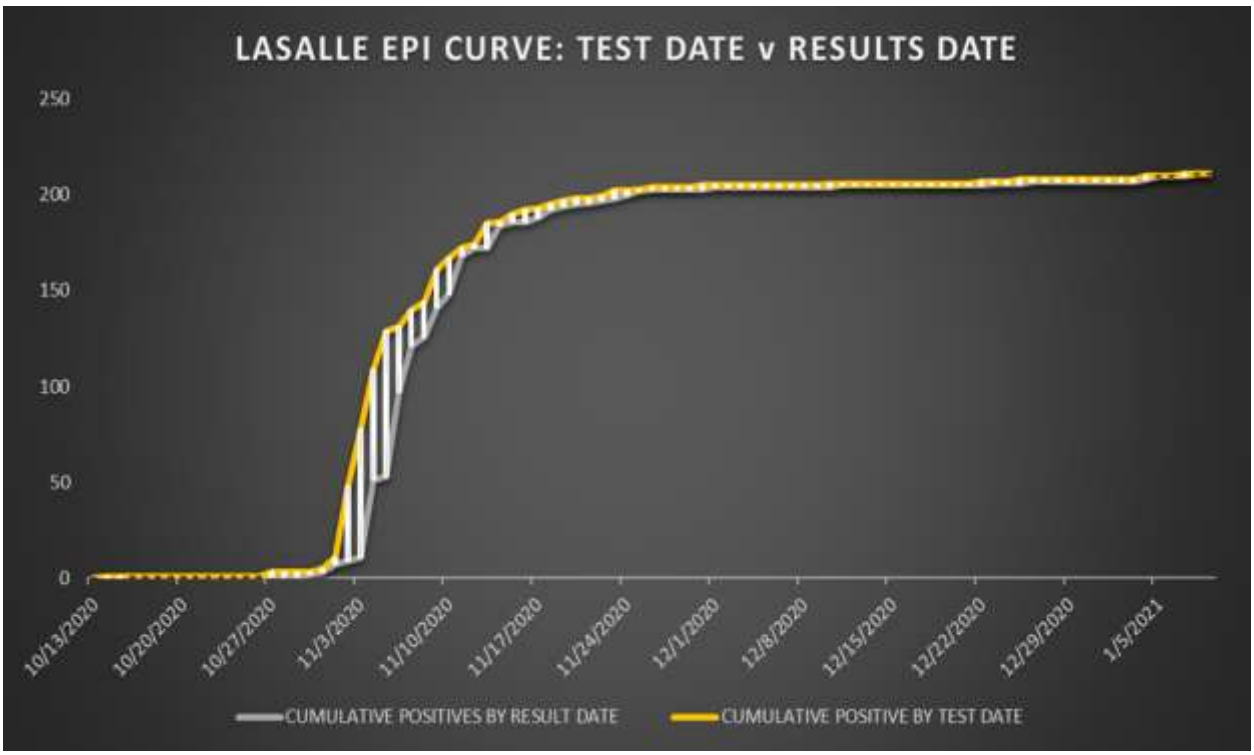
Appendix 5d. Summary of Infection Control Assessment & Response - Quincy Veterans' Home

ICAR Section	Suggested Program Enhancement, 12/09/2020	Program Enhancement Observed, 1/14/2021
Section 1: Facility Demographics & Critical Infrastructure	• Establish IP position: at least one person with 1.0 FTE dedicated IP hours; direct report to administration. • Collaborate with other IDVA sites and LHD. • Utilize private quarantine/isolation rooms when space available.	• IP is working directly with administrator and DON. • Collaboration is occurring on a weekly basis with other IDVA sites; also, closer relationship with LHD now since working together on vaccine.
Section 2: Personal Protective Equipment (PPE)	• Ensure availability of PPE at point of care. • Monitor PPE donning and doffing. • Train and verify competency for PPE use. • Standardize isolation signage.	• PPE readily available and supply monitored. • Routine checks are occurring. • Education and competency completed and ongoing. • Signage standardized.
Section 3: Hand Hygiene	• Educate and competency HH. • Audit and document HH observations.	• CDC-recommended ABHR is at point of care including inside resident rooms. • Inservice training with return demonstration is completed to validate competency and practice. • Auditing and documenting HH observations.
Section 4: Environmental Services	• Ensure EPA list N cleaner/disinfectants are at all points of care. • Switch to ready-to-use cleaners. • Implement routine environmental rounding of units and buildings. • Monitor and audit processes and supply of product. • Suggest adding products on resident equipment. • Ensure proper use of food service sanitizers. • Ensure interdisciplinary access to products for cleaning/disinfecting at point of care (not locked away with limited access; consider door keypads).	• List N and EPA sporicidal products available at point of care. • Transitioned to ready-to-use cleaning formulations. • Active, routine rounding and monitoring of practice with just in time training to ensure correct use, continued supply of products at point of care.
Section 5: Infection Prevention and Control Policies	• Standardize infection prevention policies with a system-wide interdisciplinary committee. • Implement CMS Quality Assurance Performance Improvement (QAPI) Performance Improvement Project (PIP).	• Started to standardize policies and procedures.
Section 6: Resident Related Infection Prevention & Control Policies	• Review resident teaching and education re: Hand hygiene, social distancing, mask use, reporting symptoms, group activities, visitation restrictions, and use of isolation and quarantine. • Explore enhancement of PCC EHR to enable documentation of pertinent negatives from COVID-specific symptom screen.	• Residents wearing masks and social distancing, no group activities. • Charting by exception with emphasis on symptoms screening. • Work with PCC EHR to establish prompts and alerts.
Section 7: SARS-CoV-2 Testing	• No further recommendations. • Appropriate testing performed.	• Testing frequency exceeds CDC/CMS/IDPH recommendations.
Section 8: Vaccination Plan	• Work with IDVA and local health department.	• 176 received both doses. • 59 received first dose. • Actively working to vaccinate staff.
Section 9: Respiratory Protection	• Continue fit testing plan.	• Working with local health department to manage fit testing program.

Appendix 6a. COVID-19 outbreak at IVH LaSalle

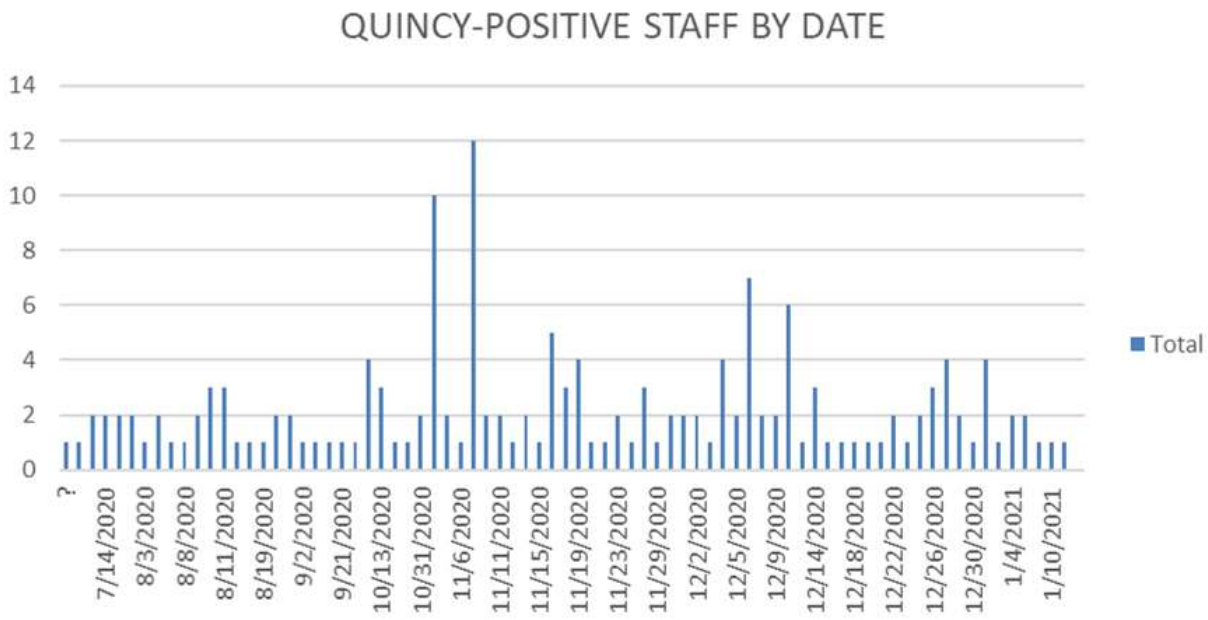
Case Counts

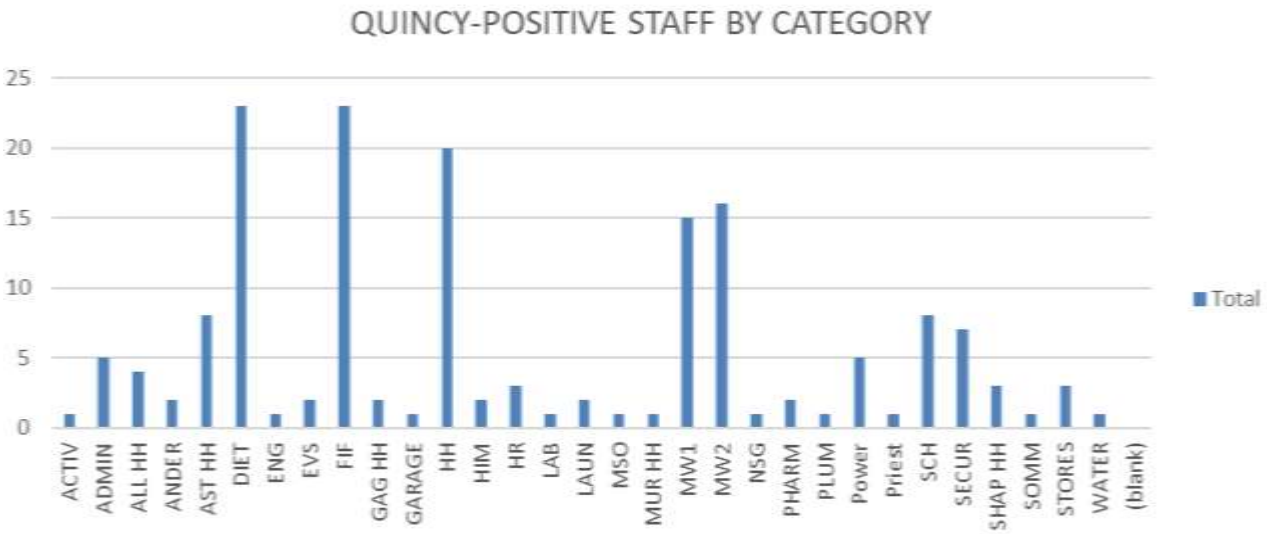




Appendix 6b. COVID-19 outbreaks at IVH Quincy

IVH Quincy: Staff patterns





The category “Dietary” on the line list accounted for 23 cases over a six-month period. There appears to been an outbreak in the Dietary department in August 2020, with 12 positive staff that month.

UNIT	Dept-Unit	Test date/onset date	Result date	Last day worked
DIET	Dietary	8/3/20	8/5/20	8/5/20
DIET	Dietary	8/6/20	8/8/20	8/5/20
DIET	Dietary	8/6/20	8/7/20	8/6/20
DIET	Dietary	8/7/20	8/9/20	8/6/20
DIET	Dietary	8/8/20	8/9/20	8/7/20
DIET	Dietary	8/9/20	8/11/20	8/8/20
DIET	Dietary	8/10/20	8/12/20	8/10/20
DIET	Dietary	8/10/20	8/13/20	8/13/20
DIET	Dietary	8/11/20	8/14/20	8/14/20
DIET	Dietary	8/14/20	8/17/20	8/13/20
DIET	Dietary	8/19/20	8/21/20	8/6/20
DIET	Dietary	8/31/20	9/2/20	8/31/20

IVH Quincy: Staff positives in November

In late October there were single positive staff tests on or about 10/27, on 10/30, and on 10/31. Then, on 11/02, testing identified 10 positive staff in a single day. Notably, four of these were in Fifer staff.

UNIT	Dept-Unit	Test date/onset date	Result date	Last day worked
ADMIN	Adj Office	11/2/20	11/4/20	11/4/20
DIET	Dietary	11/2/20	11/5/20	11/5/20
FIF	MDS-Fifer	11/2/20	11/2/20	11/2/20
FIF	PSA-Fifer	11/2/20	11/4/20	11/4/20
FIF	NSG-Fifer	11/2/20	11/4/20	11/4/20
FIF	NSG-Fifer	11/2/20	11/5/20	11/1/20
MW2	NSG-MW2	11/2/20	11/5/20	11/3/20
PLUM	Plumber	11/2/20	11/4/20	11/2/20
SHAP HH	EVS--HH-Shapland	11/2/20	11/5/20	10/30/20
STORES	Gen. Stores	11/2/20	11/2/20	11/4/20

There were a few scattered positives over the following week; then testing on 11/09 identified 12 more positive staff, including two more in staff assigned to Fifer Hall.

UNIT	Dept-Unit	Test date/onset date	Result date	Last day worked
ANDER	EVS-has been off for 2 months	11/9/20	11/10/20	9/21/20
DIET	Dietary	11/9/20	11/10/20	11/9/20
FIF	NSG--PRN-Fifer	11/9/20	11/10/20	11/1/20
FIF	NSG-Fifer	11/9/20	11/10/20	11/10/20
HH	Rehab--HH	11/9/20	11/10/20	11/10/20
HR	HR	11/9/20	11/10/20	11/2/20
MW2	RN-MW2	11/9/20	11/10/20	11/8/20
NSG	NSG-Sch	11/9/20	11/10/20	11/9/20
PHARM	Pharmacy	11/9/20	11/10/20	11/10/20
SCH	EVS-Sch	11/9/20	11/10/20	11/10/20
SECUR	Security	11/9/20	11/9/20	11/6/20
SOMM	EVS-Somerville	11/9/20	11/10/20	11/9/20

IVH Quincy: Fifer Hall Outbreak

Duration: 11/02/2020-12/09/2020
Residents: 14 (1 death); Staff: 16

At Fifer Hall, 4 staff members tested positive on 11/2/2020, followed by 2 on 11/09 and 6 more between 11/12 and 11/17. The outbreak among residents of Fifer Hall (mostly Unit D) began 11/13/2020 with four residents testing positive on that day. It progressed through almost the entire wing by 11/27/2020.

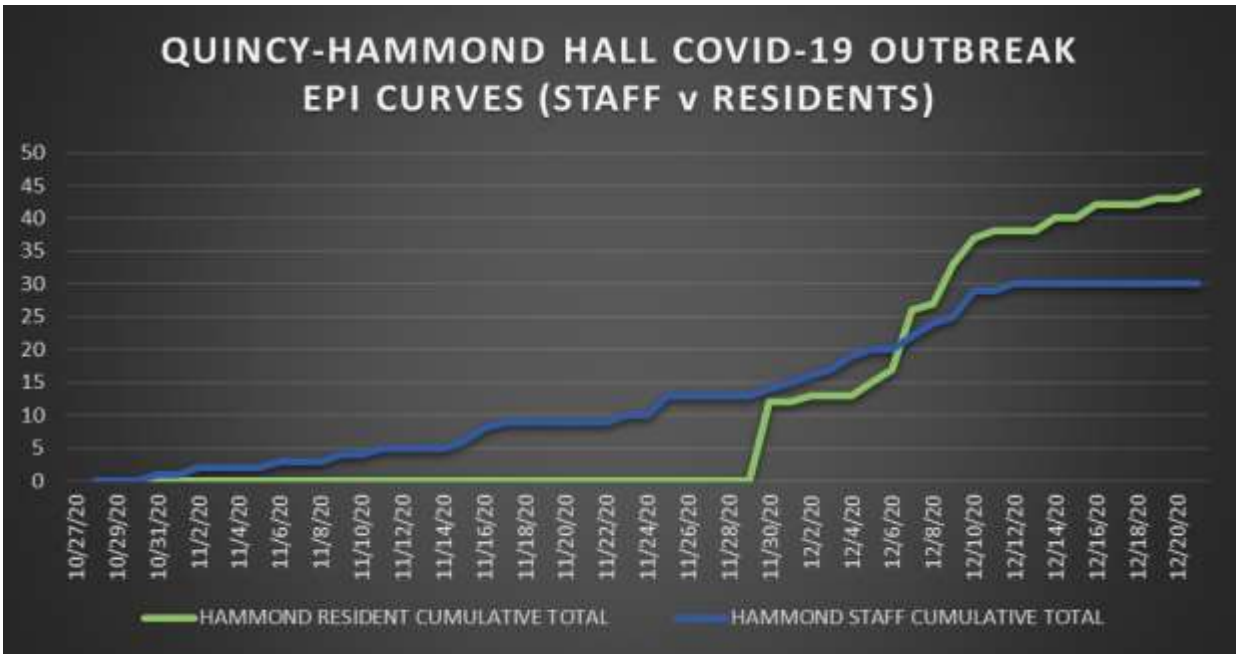
UNIT	Resident's Room	Test Date	Result date
FIF A	Fifer A 101	11/13/20	11/15/20
FIF D	Fifer D 104B	11/13/20	11/13/20
FIF D	Fifer D 104A	11/13/20	11/13/20
FIF D	Fifer D 113A	11/13/20	11/15/20
FIF D	Fifer D 112A	11/14/20	11/14/20
FIF D	Fifer D 112B	11/14/20	11/14/20
FIF D	Fifer D 113B	**11/15/20**	**11/15/20**
FIF D	Fifer D 105A	11/16/20	11/17/20
FIF D	Fifer D 111B	11/17/20	11/17/20
FIF D	Fifer D 111a	11/21/20	11/21/20
FIF D	Fifer D 110A	11/22/20	11/22/20
FIF D	Fifer D 106A	11/22/20	11/22/20
FIF D	Fifer D 107B	11/23/20	11/23/20
FIF D	Fifer D 106B	11/27/20	11/27/20

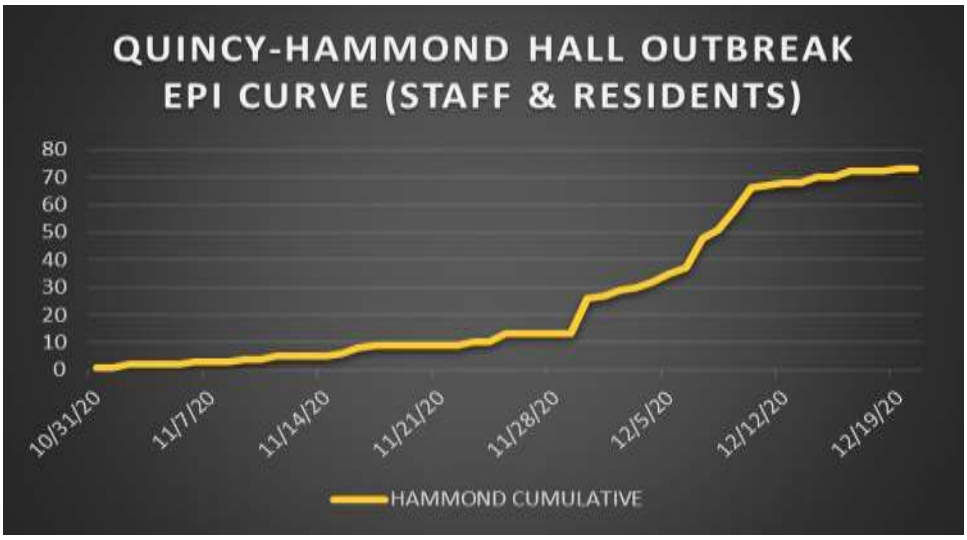
IVH Quincy: Hammond Hall Outbreak

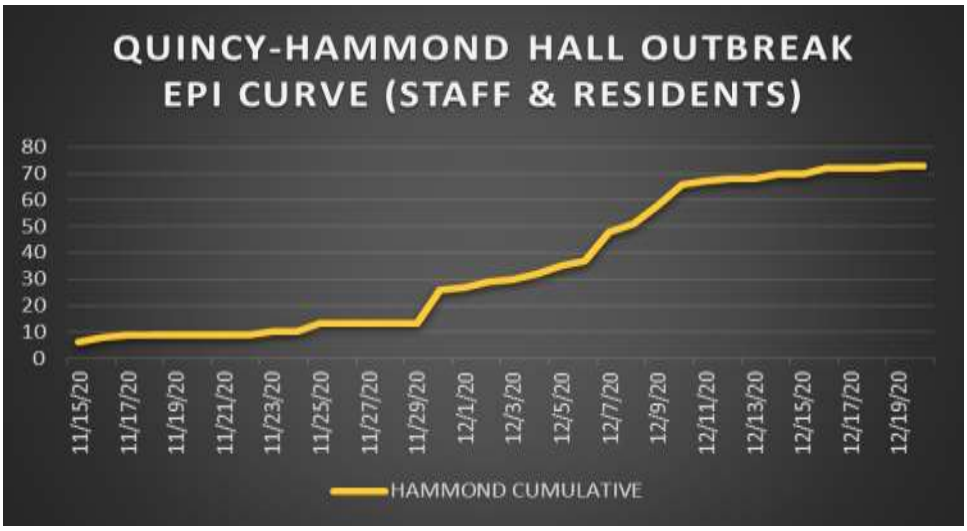
Duration: 10/31/2020-1/10/2021.
Staff vs resident duration quite distinct: Staff 10/31/2020-1/10/2021; Residents 11/30-12/21
Residents: 44 positives (9 deaths from 12/12/2020-1/07/2021); Staff: 34 positives

Hammond Hall staff positivity began trending on 10/31 with one positive staff member, followed by others every few days with an initial cumulative of 5 by 11/11 and 10 by 11/24. Resident positives began abruptly with 12 cases on 11/30 (11 from Allen Unit and 1 from Asten Unit). By 12/05, the cases had started shifting to Asten and 12/07 saw three newly impacted units (Gage, Murphy, and Shapland) with 9 new positives. The cumulative positives in Hammond Hall residents reached 26 by 12/07.

Allen Unit's last positive resident was on 12/19 with a total of 15. Asten's last positive resident was 12/16 for a total of 14. Gage's last positive resident was 12/14 for a total of 9. (Due to overlapping outbreaks, the dedicated COVID unit in Fifer C was full and Gage was utilized briefly for an overflow COVID ward.) Murphy's last positive resident was 12/16 for a total of 4. Shapland's last positive resident was 12/21 for a total of 2. The last positive resident in Shapland was the last positive resident identified in the Hammond Hall outbreak.




QUINCY-HAMMOND HALL OUTBREAK
EPI CURVE (STAFF & RESIDENTS)
80
70
60
50
40
30
20
10
0
10/31/20
11/7/20
11/14/20
11/21/20
11/28/20
12/5/20
12/12/20
12/19/20
HAMMOND CUMULATIVE


QUINCY-HAMMOND HALL OUTBREAK
EPI CURVE (STAFF & RESIDENTS)
80
70
60
50
40
30
20
10
0
11/15/20
11/17/20
11/19/20
11/21/20
11/23/20
11/25/20
11/27/20
11/29/20
12/1/20
12/3/20
12/5/20
12/7/20
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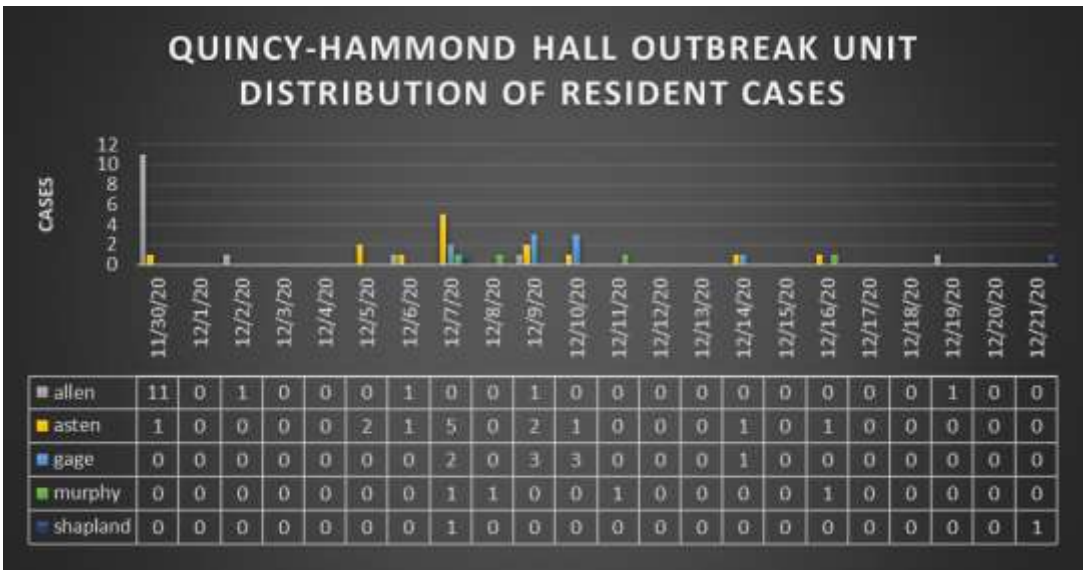
12/17/20
12/19/20
HAMMOND CUMULATIVE


QUINCY-HAMMOND HALL OUTBREAK UNIT
DISTRIBUTION OF RESIDENT CASES
CASES
12
10
8
6
4
2
0
11/30/20
12/1/20
12/2/20
12/3/20
12/4/20
12/5/20
12/6/20
12/7/20
12/8/20
12/9/20
12/10/20
12/11/20
12/12/20
12/13/20
12/14/20
12/15/20
12/16/20
12/17/20
12/18/20
12/19/20
12/20/20
12/21/20
allen 11 0 1 0 0 0 1 0 0 1 0 0 0 0 0 0 0 0 0 1 0 0
asten 1 0 0 0 0 2 1 5 0 2 1 0 0 0 1 0 1 0 0 0 0 0
gage 0 0 0 0 0 0 0 2 0 3 3 0 0 0 1 0 0 0 0 0 0 0
murphy 0 0 0 0 0 0 0 1 1 0 0 1 0 0 0 0 1 0 0 0 0 0
shapland 0 0 0 0 0 0 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 1

IVH Quincy: Markwood Hall Outbreak

Duration: 12/07/2020-1/05/2021
Residents: 61 positives (9 deaths from 12/27/2020-1/10/2021); Staff: 18 positives

Markword Hall outbreak's first identified positive was a staff member on 12/7/2020. The first positive resident was identified 12/10/2020. Positives in residents rose steadily, reaching 6 by 12/14, on which date 2 additional staff members were also identified. The staff positives rose slowly, ultimately reaching a total of 17 by 12/28 with a final total of 18 positive staff members on 1/5/2021. In contrast, the resident cumulative total reached 12 positives by 12/17, 23 by 12/19, 42 by 12/21, and 59 by 12/28 before finally totaling 61 positives on 1/3/2021.

Due to multiple overlapping outbreaks, the dedicated COVID ward in Fifer C was at capacity, so half of the second floor in Markword was utilized as a temporary COVID overflow ward. Ultimately, only 5 residents remain negative throughout the entire Markword Hall.