COVID-19 Transmission and IPC Assessment Report, FDC, June-August 2020

Assessment of COVID-19 transmission among employees and detained persons and infection prevention & control practices at the Farmville Detention Center—Farmville, VA, June–August 2020: Report
September 11, 2020

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Date: September 11, 2020

From: VA-9 CDC COVID-19 Deployment Team
William Bower, Deployment Team Co-Lead
Carolina Luna-Pinto, Deployment Team Co-Lead

To: Lilian Peake, Virginia Department of Health

Copy: Robert Nash, Virginia Department of Health, Piedmont Health District
Lyle Boelens, Immigration and Customs Enforcement
Jeff Crawford, Immigration Centers of America — Farmville

Subject: VA-9 Virginia Department of Health: COVID-19 transmission among employees
Subject: VA-9 Virginia Department of Health: COVID-19 transmission among employees and detained persons of a detention facility and infection prevention & control practices—Farmville, VA, June–August 2020: Report

Background

Preventing coronavirus disease 2019 (COVID-19) in correctional and detention facilities can be challenging because of population-dense housing, varied access to hygiene facilities and supplies, limited space for isolation and quarantine, daily entry and exit of staff members and visitors, continual introduction of newly-incarcerated or detained persons, and transport of incarcerated or detained persons in multi-person vehicles for court-related, medical, release, or security reasons. During April 2020, rapid transmission of SARS-CoV-2, the virus that caused COVID-19, in correctional and detention facilities was identified as a source of large domestic outbreaks. For example, among 37 jurisdictions reporting, 32 (86%) reported at least one confirmed COVID-19 case among incarcerated or detained persons or staff members, across 420 correctional and detention facilities. As of April 21, 2020, 4,893 cases and 88 deaths among incarcerated and detained persons and 2,778 cases and 15 deaths among staff members were reported [1]. According to the Marshall Project, as of August 31, an estimated 118,920 COVID-19 cases and 933 deaths occurred among incarcerated or detained persons in the United States. Correctional and detention facility staff are also at risk of infection; without strict adherence to mitigation efforts, staff could introduce infection to facilities after becoming infected in their community or risk introducing infection to their families and communities following infection in the facility. Therefore, effective infection prevention and control (IPC) practices in correctional and detention facilities are critical to protect the health of detained persons, workers, and the surrounding community [2].

The Centers for Disease Control and Prevention (CDC) deployed a team (VA-9 Deployment Team, or VA-9) August 9–15, 2020, in response to a request from the Virginia Department of Health (VDH) to assess IPC practices and facilitate testing among staff and detained persons at the Farmville Detention Center (FDC), a federally-contracted, privately-operated immigration detention facility managed and operated by Immigration Centers of America (ICA) and located in Farmville, Virginia. This request was made in follow up to a letter dated July 22, 2020 from Governor Ralph Northam of Virginia to the President of the United States requesting CDC’s assistance due to the identification of COVID-19 cases in detained persons at the FDC. The FDC has a maximum capacity of 700 and employs 150 to 250 staff. When the CDC team arrived August 10, the FDC housed 298 detained persons and employed 232 staff from multiple contracting agencies: ICA (primary contractor), Armor Correctional Health Services and 3 clinical sub-contractors (At Work, FlexRN, and GLC Group), Keefe Group (which operates the commissary), and Trinity Services Group (operating the kitchen). Farmville, VA is a city that has approximately 7,900 residents and is located in Prince Edward and Cumberland Counties.

The FDC is accredited by the National Commission on Correctional Health Care (NCCHC). The FDC has nine dormitory-based open, communal space housing units (“dorm”) with capacities that range from 42 to 102 detained persons per dorm. Each dorm has 3–5 communal spaces (see Appendix 1 and Appendix 2). Detained persons are assigned to units of four double-stacked bunk beds (i.e., 4 top bunks over 4 bottom bunks separated by an approximate 6-inch partition on each side shared between bunks) arranged in rows (see Appendix 3 for example of bunk bed arrangement). Meals are delivered to each dormitory with tables for eating and watching television in the dormitory communal areas. Each dorm has its own shared bathroom. The gym, chapel, and movie/game room (shared by all dorms) are currently closed due to COVID-19. The only communal area shared by all detained persons was the barber shop that reopened the week of the CDC team visit to the FDC. There are also cell-based housing units that can be used for individual isolation; 9 cell-based units in medical; 5 designed for single occupancy (includes 3 negative pressure rooms); 3 double occupancy; 1 for triple occupancy, providing a total of 14 beds in medical. There are an additional 5 cells for protective housing and 7 for segregated/restrictive housing that can also be used for isolation.

As a result of the request for assistance, the CDC team in coordination with VDH, identified the following mission objectives:
As a result of the request for assistance, the CDC team in coordination with VDH, identified the following mission objectives:

- Determine the point prevalence of SARS-CoV-2 infection among workers and detained persons in this federal detention facility
- Evaluate risk factors for SARS-CoV-2 infection among workers and detained persons
- Evaluate infection prevention and control practices in the facility
- Assess the possibility of facility-to-community SARS-CoV-2 transmission through whole genome sequencing to determine similarities between viral genomes among detained persons, workers, and community members
- Provide recommendations to reduce the likelihood of SARS-CoV-2 transmission associated with the Federal detention facility

Methods

The CDC team conducted the FDC site visit August 9–15, 2020. First, FDC staff were briefed on the CDC mission. To summarize the FDC testing of detained persons from April 8-Aug 12, 2020, the CDC team reviewed the FDC data that included detained person rosters, the FDC booking date, COVID-19 testing dates, test results, housing location at time of first test, and date released from the FDC (if applicable). Interviews with the FDC leadership and clinical staff provided additional background information. During August 11–14, 2020, the CDC team offered COVID-19 testing by observed self-collected nasal swab to all the FDC staff. The FDC staff were briefed on the COVID-19 testing opportunity during the start of day and night shift meetings for both A and B teams. Each staff member was provided an explanation of the procedure and a written consent form to sign before testing. In addition, signs were placed in high traffic areas notifying staff of the COVID-19 testing opportunity. The CDC team collected samples from 83 staff and submitted them to CDC for polymerase chain reaction (PCR) testing for SARS-CoV-2.

On August 13, 2020, the CDC team offered COVID-19 testing by observed self-collected nasal swab to all detained persons on a voluntary basis who did not have a documented positive COVID-19 test in their medical records. Each detained person was provided an explanation of the procedure and written consent form to sign prior to testing. Procedure and consent forms for detained persons were translated into Spanish and French; if needed, an explanation was given in Spanish for those with limited English proficiency. At the FDC’s request, the CDC team tested one additional detained person with a prior positive result who needed a negative test before release to another facility. The CDC team collected samples from 34 detained persons, which included the one detained person with a known prior positive test and submitted them to CDC for PCR testing for SARS-CoV-2.

A questionnaire was administered to staff and detained persons who participated in testing to assess potential risks of exposure to COVID-19. Questionnaires for detained persons were translated into Spanish and French. Questionnaire responses from staff and detained persons were entered into a database (Research Electronic Data Capture [REDCap]; version 9.5.13; Vanderbilt University) hosted at CDC. The IPC evaluation for the FDC staff was conducted by several walk-throughs of the FDC and discussions with management and staff about work practices and processes using the Interim Customizable Non-Healthcare Workplace Infection Control Assessment and Response (WICAR) tool — Coronavirus disease 2019 (COVID-19) designed to evaluate workplaces during COVID-19 pandemic. The IPC evaluation for the FDC detained persons was conducted using the COVID-19 Management Assessment and Response Tool for Correctional and Detention Facilities (CMAR). The CDC team was also able to identify 158 archived specimens collected from individuals in the surrounding community who tested positive for SARS-CoV-2 infection for possible whole genome sequencing. Preliminary results were shared verbally during an exit briefing conducted August 14, 2020 with VDH, Immigration and Customs Enforcement (ICE), the FDC, CDC, and other interested parties.

Results
Results

Review of the FDC Testing of Detained Persons, April 8–July 28, 2020

April 8 – June 2, 2020: Before Arrival of AZ and FL Detained Persons
According to data shared by the FDC, the first person tested for SARS-CoV-2, the virus that causes COVID-19, at the FDC was on April 8 in a detained person with potential exposure at a prior facility; that test was negative. The FDC continued to test detained persons with symptoms of or potential exposure to COVID-19 prior to entering the facility. Between April 8–May 15, a total of 32 detained persons were tested. Two detained persons who arrived from another facility tested positive for COVID-19 (tested on April 27). The other 30 tested during that period were negative. The two detained persons who were positive were retested at intervals and remained isolated in the medical housing unit (MHU) until negative tests were obtained, one on May 29 and the other on June 2. Therefore, the FDC leadership believed that as of June 2, there were no known cases of COVID-19 remaining in the facility. No additional details regarding isolation or other mitigation strategies were provided to the CDC team.

June 2 – June 23: Arrival and Testing of Detained Persons Transferred from Arizona and Florida
According to data shared by the FDC, on June 2 the FDC received 74 new transfers from two other detention facilities; 49 persons from an Arizona (AZ) facility and 25 persons from one in Florida (FL). This increased the number of detained persons in the FDC from 399 to 473 persons. Per the FDC report, the newly arriving people were screened in the processing area for fever and COVID-19-like symptoms. Two detained persons from AZ who were febrile during screening were sent to the local hospital emergency department (ED) for evaluation and COVID-19 testing. Both returned to FDC on June 3 and were quarantined in the MHU. On June 5 testing results for the hospital laboratory (LabCorp) confirmed one of them as positive and the other negative. The remaining 72 persons were afebrile and did not report symptoms and were quarantined in Dorm 8 (FL) and 9 (AZ). By June 8, the person from the AZ facility who had gone to the ED June 2 and tested negative, as well as two other people from the AZ group, developed symptoms, were tested by the VA Department of Health, and all three tests were reported positive 2 days later on June 10. By June 11, FDC had four confirmed cases. The four stayed in the MHU until they were transferred to Dorm 9 where detained persons with a positive test without medical issues were isolated on June 15. On June 11-12, the FDC screened and tested the remaining 45 persons from AZ, identifying two symptomatic individuals who were placed in isolation in the MHU; test results for both returned positive. Overall, 30 of the 45 persons tested on June 11-12 had positive test results. On June 16, the 24 detained persons from FL were tested. All were asymptomatic at time of testing; 17 had positive test results. In total, of the 74 detained persons transferred from AZ ad FL, all were tested during June 2–16 and 51 (69%) were positive (34 AZ, 17 FL). The remaining 23 persons (31%) were negative (15 AZ, 8 FL) (Table 1). Test results for persons tested June 2- June 23 were processed either at the VA Department of Health or at commercial laboratories when they began testing larger numbers June 11. During this time period, results were reported back to FDC an average of 5 days after testing (range 2-7 days).

Per the FDC report, any detained person who transferred from the AZ or FL detention facilities and was found to have a positive test was isolated in Dorm 2 (FL) or Dorm 9 (primarily AZ with one person from FL); those who were symptomatic were transferred to the MHU. Most people (19/23) with initial negative tests were moved to Dorm 8, which had been vacated and cleaned; the remaining four were moved to Dorm 1, Dorm 2, Dorm 5, and Dorm 9. The detained person in Dorm 9 developed symptoms on June 16 and was transferred to the MHU. The detained person in Dorm 2 developed symptoms on June 19 and was transferred to the MHU. Ultimately, all four persons moved to Dorms 1, 2, 5, and 9 tested positive during June 17–July 2, including the 2 symptomatic detained persons that had previously transferred to the MHU. On June 18, a detained person from Dorm 4 who had not transferred from the AZ or FL facilities (referred to as “general population”) developed symptoms and was transferred to the MHU. During June 18–23, seven more FDC detained persons who were not from AZ or FL and who lived in Dorms 1, 4, and 6 were transferred to the MHU because of symptoms; 6 out of 7 tested positive.

June 21 – July 8: Public Health Measures, FDC-wide Screening and General Population Testing
June 21—July 8: Public Health Measures, FDC-wide Screening and General Population Testing

On June 21, the FDC staff began screening for fever and other COVID-19 symptoms among the general population in Dorms 1, 4, and 5. An FDC lockdown (limiting the movement of detained persons to their assigned dormitory) was initiated and medical staff working in the FDC began wearing N95 respirators instead of surgical masks. As N95s became more widely available, these were procured and also issued to ICA staff and detained persons. The FDC implemented staff temperature checks and symptom screening questionnaires before work and at mid-shift. Indoor recreation and use of the multi-media room and chapel were suspended. Outdoor recreation for dorms under lockdown (Dorms 4 and 9) was also suspended. By June 22, the FDC began receiving testing results of the detained persons transferred from AZ and FL. As noted, a total of 51 (69%) of the transferred detainees tested positive, including 34 from the AZ group tested on June 11, and 17 from the FL group tested June 16. This prompted the FDC to conduct broad-based testing among the remaining detained persons in the general population.

From June 24–July 3, the FDC offered testing to all the remaining detained persons in all dorms using a private commercial laboratory. COVID-19 testing was performed each day based on staff and supply availability. One detained person was tested July 8 because he was unavailable during the planned testing period. From June 18–July 8, a total of 324 detained persons in the general population at the FDC were tested; one person refused testing (Table 1). Tests done at the commercial laboratory from June 24 – July 3 took an average of 2 – 14 days, to return. In some cases tests were not run due to collection or laboratory errors (i.e., “test not processed” [TNP]); 64 (19.8%) of the initial 324 tests could not be processed due to sample collection errors at the FDC or processing errors at the commercial laboratory. Upon learning of the 64 TNP samples, from July 14-16 the FDC retested 63 of the 64 detained persons whose samples were not processed; the remaining person whose test was not run went to the ED on July 11, tested positive, was hospitalized due to severe symptoms, and later died (August 5). By July 28, of the 324 general population detainees who were tested, 237 (73%) had tested positive. This included 41 (66%) of the 64 persons with initial TNP results; the remaining 21 (33%) tested negative, and one test (1.5%) was inconclusive. Considering all detained persons at the FDC (general population plus AZ and FL transfers), 288 (72%) ultimately tested positive for the virus causing COVID-19, including 69% of AZ transfers, 68% of FL transfers, and 73% of the general population of detainees (Table 1). While tests in mid-June were often reported within 5-7 days, results from the tests in late June and early July were often delayed, especially those with an initial TNP result. This presented a major challenge for the FDC; 42 detained persons who initially were reported as TNP later tested positive, and because return of results required up to 14 days, many of these results were unknown for nearly a month, which impacted the FDC’s COVID-19 isolation and quarantine strategy. In the meantime, these residents resided in multiple dorms (1, 5, 6, and 7).

<p>| Table 1: Summary of First COVID-19 Test of Detained Persons, June 2–July 8, 2020 |
|---------------------------------------------------------------|--|--|--|--|--|</p>
<table>
<thead>
<tr>
<th><strong>Population Tested</strong></th>
<th><strong>Date of FIRST Test</strong></th>
<th><strong>Negative</strong></th>
<th><strong>Positive</strong></th>
<th><strong>REFUSED testing</strong></th>
<th><strong>TNP</strong></th>
<th><strong>Cumulative Total</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>AZ transfers</td>
<td>2-Jun</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>8-Jun</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>11-Jun</td>
<td>15</td>
<td>28</td>
<td>0</td>
<td>0</td>
<td>43</td>
</tr>
<tr>
<td></td>
<td>12-Jun</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>AZ totals</strong></td>
<td></td>
<td>15</td>
<td>34</td>
<td>0</td>
<td>0</td>
<td>49</td>
</tr>
<tr>
<td>FL transfers</td>
<td>16-Jun</td>
<td>8</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td><strong>FL totals</strong></td>
<td></td>
<td>8</td>
<td>17</td>
<td>0</td>
<td>0</td>
<td>25</td>
</tr>
<tr>
<td>FDC General Population</td>
<td>18-Jun</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>23-Jun</td>
<td>1</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>24-Jun</td>
<td>2</td>
<td>68</td>
<td>0</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td></td>
<td>26-Jun</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>28-Jun</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
July 14 – July 28: Continued Public Health Measures and Retesting of Detained Persons

The FDC staff reported that in addition to the 64 detained persons with TNP results, many of those with negative results were retested in response to potential exposures or reported symptoms. From July 14 through July 28, nine additional persons (4 who had been transferred from AZ or FL and 5 from the general population) tested positive. The FDC staff reported that movement of asymptomatic detained persons was limited to their assigned dorms while they were awaiting test results, unless movement in the FDC was needed for reasons of transfer, release, or security.

Non-urgent care (sick calls and chronic care, laboratory, mental health, and dental visits) was canceled to permit medical staff to focus on the COVID-19 screening and testing protocols. Detained persons were encouraged to report fever and symptoms during “pill call,” (i.e., distribution of prescribed medication to detained persons) which happened twice a day, or if urgent, to report to the Detention Officer assigned to their dorm. Medical staff also screened detained persons 1–2 times per day for fever and COVID-19 symptoms.

By July 28, including 11 detained persons who were released prior to June 2, a total of 410 detained persons were tested, of whom 341 (83%) tested positive. Eight individuals were hospitalized due to COVID-19, of whom one person died while hospitalized. Figure 1 shows an epidemic curve of the positive cases from June 1–July 28. The two cases of COVID-19 that occurred during April are not included. The positive cases are summarized in Table 2.

**Figure 1. Epidemic Curve, June 1–July 28, 2020.** Newly Identified COVID-19 Cases* among Detained Persons, by Testing Date (n=339)

<table>
<thead>
<tr>
<th>Date</th>
<th>AZ &amp; FL Testing</th>
<th>General Population First Test</th>
<th>Retesting</th>
</tr>
</thead>
<tbody>
<tr>
<td>June 2 – June 16</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 18 – July 8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 14 – July 28</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Excludes two COVID-19 cases that tested positive in April and that had two consecutive negative SARS-CoV-2 tests by May 22
Table 2. Number of Detained Persons Identified as Cases and Housing Assignment* Who Were Tested June 1–July 28, 2020

<table>
<thead>
<tr>
<th>Units with individual cells</th>
<th>Dormitories with bunks</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHU</td>
<td>RHU</td>
<td>PC</td>
</tr>
<tr>
<td>Number of Cases</td>
<td>4</td>
<td>3</td>
</tr>
</tbody>
</table>

* MHU: Medical Housing Unit, RHU: Restricted Housing Unit, PC: Protective Custody

CDC Testing of Detained Persons, August 13–14, 2020, and Questionnaire Results

On August 13, when CDC began testing detained persons, 286 detained persons remained at the FDC (does not include 12 who were released August 11, two days after CDC arrived). After reviewing the FDC’s testing records for detained persons, 34 (12%) persons without a documented positive COVID-19 test were offered testing, including 31 who had previously tested negative, 1 who had refused testing, 1 who had an inconclusive test, and 1 who had previously tested positive but needed a negative test for release. All consented to testing and answered a short questionnaire. Of the 34 detainees tested, 10 reported having a job in the FDC, either in the kitchen or food service (7), painting (1), cleaning (1), or plumbing (1). Of the 34 detained persons retested, 33 had negative results for COVID-19, and one had an inconclusive result (this did not occur in the detained person who had previously tested positive). All those tested reported having had a COVID-19 test in the past except one person who had previously refused testing. The questionnaire did not ask when or where they were previously tested. However, of the those who reported having a COVID-19 test in the past, 24 (73%) reported testing negative, 4 (12%) reported an unknown result, 4 (12%) did not answer the question, and 1 (3%) reported a positive test. The detained person who had previously tested positive at the FDC was among the 4 that did not answer the test result question. The one person who reported a previous positive test only had records of a negative test while at FDC. Fifteen (44%) of the 34 detained persons who were tested reported having had 1 or more COVID-like symptoms in the last 14 days (Table 3). When asked about social distancing, 30 (80%) respondents reported not being able to social distance from other detained persons. Of those 30 respondents, 24 provided reasons for not being able to social distance including, most frequently, “beds being too close” and “everyone is too close to each other in the dormitory”. Three of the 7 respondents who did not provide an answer were housed in the restricted housing (1) or MHU (2). Most respondents reported washing their hands with soap and water for at least 20 seconds before interacting with other detainees all of the time (60%) or most of the time (17%).

Table 3. Reported Symptoms Experienced in the Last 14 Days by Detained Persons Who Underwent Testing for SARS-CoV-2 Infection (n=34)

<table>
<thead>
<tr>
<th>Symptoms*</th>
<th>Number of Detained Persons Reporting (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No symptoms</td>
<td>19 (56)</td>
</tr>
<tr>
<td>Congestion</td>
<td>6 (18)</td>
</tr>
<tr>
<td>Headache</td>
<td>5 (15)</td>
</tr>
<tr>
<td>Muscle/body aches</td>
<td>4 (12)</td>
</tr>
<tr>
<td>Cough</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Shortness of breath/difficulty breathing</td>
<td>3 (9)</td>
</tr>
<tr>
<td>Fever/chills</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Sore Throat</td>
<td>2 (6)</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>1 (3)</td>
</tr>
<tr>
<td>New loss of taste/smell</td>
<td>1 (3)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>
Nausea/vomiting 1 (3)  
New loss of taste/smell 1 (3)  
Diarrhea 0 (0)  

* Respondents may have reported more than one symptom.

Detained persons who participated were in the following dorms/units at the time of testing: dorm 1 (41.2%), dorm 3 (5, 14.7%), dorm 5 (2, 5.9%), dorm 6 (5, 14.7%), dorm 7 (2, 5.9%), dorm 8 (1, 2.9%), dorm 9 (0, 0.0%), MHU (3, 8.8%), protective custody (0), and the restricted housing unit (2, 5.9%). These detained persons were housed with other detained persons who were previously tested and had documented positive results (Figure 2). Bunk assignments were documented, noting the proximity of detained persons to one another in their assigned dormitories.

**Figure 2. Detained Persons Who Were Tested (n=34) and Not Tested Due to a Previous Positive Test (n=252) for SARS-CoV-2 Infection, August 13-14, by Dorm Assignment**

*Areas with individual cells: MHU – Medical Housing Unit, RHU – Restricted Housing Unit, PC – Protective Custody

**Testing of the FDC Staff and Questionnaire Results**

At the time testing was offered to the general population of detained persons (June 24–July 3), testing was also initially offered to the FDC staff; however, after further consultation with their own policies, the FDC was advised not to continue staff testing. Therefore, no staff were tested during this time.

During the CDC mission, all staff were offered testing August 11-14. Testing was offered during both day and night shifts. Of 232 FDC staff, 83 (36%) volunteered to be tested for COVID-19, including 14 (41%) of 34 staff working for Armor Correctional Health Services or their clinical sub-contractors, 69 (36%) of 191 ICA staff, and 1 (14%) staff member from Trinity Food Service or Keefe Group (Figure 3). Of 83 FDC staff tested, 82 tested negative, and 1 staff member had an inconclusive result.

**Figure 3. Proportion of the FDC Staff Who Were Tested and Not Tested, by Contracting Agency, August 11-24, 2020 (n=232)**
Of the 77 staff who responded to the question asking if they had a COVID-19 test in the past, 28 (34%) reported having had a test, of whom 5 (18%) reported receiving a positive test. Of the 77 staff who responded to the question asking if they had experienced COVID-19-like symptoms in the last 14 days, 18 (23%) reported having had symptoms (Table 4), of whom 10 (55%) reported working (Table 5) while experiencing headaches, cough, diarrhea, nausea, muscle aches, fatigue, or shortness of breath. Most staff reported wearing gloves always (86%) or most of the time (13%) when interacting with detained persons known to have COVID-19. Most staff reported always wearing an N95 respirator (95%) and face shield (70%) when interacting with detained persons known to have COVID-19; however, some staff also reported wearing a surgical mask (68%) when interacting with detained persons known to have COVID-19. Fifty-five (67%) staff members reported being able to practice social distancing while at work (maintaining a distance of at least 6 feet from other staff or detainees); 98–100% reported having access to handwashing sinks and hand sanitizer, respectively. Most staff reported wearing their hands with soap and water for 20 seconds before interacting with detainees always (60%) or most of the time (32%). Additionally, of the 74 who responded, 56 (76%) staff members felt that they had adequate resources to quickly and effectively isolate detained persons who test positive for COVID-19 to prevent further transmission to themselves, other detention center employees, and other detained persons.

Table 4. Symptoms Reported by Staff in the Last 14 days (n=77)

<table>
<thead>
<tr>
<th>Symptoms*</th>
<th>Number of Staff Reporting (% of times symptom selected)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No symptoms</td>
<td>62 (81)</td>
</tr>
<tr>
<td>Headache</td>
<td>9 (12)</td>
</tr>
<tr>
<td>Cough</td>
<td>5 (7)</td>
</tr>
<tr>
<td>Fatigue</td>
<td>3 (4)</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Nausea/vomiting</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Congestion/runny nose</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Muscle/ body aches</td>
<td>2 (3)</td>
</tr>
<tr>
<td>Sore throat</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Shortness of breath/difficulty breathing</td>
<td>1 (1)</td>
</tr>
<tr>
<td>New loss of taste/smell</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Fever/chills</td>
<td>0 (0)</td>
</tr>
</tbody>
</table>

* Respondents may have reported more than one symptom.

Table 5. Number and Proportion of Staff Who Reported Experiencing COVID-19-like Symptoms Who Continued to Work (n=18)

<table>
<thead>
<tr>
<th>Reported Working with Symptoms</th>
<th>Number of Staff (%)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>10 (56)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>6 (33)</td>
<td></td>
</tr>
<tr>
<td>Don't know</td>
<td>2 (11)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>18 (100%)</td>
<td></td>
</tr>
</tbody>
</table>

In terms of interactions outside of the FDC, only 5% of staff reported working a second job. Staff members also reported staying at home and avoiding interactions with others all of the time (27%) or most of the time (62%), practicing social distancing (keeping at least 6 feet apart from others) all of the time (49%) or most of the time (48%), and wearing cloth face coverings in public places all of the time (72%) or most of the time (21%) as recommended by CDC. Of the 14 staff members who reported living alone, 13 (93%) reported wearing a cloth face covering in public all of the time. Of the 40 staff members who reported living with 2–4 people, 23 (57.5%) reported wearing a cloth face covering in public all of the time.
sick of proper PPE based on activities to reduce providing additional spacing in dormitories consistent exclusion from (surveillance of symptoms quarantine laboratory delays in receiving testing results
design and limited number of rooms to medically isolate or quarantine T
Conclusion  following other interested parties On August Recommendations detained person are underway to identify whether in inconclusive, Given that the results for testing whole genome analysis of the FDC staff and detained persons were negative or inconclusive, the whole genome sequence (WGS) analysis was not undertaken. Further actions are underway to identify whether any of the 158 community samples come from the FDC staff or detained persons. If sufficient numbers can be identified, WGS analysis may be undertaken.

Recommendations
On August 14 a briefing was held with representatives from VDH, ICE, the FDC, CDC, and other interested parties where several recommendations were provided that are outlined in the following appendices:

- Appendix 4 provides recommendations to improve COVID-19 infection prevention and control policies and case management among detained persons
- Appendix 5 provides recommendations to improved worker safety related to COVID-19 exposure
- Appendix 6 provides a listing of materials shared with the FDC as part of the recommendations provided

Conclusion
The COVID-19 outbreak in the FDC was difficult to manage and mitigate due to the housing design and limited number of rooms to medically isolate or quarantine persons who were sick or were waiting for test results to return. The initial focus of testing symptomatic persons, long delays in receiving testing results, and issues that prevented samples from being processed by the laboratory limited the FDC’s ability to implement appropriate medical isolation and timely quarantine cohorting.

The risk of reintroduction of SARS-CoV-2 into the FDC still exists. Continued and enhanced surveillance of symptoms among detained persons, staff, and visitors; testing of detained persons (including at the time of transfer and release) and staff; prompt medical isolation (including exclusion from indoor or outdoor recreation or assigned jobs) for persons testing positive; consistent implementation of medical isolation for persons testing positive and quarantine for their close contacts; serial testing for close contacts who are quarantined as cohorts; and providing additional spacing in dormitories and bunk bed assignments will remain critical activities to reduce COVID-19 among detained persons in this facility. For staff, continued use of proper PPE based on the FDC policy (if engaged in screening, medical services or interaction with detained persons), proper social distancing, and education on importance of not working if sick will also remain important to mitigate the reintroduction of SARS-CoV-2 to the FDC.
of proper PPE based on the FDC policy (if engaged in screening, medical services or interaction with detained persons), proper social distancing, and education on importance of not working if sick will also remain important to mitigate the reintroduction of SARS-CoV-2 to the FDC.

References


Appendix 1: The Farmville Detention Center Floor Plan

Appendix 2: The Farmville Detention Center Floor Plan with Housing Areas and Bed Capacities Highlighted
Appendix 2: The Farmville Detention Center Floor Plan with Housing Areas and Bed Capacities Highlighted

Appendix 3: Photograph of Bunk Units in a Farmville Detection Center Dormitory.

Source: Provided by Farmville Detention Center


DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Disease Control and Prevention (CDC)

Memorandum

Date: September 11, 2020

From: VA-9 CDC COVID-19 Deployment Team
William Bower, Deployment Team Co-Lead
Caroline Luna-Pinto, Deployment Team Co-Lead
From: VA-9 CDC COVID-19 Deployment Team  
William Bower, Deployment Team Co-Lead  
Carolina Luna-Pinto, Deployment Team Co-Lead

To: Lilian Peake, Virginia Department of Health

Copy: Robert Nash, Virginia Department of Health, Piedmont Health District  
Lyle Boelens, Immigration and Customs Enforcement  
Jeff Crawford, Immigration Centers of America – Farmville


Background
The CDC team (VA-9) conducted an assessment of the Immigration Centers of America (ICA) Detention Center at Farmville, VA (FDC) August 10 – 14, 2020. We used the COVID-19 Management Assessment and Response Tool for Correctional and Detention Facilities, or CMAR, developed by CDC, to assist with the assessment of the FDC for COVID-19 preparedness and response. The CMAR tool asks questions about the demographics of the persons incarcerated or detained, how they are housed, COVID-19 testing and cases in the FDC, and intake and release practices. The outbreak management section facilitates discussion around how the FDC is managing COVID-19 infections and outbreaks, including medical isolation and quarantine practices, and prevention practices, including signage and education efforts, limiting contacts, use of personal protective equipment (PPE) and masks, and hygiene. It also asks about screening and monitoring of staff and environmental cleaning and supplies. Information for this report was generated from interviews with Jeffery Crawford, Director, ICA at Farmville; Teresa Moore, Armor Correctional Health Services Medical Director; and Danielle Fifield, Armor Correctional Health Services Administrator. The FDC is a private contractor to Immigration and Customs Enforcement (ICE) to house detained persons. This information was also augmented by additional observations and discussions with other staff. This report provides a distillation of assessments and observations, and recommendations for improvement, to closely align with CDC guidance for correctional and detention facilities.

FDC Information
The FDC is accredited by the National Commission on Correctional Health Care (NCCHC). The FDC has the capacity to house 700 adult males. The FDC has nine dormitory-based (open, communal space) housing units with capacities that range from 42 to 102 detained persons and 3-5 communal spaces in each dorm. Units of four double-stacked bunk beds (i.e., 4 on the bottom and 4 on top separated by an approximate 6-inch partition on each side shared between bunks) are arranged in rows. Meals are delivered to the dormitory with tables for eating and watching television in the dormitory communal areas. Each dorm has its own shared bathroom facilities. The gym, chapel, and movie/game room (shared by all housing units) are currently closed due to COVID-19. The only communal area shared by all detained person was the barber shop that reopened the week the CDC team visited the facility. There are also cell-based housing units that can be used for individual isolation; 9 cell-based units in the MHU; 5 designed for single occupancy (includes 3 negative pressure rooms); 3 double occupancy; 1 for triple occupancy, totaling 14 individual beds in the MHU. There are an additional 5 cells, 2 beds per cell, in protective custody housing and 7 single-bed cells for segregated/restrictive housing that can also be used for isolation for a maximum of 21 units for individual isolation; however, it might not be possible to free up all these cells as some of these need to be free for security and protection needs, or other non-COVID-19 related medical needs.

When CDC arrived on August 10, 2020, 298 detained persons were housed at the FDC with 232 staff. Staff were divided into Team A and Team B. Each team worked two to three days and then was off two to three days, (i.e., Team A worked Monday and Tuesday; Team B would work Wednesday and Thursday; Team A would work Friday, Saturday, and Sunday) Each team was divided into two 12-hour shifts.

COVID-19 Screening, Evaluation, and Testing at the FDC
As of the date of this report, the FDC last received individuals transferred from another facility on June 2, 2020. According to the FDC, detained persons were received, checked in and screened for fever and COVID-19-like symptoms. If symptoms were present, they were sent to the MHU. The FDC staff also performed surveillance, routine and outbreak-based testing. The facility is following CDC guidance for correctional and detention facilities.
As of the date of this report, the FDC last received individuals transferred from another facility on June 2, 2020. According to the FDC, detained persons were received, checked in and screened for fever and COVID-19-like symptoms. If symptoms were present, they were sent to the local hospital emergency department for evaluation and COVID-19 testing. If hospitalization was not warranted, they were placed in medical isolation at the FDC. If detained individuals passed screening (i.e., reported no symptoms and had no fever noted), they were quarantined in a separate dormitory for 14 days as new intakes. At the time of this written report, the FDC policy was to only test detained persons who have COVID-19-like symptoms.

Recommendations:

1. CDC recommends testing for all new intakes, existing detained persons if symptomatic, close contacts of symptomatic persons, and all detained persons before release or transfer. A 14-day quarantine period can also be considered for new intakes before they join the rest of the population, and for those awaiting transfer or release. While awaiting entry, transfer, or release, detained persons can be housed together if they have not tested positive or have symptoms or known exposures to individuals with confirmed COVID-19.

2. CDC recommends that in addition to testing symptomatic detained persons, asymptomatic close contacts of COVID-19 cases should also be tested, particularly in congregate settings where the risk of widespread transmission is high. If due to lack of available space to separate detained persons, close contacts are quarantined as a cohort, consider testing every 3-7 days and placing any individuals testing positive under medical isolation; continue quarantine until 14 days have passed with no additional cases.

3. Testing before release from quarantine is also a best practice, although not explicitly recommended in current CDC guidance.

4. The FDC may wish to explore additional testing options such as with a private laboratory or partnering with nearby academic institutions to allow for a higher volume of testing and more rapid return of test results in the future and to diversify testing sources to prevent a backlog.

Screening and Monitoring of Detained Persons
Prior to CDC’s arrival, the FDC officials stated they made adjustments to intake and screening processes for detained persons and staff and modified the FDC prevention practices to screen for COVID-19 illness and practice source control. As of the date of this report, the FDC is not receiving transfers. The FDC stated that when they did receive new intakes, they screened them at entry for fever and symptoms, and then quarantined them separately. The FDC will continue this practice when they resume receiving new intakes. Currently, all detained persons are screened for fever and COVID-19-like symptoms at least once per day and have the opportunity to be screened and interact with medical staff twice a day during “pill call.”

Recommendation:

1. The FDC should consider spreading people out into the unused portions of the FDC to provide more physical space between people; ideally at least 6 feet between bunks.

Isolation and Quarantine
The FDC stated they isolate COVID-19 confirmed positive detained persons individually or as a cohort with other COVID-19 positive detained persons. The FDC has a maximum of 21 individual cells where individuals with COVID-19-like symptoms can be isolated pending COVID-19 test results. Once space is no longer available to individually isolate symptomatic detained persons awaiting test results, the FDC’s current plan is to cohort symptomatic people with pending test results in the same space. Close contacts of confirmed COVID-19 cases are not quarantined. The FDC is not able to implement a policy of quarantining a detained person 14 days prior to release, because usually only 1–2 days’ notice of release is given.

Recommendations:

1. People with confirmed COVID-19 infection should be medically isolated away from others to prevent transmission. They can be isolated individually or as a cohort but should be separate from the rest of the population, and for those awaiting transfer or release. While awaiting entry, transfer, or release, detained persons can be housed together if they have not tested positive or have symptoms or known exposures to individuals with confirmed COVID-19.
1. People with confirmed COVID-19 infection should be medically isolated away from others to prevent transmission. They can be isolated individually or as a cohort but should be separated from suspected cases.

2. CDC recommends the FDC develop an alternate plan to individually house suspected cases with pending results because some symptomatic individuals may not be infected with SARS-CoV-2 and would be exposed to others who are infected if cohorted. This scenario is made more plausible as influenza season approaches since there can be similarities in symptoms between influenza and COVID-19.

3. CDC guidance recommends offering influenza vaccination to all detained persons and staff. Preventing cases of influenza will make COVID-19 cases easier to identify since some symptoms are similar.

4. Currently, empty dorms could be used to cohort confirmed cases. Suspected cases should be housed in cell-based housing units individually until test results come back.

5. CDC recommends that close contacts among detained persons should be quarantined for 14 days (ideally individually, to prevent further transmission). If cohorting quarantined close contacts, consider testing each contact every 3–7 days, and immediately isolate any who test positive. Continue quarantine until no additional cases have been identified for 14 days after the last exposure. Consider testing at the end of the 14-day period and requiring a negative result before lifting quarantine-based precautions.

6. CDC also recommends that detained persons to be released are tested for SARS-CoV-2 and placed in 14-day quarantine prior to release, when possible.

Social distancing and limiting contact
Since June 21, access to indoor common areas (e.g., chapel, game room) has been restricted since COVID-19 management protocols began. All common areas except the barber shop (recently opened) are closed. In the barber shop, masks are required for detained persons and the barber. Detained persons from different housing units do not mix for recreation, dining, or programmatic activities. However, detained persons working in the kitchen come from different housing units, and individuals receiving services from the barber come from different housing units. Based on a review of shift assignments, staff are not consistently assigned to work in the same housing units or areas.

Recommendations:
1. CDC guidance recommends limiting work details to people from a single housing unit to prevent mixing (e.g., kitchen). Additionally, mixing across housing units in communal areas (e.g., barber shop) should be avoided.

2. CDC recommends that staff be assigned consistently to the same housing units over time to reduce the risk of transmission between housing units through staff movements. The FDC could consider keeping the same staff assigned to the same units, instead of having a staff member assigned to Unit A on Monday, B on Tuesday, etc., to reduce the risk of transmission across housing units.

3. Use signage and visual cues to promote social distancing among staff. Signage and visual cues should also encourage wearing face masks and keeping the physical distance needed to minimize congregating in communal areas such as break rooms, screening at the entrance, clocking in and out, and between the Sally port doors.

Environmental Cleaning, Hygiene, and Supplies
Three of the four disinfectants used at the FDC are not on the EPA list of registered disinfectants.

Recommendations:
1. Use disinfectants on the EPA registered disinfectant list. The list can be found at https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19.
Personal Protective Equipment

Inconsistent use of PPE was observed. N95 respirators with exhalation valves or vents were also observed. Answers on the questionnaire also suggest the need to clarify PPE policy at the FDC to indicate when N95s are needed versus cloth face coverings. Very little signage indicating how to don and doff PPE was observed. Signage encouraging social distancing was not posted. These observations were discussed with the FDC Director as part of the CMAR.

Recommendations:

1. Provide training to staff on when and why PPE should be used, and how to put on and take off PPE. Provide regular education and reminders to staff and detained person (in native language) about how and when to use masks, and how masks prevent SARS-CoV-2 transmission as source control.

2. Add signage about proper donning and doffing of PPE, particularly in areas where additional PPE is required based on the FDC policies.

3. Ensure that PPE donning and doffing stations have been set up outside areas where PPE will be used, including trash cans to dispose of used PPE as well as soap and running water or alcohol-based sanitizer with at least 60% alcohol for hand hygiene.

4. Discontinue use of N-95 respirators with exhalation valves or vents, or add a surgical or cloth mask cover for source control.

End of Memo

Appendix 5: Memorandum from CDC to Virginia Department of Health - Worksite Infection Prevention and Control Assessment to Prevent Transmission of COVID-19 – Results and Recommendations
Background
On July 30, 2020, the Centers for Disease Control and Prevention (CDC) received a request for technical assistance from the Virginia Department of Health. The Virginia Department of Health asked for a site assistance visit to conduct an assessment of infection prevention and control (IPC) measures related to coronavirus disease 2019 (COVID-19) currently in place at the Immigration and Customs Enforcement (ICE) facility operated by the Immigration Centers of America (ICA) in Farmville, VA. SARS-CoV-2 is the virus that causes the illness COVID-19.

On August 10–14, 2020, a CDC team (VA-9) conducted a site visit of the ICA-Farmville detention center. The team’s objectives included the following:

- Determining the point prevalence of SARS-CoV-2 infection among workers and detained persons in the detention center;
- Evaluating risk factors for SARS-CoV-2 infection among workers and detained persons;
- Evaluating IPC practices in the facility;
- Assessing the possibility of facility-to-community SARS-CoV-2 transmission through whole genome sequencing to determine similarities between viral genomes among detained persons, workers, and community members; and
- Providing recommendations to reduce the likelihood of SARS-CoV-2 transmission associated with the detention center.

Two VA-9 team members, from CDC’s National Institute for Occupational Safety and Health (NIOSH), conducted an on-site assessment focused on strengthening IPC and worker safety and health programs related to COVID-19. The findings from this assessment are described in this report.

Setting and FDC Description
The ICA-Farmville detention center has the capacity to house approximately 700 detained persons. At the start of the CDC site visit, 298 detained persons were in the FDC, of whom 262 (88%) had previously tested positive for COVID-19. At the time of the site visit, 232 employees worked in the detention facility managed by ICA. This employee figure included ICA employees (n = 191) and staff from three contractors: Armor Correctional Health Services (n = 34), Trinity Services Group (n = 5), and Keefe Group (n = 2). Trinity Services Group, which operated the kitchen, and Keefe Group, which operated the commissary, were owned by the same parent company. ICA employees worked 12-hour shifts on days 1, 2, and 5–7 of a 10-day cycle and were off on days 3, 4, and 8–10; employees rotated between day and night shifts every 3 months. Medical staff worked 8–12-hour shifts. Most kitchen workers worked on one of two shifts each day. Approximately 28 employees reportedly tested positive for COVID-19 prior to the site visit. At the time of the site visit, detained persons worked in cleaning, food preparation, and the barber shop within the detention facility. Detained persons were permitted to work a maximum of 40 hours per week.

Observations and Discussion
This report is based only on observations made at the FDC and discussions with the FDC management and employees that occurred during the site visit regarding IPC practices pertaining to workers. CDC/NIOSH investigators were guided by the Interim Customizable Non-Healthcare Workplace Infection Control Assessment and Response (WICAR) tool — Coronavirus disease 2019 (COVID-19). This report is not intended to document every observation and intervention that occurred at the FDC. At the time of the visit, management representatives reported that they are “doing their best” to follow the Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities and other general CDC guidance on how to protect oneself and others. Investigators observed that the FDC had implemented many CDC recommendations prior to the visit. During the site visit, CDC team members discussed additional recommendations with detention center management, which were implemented during the visit. A summary of observations and discussions for the detention center is provided below.
additional recommendations with detention center management, which were implemented during the visit. A summary of observations and discussions for the detention center is provided below.

Entrance and screening
The detention center had incorporated health screening into existing security screening procedures in the lobby. A screener asked employees and visitors (1) whether they had fever, felt feversish, or had chills in the past 24 hours and (2) whether they had contact with a person known to be infected with COVID-19 while not wearing the recommended personal protective equipment (PPE) in the past 14 days. CDC/NIOSH investigators observed some inconsistency in how these screening questions were phrased. The screener also measured temperature using a handheld touchless thermometer before the person was allowed to walk through a metal detector while their belongings were scanned with an x-ray machine.

If a person had a temperature of 100.4 °F or greater, a temperature was taken again in 10 minutes. If the employee or visitor’s answers to screening questions indicated possible COVID-19 illness or exposure or a second temperature reading was 100.4 °F or greater, the person was not allowed into the FDC and was instructed to seek evaluation from their health care provider. Employees also presented for temperature and symptom screening once during their shift.

CDC/NIOSH investigators observed that it was often difficult to maintain social distancing during the screening process as belongings were being loaded into and retrieved from x-ray machine trays. During shift changes, employees were exiting as others were entering via the lobby area. Screeners wore face shields, N95 or KN95 respirators, and gloves. The FDC implemented the CDC team’s recommendation for screeners to wear disposable gowns as well.

After security and health screening, employees presented and left a form of identification with an officer in an adjoining room (with the upper half of the wall in glass) in the lobby area through a slot. Visitors left a form of identification with the officer, received a visitor’s badge, and were asked to sign a logbook. At the time of the site visit, the FDC was only allowing visits by attorneys in visitation rooms without direct contact with detained persons or official visitors.

Occupational health and worker benefits
The FDC management reported consulting with local health department officials regarding the management of employees with COVID-19, symptoms consistent with COVID-19, and potential exposure events (i.e., if employees were within 6 feet of a person with COVID-19 for 15 minutes or more without wearing PPE, etc.).

Respiratory protection programs varied by employer. According to ICA managers, some detention officers who might be involved in transporting detained persons underwent medical evaluation and respirator fit testing in response to the COVID-19 pandemic. According to Armor managers, medical staff underwent an annual medical evaluation, respirator fit testing, and training in an established respiratory protection program. Trinity/Keefe employees at this facility were required to undergo a virtual respiratory protection training but not medical evaluation or fit testing. Trinity/Keefe followed the FDC requirements with regard to N95 respirator use.

Regarding sick leave, ICA and Trinity/Keefe employees were encouraged to report illness to their supervisors and seek medical care. They received their regular pay for up to 14 days and did not need to use sick leave if they were unable to work due to COVID-19. Armor employees used their annual allotment of paid time off and were allowed to have a negative balance if necessary for time off related to COVID-19. Regarding return-to-work criteria for employees with COVID-19, the FDC reported following the guidance of the employee’s health care provider or the local health department.

The FDC plans to offer free, on-site influenza vaccination for employees, as in previous years.

Offices and common areas
The detention center contained single-occupancy and shared offices. To reduce the number of employees entering the building each day, administrative employees rotated between one week of working remotely and one week working on-site. In general, offices were large enough to
The detention center contained single-occupancy and shared offices. To reduce the number of employees entering the building each day, administrative employees rotated between one week of working remotely and one week working on-site. In general, offices were large enough to accommodate social distancing (i.e., a distance of 6 feet or more between persons). Most employees observed in offices were wearing a respirator or face covering.

Other common areas in the detention center included the employee break room, employee restrooms, and employee gym. The control room was also a shared space. To increase the ability to maintain social distancing in the break room, the FDC representatives reported that the conference room was available as overflow when it was not in use. The briefing at the beginning of each shift was reportedly held in both rooms. The break room included two rows of tables where employees were observed to be sitting facing each other within 6 feet while eating. Group trainings in the employee gym were reportedly suspended, but employees were able to use the gym on their own.

CDC/NIOSH investigators observed some high-traffic areas in the non-restricted area of the detention center, such as the hallway leading to the employee restrooms and the area near the clock in/clock out stations. It was not possible to maintain a distance of 6 feet when employees passed each other in the hallway in the non-restricted area. CDC/NIOSH investigators also observed multiple persons between the interlocking doors waiting to transit between the non-restricted and restricted areas of the detention center. During the site visit, the FDC posted signs as reminders to maintain social distancing.

**Functional areas of the detention center**

CDC/NIOSH investigators observed work in several functional areas of the detention center, including the kitchen, laundry room, barber shop, and hearing rooms for detained persons. CDC/NIOSH investigators discussed work practices in the commissary and laundry distribution areas with the FDC employees.

**Kitchen**

Kitchen workers underwent temperature screening prior to entering the kitchen for their shift. Workers wore hairnets, N95 or KN95 respirators, and disposable gloves in the kitchen area. Kitchen workstations allowed workers and supervisors to maintain 6 feet of distance from each other during food preparation. During meal assembly, two rows of workers faced each other, standing more than 6 feet apart, and placed meal components on disposable trays that moved down a central conveyor belt. Workers side-by-side were spaced less than 6 feet apart. One worker stood at the end of the conveyor belt to close the trays. Workers at the end of the assembly line periodically moved off the assembly line to place completed trays onto carts for distribution to various dormitories. Meal assembly lasted approximately 30 minutes.

**Laundry**

Workers in the laundry room loaded items into and removed items from washing and drying machines. Workers in the laundry area wore N95 or KN95 respirators, face shields, and gowns. Laundry carts were cleaned and sprayed with a disinfectant. The FDC managers described that cleaned laundry were returned to each dormitory and laid out on a table and detained persons would be called up to sign for their laundered items.

**Barber shop**

The barber shop contained two barber chairs and several chairs for detained persons waiting for haircuts. CDC/NIOSH investigators observed barbers wearing respirators while clipping hair of detained persons who were not wearing respirators or face coverings. Detained persons waiting for haircuts were seated less than 6 feet apart; most were wearing respirators while waiting. A detention officer, wearing coveralls and a respirator, supervised the barber shop from the hallway.

**Hearings for detained persons**

CDC/NIOSH investigators observed detained persons attending hearings through videoconferencing in a private room with the door closed. A detention officer remained in the hallway wearing a N95 or KN95 respirator, gown, and gloves and observed the detained person through a large glass window.
hallway wearing a N95 or KN95 respirator, gown, and gloves and observed the detained person through a large glass window.

Commissary
Detention center representatives reported that one Trinity/Keefe employee fulfilled commissary orders placed by detained persons through an electronic touchscreen in each dormitory. This employee placed the ordered items onto a cart for delivery to the dormitories. Carts were reportedly sprayed with disinfectant between uses. Detention officers in the dormitories distributed the commissary orders.

Intake and transportation
At the time of the site visit, the detention center was not accepting any new intakes of detained persons. Detention center representatives described the process of transporting detained persons away from the FDC for medical evaluation or release. According to detention center representatives, approximately 90% of transports were performed by ambulance, which was not operated by the detention facility. Detention officers would wear a face shield, respirator, gloves, and gown when accompanying a detained person transported by ambulance. If a detained person did not require transportation by ambulance, two officers transported the detained person in a 15-passenger vehicle while wearing respirators and gloves. The vehicle reportedly had a plexiglass and metal partition between the officers who were in the front of the vehicle and the detained person or persons in the passenger area. Detained persons were reportedly required to wear masks and were spaced as far apart as possible within the vehicle.

Dormitories
The detention center had nine dormitories with capacity ranging from 42 to 102 detained persons. During the site visit, two dormitories were not in use. The detention center also had 12 cells designed for two persons in the protective custody and restricted housing units. CDC/NIOSH investigators did not evaluate these housing units.
A detention officer was stationed in each dormitory, containing bunk beds, restrooms, showers, and tables for meals and other activities. The FDC representatives reported that dormitory officers were required to walk through the dormitory each hour for a “wellness check” which took approximately 15 minutes. From the officer’s station, officers dispensed alcohol-containing hand sanitizer into the hands of detained persons upon request. CDC/NIOSH investigators observed the dormitory officer and an additional detention officer conducting an evening count of detained persons and distributing meals. These activities required detention officers to be within 6 feet of detained persons for more than 15 minutes combined. Detained persons placed their used food service items into a trash bag. Dormitory officers and other employees who had prolonged contact with detained persons were required to wear face shields, N95 respirators, gloves, and coveralls or gowns in the dormitory. CDC/NIOSH investigators did not observe signs stating PPE required at the entrance to each dormitory. Dormitory officers were relieved by other detention officers for two 15-minute breaks, lunch or dinner, and restroom breaks as needed during their shift.

Medical unit and related functions
The MHU contained examination rooms, offices, and medical isolation rooms. There were five isolation rooms (including three negative pressure rooms) designed for one person, three isolation rooms designed for two persons, and one isolation room designed for three persons. CDC/NIOSH investigators observed signs indicating the types of PPE required to enter occupied isolation rooms but no designated PPE donning and doffing areas outside each isolation room. CDC/NIOSH investigators observed medication dispensing by medical staff at two dormitories. A medical staff member brought a mobile medication cart to a medication room, accessed from the hallway, and having a clear partition on the wall facing the dormitory. Detained persons placed their identification card on the edge of the partition for the medical staff member to confirm their identity. Medications were passed through a small hole in the partition or through a metal drawer below the partition. The dormitory officer observed that the detained person swallowed the medication from inside the dormitory. The medical staff member wore a face shield, N95 respirator, gown, and gloves during medication dispensing. The medical staff member cleaned the surface of the medication cart and surfaces in the medication room with disinfectant after dispensing medication for the dormitory. Medical staff members performed daily temperature and symptom screenings of detained persons.
member cleaned the surface of the medication cart and surfaces in the medication room with disinfectant after dispensing medication for the dormitory. Medical staff members performed daily temperature and symptom screenings of detained persons in the dormitory. Each detained person was called to the front of the dormitory for screening. Temperature was measured with a handheld contactless thermometer. Medical staff wore face shields, N95 respirators, gowns, and gloves during screening.

**Cleaning and disinfection**

CDC/NIOSH investigators interviewed staff regarding cleaning and disinfection procedures throughout the FDC and observed one staff cleaning crew while working in the MHU. Investigators also observed detained persons cleaning in the kitchen. At the time of the site visit, the kitchen was being cleaned primarily by detained persons. Similarly, each dormitory was cleaned by crews of two detained persons who were housed in that dormitory. Staff indicated that spray disinfectant is always available at the officer’s station at any time to detained persons. They reported the spray disinfectant was primarily used by detained persons in their personal areas but could also be used in any area of the dormitory. Staff reported that detained persons were normally hired for cleaning in other areas as well, but that interest in those jobs has waned due to COVID-19. Therefore, most of the cleaning outside the kitchen and dormitories was being performed by ICA staff.

Staff also reported that detained persons were provided with goggles, gloves, and masks for cleaning in the dormitories. CDC/NIOSH investigators observed detained persons wearing gloves and masks while cleaning. Staff were also observed to be wearing gloves and masks while performing cleaning and disinfecting tasks in the MHU. It was reported that the barber shop was cleaned once daily at the end of use, and other areas of the FDC including the dormitories, hallways, common areas, and the MHU were cleaned twice daily. Kitchen staff reported that the kitchen was cleaned continuously throughout the day while being used, which matched observations of CDC/NIOSH investigators.

Trinity Services Group uses one primary cleaner/disinfectant (Eco Lab Oasis 146), which is readily available in the kitchen and is dispensed from an automatic dilution system. Although the supplier’s literature suggests the disinfectant is effective for COVID-19, the agent is not listed on the [EPA List N: Disinfectants for Use Against SARS-CoV-2 (COVID-19)](https://www.epa.gov/pesticide-registration/disinfectants-use-against-sars-cov-2) (COVID-19). ICA purchases three different cleaners/disinfectants (RE-JUV-NAL, SUPROX – Heavy Duty, Spray-N-Go) that are used throughout the rest of the FDC. One of these three cleaners (RE-JUV-NAL) is on the EPA List N.

**Hand hygiene**

Pump-top dispensers for alcohol-free hand sanitizer containing benzalkonium chloride were available at the FDC’s entrance/exit and by the officer’s station in the dormitories. According to the FDC representatives, alcohol-containing hand sanitizer became permitted in the detention center during the COVID-19 pandemic. During the site visit, staff had access to bottles of hand sanitizer containing at least 60% alcohol. Dispensers stocked with hand sanitizer were observed in the hallways near doors in the detention center’s restricted area and in the lobby area. Portable sinks and soap were available at PPE donning and doffing areas in the hallway outside of dormitories. Access to soap and running water were available in employee restrooms, the employee break room, kitchen, and other areas.

**Masks**

CDC/NIOSH investigators observed some employees wearing cloth masks with exhalation valves. The FDC representatives reported that detained persons were issued two cloth face coverings and an unknown number of N95 respirators. The FDC staff reported that some detained persons were removing the metal nosepieces from N95 respirators and sharpening them, which can pose a safety hazard for staff, themselves and other detained persons.

**Personal protective equipment**

According to the FDC management, all employees were required to wear a N95 filtering facepiece respirator and visitors were required to wear cloth masks or disposable facemasks inside the detention center. CDC/NIOSH investigators observed employees wearing N95 respirators, KN95 respirators, and surgical masks as well as cloth face masks (which are considered source control, not PPE). KN95 respirators are approved under standards used in China that are similar to NIOSH-approved N95 respirators; however, KN95 respirators are not licensed or registered by NIOSH.
respirators, KN95 respirators, and surgical masks as well as cloth face masks (which are considered source control, not PPE). KN95 respirators are approved under standards used in China that are similar to NIOSH-approved N95 respirators; however, KN95 respirators are not NIOSH-approved respirators. Use of non-NIOSH approved respirators from other countries is considered a crisis strategy when there are known shortages. Some employees wore N95 respirators with exhalation valves. Of the employees observed wearing N95 or KN95 respirators, most were wearing them incorrectly. For example, some staff were wearing respirators with the straps incorrectly placed or not fitting tightly around the nose. CDC/NIOSH investigators also observed staff wearing N95 or KN95 respirators who had facial hair across the seal of the respirator, which does not permit a tight fit. Among medical staff observed wearing N95 respirators, all appeared to be wearing them appropriately.

PPE donning and doffing stations were located in hallways outside of dormitories. The stations included a supply of laundered coveralls, a handwashing station, and containers for used coveralls and disposable PPE after doffing. At the suggestion of the CDC team, the FDC placed signs about how to don and doff PPE at the stations. The FDC representatives reported initially experiencing some challenges in sourcing N95 respirators and gowns. Employees were issued several N95 or KN95 respirators and paper bags to store them for re-use in their personal vehicles. Because of shortages in disposable gowns during the beginning of the pandemic, the FDC also provided coveralls that were laundered on-site. At the time of the site visit, both washable coveralls and disposable gowns were available at the donning/doffing stations.

Ventilation system
CDC/NIOSH investigators interviewed the FDC staff regarding the ventilation system. It was reported that the dormitories are on isolated systems separate from systems for the rest of the FDC. Three of the dormitories were spot checked and verified to be at a negative pressure relative to the hallway, such that any air flow during door-opening or leaks around doors goes from the hallway into the dormitory. Staff replace filters in the ventilation system every month. A contract company performs routine maintenance of the systems, consisting primarily of testing and balancing flows to ensure proper operation, on a quarterly basis.

Although not directly related to the FDC’s ventilation system, staff indicated that they were unaware of the use of personal fans by anyone at the FDC. This matched observations made by CDC/NIOSH investigators.

Recommendations
Based on observations, discussions with management and employees, and existing CDC guidance, the following actions are recommended to reduce the spread of SARS-CoV-2 between workers at the detention center. Interim recommendations for correctional and detention centers are available and should be considered when developing or refining facility COVID-19 response plans. The recommendations in this report are specific to the ICA-Farmville detention center, including the contractors that support it. With ongoing community transmission, COVID-19 cases among staff might continue to impact the workforce. However, a combination of control measures with ongoing education and training can help reduce COVID-19 transmission in the workplace.

Hierarchy of controls
The following recommendations should be implemented according to the hierarchy of controls. The hierarchy of controls is an approach to hazard intervention that emphasizes implementing, when possible, the most effective controls first. For COVID-19, the preferred approach is, in order, to eliminate the hazard, install engineering controls, and implement appropriate cleaning and disinfecting practices to reduce worker exposure. Administrative measures, PPE, and source controls (e.g., cloth masks) are also recommended.

Entry screening
Screening workers and visitors for COVID-19 symptoms is a strategy to help ensure that symptomatic workers or visitors do not enter the FDC. Actions to improve existing screening policies and processes include:
1. Use signs, tape marks, or other visual cues such as decals or colored tape on the floor, placed 6 feet apart, to show persons where to stand while waiting for screening.
policies and processes include:
1. Use signs, tape marks, or other visual cues such as decals or colored tape on the floor, placed 6 feet apart, to show persons where to stand while waiting for screening.
2. Continue to provide screeners with gowns, in addition to face shields, N95 respirators, and gloves.
3. Waive the requirement for employees to leave a form of identification at the entrance to improve the ability to maintain social distancing in the lobby area. This change would also potentially allow employees to leave through a separate exit.
4. Waive the requirement for visitors to sign the logbook to minimize sharing of pens and logbook handling.

Contact tracing
Contact tracing is important for identifying workers who have been exposed to a person with COVID-19 so that exposed workers can be excluded from the workplace and/or closely monitored for onset of symptoms. Policies and procedures for contact tracing should be developed in consultation with state and local health officials. Actions to improve existing policies and procedures include:
1. Identifying close workplace contacts for each worker with COVID-19 starting 48 hours before the worker became symptomatic, as defined by the CDC Interim Guidance for Implementing Safety Practices for Critical Infrastructure Workers Who May Have Had Exposure to a Person with Suspected or Confirmed COVID-19. These might include detained persons, people who work in the same area of the FDC, take breaks together, ride to work together, or live in the same household.
2. Critical infrastructure workers determined to be a close contact of a person with confirmed COVID-19 may be permitted to continue work, provided they remain asymptomatic and additional precautions are implemented for 14 days after their last exposure (see CDC Interim Critical Infrastructure Worker Guidance). Precautions include temperature and symptom screening before entering the workplace, wearing a mask while in the workplace, and adhering to social distancing (remaining 6 feet or more from others).
3. If an employee develops symptoms at work, they should be sent home immediately.

Sick leave policies
Review leave and incentive policies to ensure that they are flexible, non-punitive, and actively encourage employees who are sick to not come to work. Consider the following actions to improve the existing sick leave policies and practices:
1. Continue leave policies that ensure that ill employees are not in the workplace. Consider not requiring Armor employees to use paid time off for COVID-19–related leave to align with leave policies for other FDC employees. Ensure that employees are aware of and understand these policies, particularly how they might differ from usual policies.
2. Analyze incentive programs so that employees are not penalized or miss opportunities to earn higher pay by not working if they have COVID-19.

Social distancing
In addition to everyday steps to prevent COVID-19, keeping a distance of at least 6 feet between individuals (social distancing) is one of the best strategies to avoid being exposed to the virus and slowing its spread. In addition to work areas, social distancing should be emphasized in all areas where workers congregate, such as restrooms, break rooms, parking lots, hallways and corridors, sally ports, and entrance/exit areas. Barriers are one method to physically separate workers in areas of the FDC where social distancing is not possible. Physical barriers should not be used as a replacement for social distancing and should only be used when distancing is not possible, due to workspace design or task to be completed (e.g., multiple people needing to work together on a single task). The following best practices are recommended:
1. At shift change, employees leaving the FDC should minimize close contact (within 6 feet) with employees entering the FDC. If possible, provide a separate exit for employees leaving the FDC. Staggering work shift start and stop times can also help minimize contact between employees.
2. Move chairs within offices, break rooms, conference rooms, and other common areas to maximize distancing of at least 6 feet between individuals. Floor markings can be used to denote distances of 6 feet. This provides a visual cue to remind workers to maintain
2. Move chairs within offices, break rooms, conference rooms, and other common areas to maximize distancing of at least 6 feet between individuals. Floor markings can be used to denote distances of 6 feet. This provides a visual cue to remind workers to maintain social distancing.

3. Install transparent shields or other physical barriers where possible to separate employees where social distancing is not possible, such as the break room.

4. Modify the alignment of workstations or remove some workers in the meal assembly line, if feasible, so that workers are at least 6 feet apart in all directions (e.g., side-to-side and when facing one another). Ideally, modify the alignment of workstations so that workers do not face one another. Consider using markings and signs to remind workers to maintain their location at their station away from each other and practice social distancing on breaks. Use physical barriers, such as strip curtains, plexiglass or similar materials, or other impermeable dividers or partitions to separate workers from each other, if feasible and when they do not pose a security concern (e.g., reduced visibility for detention officers).

5. Post signs and floor markings to encourage social distancing among persons waiting between the interlocking doors separating the restricted and non-restricted areas of the detention center.

6. Empower supervisors and workers to provide corrective guidance to other workers about improper social distancing.

Source control
Source control is a term used to describe measures (e.g., masks or cloth face coverings) intended to prevent infected individuals from spreading disease. Masks are generally recommended as an addition to social distancing for source control, as they help keep the person wearing the mask from spreading respiratory droplets when talking, sneezing, or coughing. A mask is meant to protect other people in case an individual is infected but not symptomatic. Consider the following actions to improve source control:

1. Provide additional masks to detained persons at no charge and ask detained persons to return N95 respirators for disposal. Routine use of N95 or other respirators by detained persons is not recommended to prevent SARS-CoV-2 transmission. Continue to offer cloth face masks and launder them routinely.

2. Discourage the use of masks with exhalation valves in the detention center because they can allow exhaled respiratory droplets to reach others and potentially spread SARS-CoV-2.

Hand hygiene and sanitation
Hand hygiene and sanitation are important tools to avoid being exposed to the virus and slowing its spread. Follow and frequently monitor the CDC recommendations for cleaning and disinfection during the COVID-19 response for updates. Cleaning and disinfection of surfaces and objects that are frequently touched, especially in common areas, several times per day is an important component to control the spread of COVID-19. Consider the following actions to improve hand hygiene and sanitation:

1. Continue to encourage frequent handwashing with soap and water for at least 20 seconds.
2. Provide hand sanitizer with at least 60% alcohol in areas where soap and water are not readily available and alcohol-based hand sanitizer is permissible based on security restrictions, such as by the entrance/exit, staff gym, and clock in/clock out area.
3. Continue to monitor and ensure all hand sanitizer dispensers are fully stocked.
4. Educate workers on proper alcohol-based hand sanitizer use.
   a. Additional information on proper hand sanitizer use can be found at: https://www.cdc.gov/handwashing/hand-sanitizer-use.html.
   b. Consider the use of videos such as these videos from YouTube: https://www.youtube.com/watch?v=Qe5byXjEmkY or https://www.youtube.com/watch?v=ZnSjFr69JI. Videos in languages other than English are also available.
5. Install additional touchless sinks, soap dispensers, hand sanitizer dispensers, and paper towel dispensers (preferred over air hand dryers) wherever possible, for example in the employee gym, break room, and by the clock-in/clock-out station and the interlocking doors between the restricted area and non-restricted area. If available, choose hand dryers.
towel dispensers (preferred over air hand dryers) wherever possible, for example in the employee gym, break room, and by the clock-in/clock-out station and the interlocking doors between the restricted area and non-restricted area. If available, choose hand sanitizer dispenser units that are touch-free when new or replacement units are being purchased.

6. Emphasize proper hand hygiene after gloves are removed and before and after facial coverings are donned or doffed. Continue to have portable sinks in PPE donning and doffing areas.

7. Continue to conduct targeted and more frequent cleaning of high-touch areas of common areas (e.g., timekeeping equipment, bathroom fixtures, break room tables and chairs, vending machines, railings, door handles).

8. Follow [CDC guidance for disinfection](https://www.cdc.gov/coronavirus/2019-ncov/community/reopen-guidance.html) and use disinfectants from the [EPA list of disinfectants approved for use against COVID-19](https://www.epa.gov/covid-19-disinfectants). When EPA disinfectants are not available, alternative disinfectants can be used (for example, 1/3 cup of bleach added to 1 gallon of water, or 70% alcohol solutions).

**Ventilation**

1. It is advisable, as much as possible, to create a clean-to-less-clean air flow from areas of lower risk of contamination (e.g., staff rooms and corridors) to areas with a higher risk of contamination (dormitories for detained persons with suspected or confirmed COVID-19). This approach can be encouraged by strategically making high-risk areas negative pressure relative to the low-risk areas.
   a. Because the low-risk areas are reportedly on a separate air supply system from high-risk areas, a negative pressure can be induced in high-risk areas by exhausting/returning more air than is supplied for each high-risk detainee dorm on that system.
   b. Lower-risk areas can be made positive pressure relative to contaminated areas by supplying more air to the low-risk areas than is exhausted/returned.

2. Collect respiratory specimens for SARS-CoV-2 testing in environments that are protective for testing staff and other nearby persons. Options to do this include collecting specimens in the negative pressure rooms, using a system that incorporates local exhaust ventilation and HEPA filtration like a sputum booth or portable swabbing booth, or collecting the specimens outdoors. If outdoor testing is conducted, require detained persons to wear masks when walking through the corridor to the outdoor location.

3. To avoid the potential for ‘short-circuiting’ airflow in the dorms, the supply air should be discharged downward with sufficient velocity such that it reaches the occupied zone.

4. As much as possible within the limitations of the heating, ventilation, and air conditioning (HVAC) equipment and environmental conditions, maximize outdoor air supply in the HVAC system while maintaining temperature and humidity set points.

5. Consult an HVAC professional to investigate increasing filtration efficiency to the highest level compatible (minimum efficiency reporting value [MERV] 13 desired) with the HVAC system without significant deviation from designed airflow. Verify that installed filters are properly maintained and installed within the filter racks to minimize bypass.

6. Ensure staff wear a respirator, gloves, and face shield when replacing ventilation filters and wash their hands after performing the task.

**Personal protective equipment**

Because the effectiveness of PPE depends heavily on the user and requires training and supervisory monitoring and oversight, PPE is considered the least effective type of control measure. Different makes and models of PPE were available at the detention center, so training, monitoring, and oversight are very important to ensure that workers use PPE correctly. The recommendations below are intended to improve proper fit and use of PPE as well as proper donning and doffing procedures. [Situation-appropriate PPE](https://www.cdc.gov/coronavirus/2019-ncov/community/reopen-guidance.html) is necessary to provide protection for workers, particularly if those workers are likely to have close interaction with detained persons who are suspected or confirmed to have COVID-19.

1. Respirators should be prioritized for the FDC employees who are likely to have close contact with detainees suspected or confirmed to have COVID-19, or during aerosol generating procedures on persons with suspected or confirmed COVID-19.
1. Respirators should be prioritized for the FDC employees who are likely to have close contact with detainees suspected or confirmed to have COVID-19, or during aerosol generating procedures on persons with suspected or confirmed COVID-19.

2. Any worker required to use an N95 respirator should be part of an Occupational Safety and Health Administration (OSHA)-compliant respiratory protection program, which includes medical evaluations, training, and fit testing (29 CFR 1910.134). Please see the following webpage for more details on OSHA's enforcement of this standard during the COVID-19 pandemic: [https://www.osha.gov/memos/2020-04-03/enforcement-guidance-respiratory-protection-and-n95-shortage-due-coronavirus](https://www.osha.gov/memos/2020-04-03/enforcement-guidance-respiratory-protection-and-n95-shortage-due-coronavirus).

3. If only a respirator with an exhalation valve is available and source control is needed, the exhalation valve should be covered with a surgical mask, procedure mask, or a cloth mask that does not interfere with the respirator fit.

4. Post signs at entrances to dormitories and other areas indicating what types of PPE are required for entry. Ensure that all types of PPE required for entry are available at nearby PPE donning stations.

5. Instruct any worker who wears an N95 respirator on how to properly put on the respirator to achieve a good seal around the face. CDC/NIOSH has an infographic showing facial hairstyles that are compatible with tight-fitting respirator use.

6. Consider strategies for optimizing supply of PPE and other equipment during shortages. Use of respirators from other countries (e.g., KN95 respirators) is considered a crisis strategy. Information about determining the reliability of imported respirators, if used, can be found at [https://blogs.cdc.gov/niosh-science-blog/2020/04/23/imported-respirators/](https://blogs.cdc.gov/niosh-science-blog/2020/04/23/imported-respirators/).

Training and communication

When developing training and communication materials, the FDC should use current, correct messaging from a trusted source. Training should be reinforced using signage (preferably infographics or simple signs with a single, clear message) placed in strategic locations. Graphics and suggested messages are available from CDC for use on social media profiles and web pages. Print resources and communication guidance also are available from CDC and are available in multiple languages. Videos are also available for use. Use definitions and examples to explain technical terminology and concepts used in training or communications to help improve understanding.

CDC's Interim Guidance for Businesses and Employers Responding to Coronavirus Disease (COVID-19) also provides a thorough list of topics for educating workers about how they can reduce the spread of COVID-19. Consider the following actions to improve your training and communication efforts:

1. Continue to provide COVID-19 informational signage throughout the FDC. In areas where workers and detained persons interact, signs and floor markings should be in relevant languages.
2. Post additional signage in areas where workers might congregate, to remind workers about hand hygiene, social distancing, and mask use.
4. Remove as much outdated signage as possible. “Refreshing” messages by putting up new signs (even if they have a similar message) helps make the signs stand out to workers.
5. Do not post signs in spaces that are already congested with other signs or postings as they are hard to pick out in these settings.
6. Use more pictures/pictograms with minimal text in relevant languages to increase the percentage of the workforce that engages with signs and messaging.
7. Ensure that signage is at eye level and can be easily seen by workers.
8. Use alternative sources for communicating with workers, such as sending hyperlinks along with messages to provide additional information on COVID-19.
9. Develop or provide existing training and messaging for social distancing, hand hygiene, donning and doffing cloth masks and PPE, cough and sneeze etiquette (even when wearing a mask), disinfecting reusable PPE and masks, and messaging about what to do if you are sick.
10. Use alternatives to traditional in-person trainings for delivery of this information (e.g., videos, phone applications).
   a. Develop a method to verify worker understanding and participation.
10. Use alternatives to traditional in-person trainings for delivery of this information (e.g., videos, phone applications).
   a. Develop a method to verify worker understanding and participation.
   b. Partner with community organizations and the local health department to distribute messaging to workers.

11. Provide training to workers, supervisors, and management whenever changes are implemented in the workplace. Refresher training should be provided on a regular basis.

Updated information and guidance
Check back frequently on the [CDC COVID-19 webpage](https://www.cdc.gov) for updated information and guidance on preventing and mitigating the spread of SARS-CoV-2 among workers while they are at work. Continue communicating and working with the Virginia Department of Health and other stakeholders and partners.

End of Memo

Appendix 6: Materials Shared with the FDC

The following items were shared with the FDC Director:

- **Signage**
  - Facemasks Do’s and Don’ts (English/Spanish)
  - Respirators On and Off (English/Spanish)
  - COVID19 Symptoms (English/Spanish)
  - Keep Calm Wash Your Hands
  - Mask Up (English/Spanish)
  - PPE instructions posters (English/Spanish)
  - Key Times to Wear Gloves poster (English only)

- **Training**
  - COVID-19 and Correctional Facilities: Training for Correctional and Detention Facility Workers

- **PPE Related Videos**
  - [Demonstration of Donning (Putting On) Personal Protective Equipment (PPE)](https://www.cdc.gov/video/socialmedia/316343_DonningPPE_final_lowres_2.wmv)
  - [Demonstration of Doffing (Taking Off) Personal Protective Equipment (PPE)](https://www.cdc.gov/video/socialmedia/316343_DoffingPPE_final_lowres.wmv)

  - **Key Times to Wear a Mask**
    - English: [https://www.youtube.com/watch?v=tnS9yC_bYHY](https://www.youtube.com/watch?v=tnS9yC_bYHY)

  - **How to Wear a Mask (in public)**
    - English: [https://www.youtube.com/watch?v=vMCS6gT8SzQ](https://www.youtube.com/watch?v=vMCS6gT8SzQ)

Other VIDEOS

- **Symptoms of Coronavirus Disease 2019**

- **How to Clean and Disinfect Someone Has COVID-19**
  - English: [https://www.youtube.com/watch?v=vMCS6gT8SzQ](https://www.youtube.com/watch?v=vMCS6gT8SzQ)

End of memo