Oregon
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NF-20-140 – Provider Alert

Date: October 23, 2020

To: All Nursing Facilities
All Assisted Living Facilities
All Residential Care Facilities

FROM: Jack Honey, Administrator
DHS Safety Oversight and Quality (SOQ)

Re: Limited COVID-19 Indoor Visitation Policy

Background: While infection prevention and outbreak mitigation efforts remain critically important in long-term care settings where residents are more vulnerable to virus exposure, Oregon Department of Human Services (ODHS) acknowledges that it is equally important to consider the quality of life and dignity of individuals living in long-term care settings, and the critical role of family relationships to overall health.

Based on recent guidance from Centers for Medicare and Medicaid Services (CMS), Safety, Oversight and Quality (SOQ) has been evaluating how to responsibly ease visitation restrictions while COVID-19 exists. This guidance is based on the September 17, 2020 CMS Guidance QSO-20-39-NH - Nursing Home Visitation - COVID-19 and may be updated as additional information becomes available.

Settings: Although this CMS guidance was developed for nursing facilities, SOQ has adopted the guidance to include assisted living and residential care facilities. The objective is to keep safe practice standards as consistent as possible across congregate care settings.

Purpose: This guidance allows for the possibility of limited, structured indoor visitation utilizing best practices for physical distancing. This limited indoor visitation policy is intended to offer specific guidelines under which structured indoor visitation can be accommodated.

Effective November 2, 2020, facilities must accommodate safe and controlled indoor visitation, including visits for reasons beyond

compassionate care situations, according to the risk-based criteria contained in this transmittal. The following criteria are intended to offer guidance as you facilitate indoor visitation with an aim to minimize the risk of exposure to COVID-19:

Core Principles of COVID-19 Infection Prevention
Facilities must apply core principles of COVID-19 infection prevention for visitors including:

- Screening of all potential visitors who enter the facility for signs and symptoms of COVID-19 including but not limited to:
    - Temperature check
    - Questions for screening, observations about signs or symptoms, screen for exposures to confirmed cases and test results pending. Those currently in isolation or quarantine should not visit and those with signs or symptoms should not enter.
    - Hand hygiene is performed with the use of alcohol-based hand rub (ABHR) prior to and following visit.
    - Face covering or mask covering both mouth and nose.
    - Physical distancing of at least six feet between persons, 12 ft for those who cannot wear a mask due to medical condition.
    - Instructional signage is placed throughout the facility and to include proper visitation education on the pandemic and infection control practices.
    - Proactive and ongoing visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated visiting area, hand hygiene) will be provided.
    - Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit.
    - Use of Personal Protective Equipment (PPE) by both visitors and residents during visit.
    - Effective resident placement (e.g., private rooms or separate areas dedicated COVID-19 care) to protect residents and visitors for possible exposure.

Indoor Visitation Criteria

- Allow indoor visitation only when there has been no new onset of COVID-19 cases in the last 14 days and the facility is not

currently conducting outbreak testing;

- Facilities currently under an ODHS Executive Order (EO) **may not** implement indoor visitation;
- Visitors must be able to adhere to the core principles of symptom screening on entry including handwashing, appropriate use of PPE and other infection control protocols. Facility staff must provide monitoring for those who may have difficulty adhering to core principles, such as children;
- Visitors should be instructed to wear their own mask/ face covering upon arrival to and throughout their stay in the facility. If they do not have a face covering, they should be offered a mask or face covering, as supplies allow.
- Facilities must comply with all public health investigation and contact tracing processes to ensure that potential exposures between visitors and residents or facility staff are promptly addressed.
- Facilities should schedule staggered visits and limit the number of visitors per resident to two visitors at any given time. Facilities should limit the number of residents with visitors at any given time to 5 residents or 20% of residents, whichever is less. Facilities should limit a maximum of 1 resident and 2 visitors in resident and designated visitation rooms. Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and allow special considerations for visitors traveling for visitation.
- Facilities should limit movement within the facility to the maximum extent possible. For example, visitors should not walk around different halls or other areas of the facility. Rather, they should go directly to the resident's room or designated visitation room. Visits for residents who share a room should generally not be conducted in the resident's room. Common areas where visits are conducted should be set up to ensure appropriate physical distancing between all individuals and should be disinfected by facility staff immediately after use.
- Facilities must exclude visitors with a known exposure to COVID-19 in the past 14 days (i.e., people in quarantine), and visitors who are confirmed or presumptive COVID-19 cases who meet criteria for isolation.
- Facilities must keep a log of all visitors to the facility (indoors and

outdoors). Facilities must capture name, address and phone number of visitors to facilitate potential future contact tracing efforts.

NOTE: For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

All facility settings must use the COVID-19 county positivity rate, found on the COVID-19 Nursing Home Data site to determine how to facilitate indoor visitation:

- **Low Positivity Rates** (<5%) and **Medium Positive Rates** (5%-10%): Visitation shall be permitted according to the criteria contained in this transmittal.
- **High Positivity Rates** (>10%) = Visitation may only include compassionate care situations.

Facilities may also monitor other factors to understand the level of COVID-19 risk, such as rates of COVID-19-like illness visits to the emergency department, or the positivity rate of a county adjacent to the county where the facility is located. The county positivity rate does not need to be considered for outdoor visitation.

Visitor Testing is not required but facilities are encouraged to test visitors, if feasible, when the county positivity rates are medium or high. Facilities should prioritize testing of visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days) with proof of negative test results and date of test. If testing visitors, facilities must first ensure they have adequate supplies to meet all requirements for routine and outbreak testing of staff and residents.

Compassionate Care Visits: End-of-life situations have been used as examples of *compassionate care*, though the term does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to:

- A resident who was living with their family before recently being admitted to a nursing home, is struggling with the change in

environment and lack of physical family support.

- A resident who is grieving after a friend or family member recently passed away.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

Allowing visits in these situations would be consistent with the intent of "compassionate care situations." In addition to family members, compassionate care visits may be conducted by any individual who meets a resident's specified needs, such as clergy or lay persons offering religious and spiritual support. This is not an exhaustive list, and other valid compassionate care situations may be identified.

At all times, visits should be conducted using social distancing and use of appropriate PPE. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Long-Term Care Ombudsman program to identify the need for compassionate care visits.

Required Visitation: We believe the guidance above represents reasonable ways facilities can enable in-person visitation. Except for on-going use of virtual visits, facilities may still restrict visitation due to the COVID-19 county positivity rate, the facility's COVID-19 status, a resident's COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factors related to the COVID-19 public health emergency.

However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v) Residents' Rights. For example, if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a facility **must** facilitate in-person visitation consistent with the rules and regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR 483.10(f)(4) deficient

practice, and the facility would be subject to citation and corrective actions.

NOTE: Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. However, this restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described above.

Health Care Workers and Other Service Providers: Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened.

NOTE: EMS personnel responding to an emergent situation should not be screened so they can attend to an emergency without delay. All facility staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with administrative rules for COVID-19 Testing in Licensed Assisted Living Facilities, Nursing Facilities and Residential Care Facilities.

Access to the Long-Term Care Ombudsman: In-person access may be limited due to infection control concerns and/or transmission of COVID-19; however, in-person access may not be limited without reasonable cause. If in-person access is not advisable, such as the Ombudsman having signs or symptoms of COVID-19, facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology.

Nursing homes are also required under 42 CFR 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by State law.

Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs: Facilities must allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000).

Nursing Facilities Only - Use of CMP Funds to Aid with Visitations: Technology can help improve social connections for some residents by helping to support and maintain relationships with loved ones. CMS has previously approved the use of CMP funds (See QSO-20-28-NH) to purchase communicative devices, such as tablets or webcams, to increase the ability for nursing homes to help residents stay connected with their loved ones. To ensure a balanced distribution of funds, facilities are limited to purchase one communicative device per 7–10 residents, up to a maximum of $3,000 per facility.

Additionally, facilities may apply to use CMP funds to help facilitate in-person visits. CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar product) to create a physical barrier to reduce the risk of transmission during in- person visits. Funding for tents and clear dividers is also limited to a maximum of $3,000 per facility. NOTE: When installing tents, facilities need to ensure appropriate life safety code requirements found at 42 CFR 483.90 are met, unless waived under the PHE declaration.

To apply to receive CMP funds for communicative devices, tents, or clear dividers, please contact your state agency's CMP contact.

If you have questions, please contact your licensing team:
CBC.team@dhsoha.state.or.us
NF.licensing@dhsoha.state.or.us

General questions may be sent to:
SOQ.LTCInfo@dhsoha.state.or.uswww.oregon.gov/DHS/.