Testimony on SB 2145
House Human Services Committee
March 16, 2021

Good afternoon Chairman Weisz and members of the House Human Services Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We represent 211 assisted living, basic care, and skilled nursing facilities in North Dakota. I am here to testify on SB 2145.

COVID-19 has had a devastating impact on individuals living in congregate care setting, their families, the staff taking care of residents, and the facilities themselves. The global outbreak of COVID-19 has been traumatic unlike anything we have ever experienced in long term care. Last week we reached the one year milestone of the pandemic, everyone is feeling the toll, including the dedicated facility staff members who are doing everything in their power to provide the best possible care in an extremely difficult situation. In the United States, long term care facilities have emerged as hotspots for COVID-19 outbreaks.

North Dakota long term care facilities, residents, and staff represent 9.6% of all the cases, yet bear 60% of all deaths. Of the 1455 total deaths, (as of 3-14-21), related to COVID-19 in North Dakota, 883 were deaths in long term care. Of the 215 long term care facilities counted in the data, 170 facilities have had outbreaks, (79%). Since the beginning we have had 4012 positive resident cases and 5109 positive staff, (as of 02-25-21). Using the numbers reported for occupancy residents are estimated at 8155, thus almost half of the residents have had COVID-19.

NORTH DAKOTA LONG TERM CARE CASES AND DEATHS THROUGH FEBRUARY 25, 2021

Cases and Deaths	Number (%)
Total Cases in ND	99,621
Total Cases in LTC (%)	9,121 (9.6%)
Staff	5,109
Residents	4,012
Total Deaths in ND	1,441
Total Deaths in LTC (%)	877 (61%)

States with the highest percent of COVID-19 deaths occurring in long term care as of 1-14-21:

NH	74%
RI	67%
KY	66%
MN	64%
ND	60%

The vast majority of facilities are open for visitation, that is the good news. Hopefully, we never go back to universally closing facilities again. But no one knew what we were facing and there was fear of unprecedent death for our vulnerable population.

Effective Friday, March 12th, the executive order for basic care, assisted living and nursing facilities was rescinded. Effective Wednesday, March 10th, CMS updated their visitation guidance. These orders and requirements we believed saved lives, but would we do things differently or make changes sooner, probably but we didn't have the authority. All of us from the feds, the state, association, and facilities were driven by one goal, keep residents and tenants alive.

At the beginning and mid-summer, we thought we could beat this virus. We thought we would be spared the ravages of what some other states were experiencing. March 2020, when the declaration of the public health emergency was made, all long term care shut down visitation, put stringent mitigation strategies in place and learned everything we could. We were distraught to see and hear what was occurring in some nursing facilities across the nation. CMS, CDC, Health Department guidance and executive orders determined what we should and must be doing during this pandemic. We have relied upon the guidance and mandates as we wanted to protect every single person in our care. No one wanted to be the first case or have the first death. We are probably now at over 10,000 positive staff and resident cases and unfortunately 883 deaths in long term care. Some facilities had multiple deaths in a short period of time. I do not know if facilities and staff will ever fully recover. We know families will be forever impacted. Some families were allowed in for compassionate care visits. Initially they were limited in numbers and duration, but today compassionate care visits are frequent.

Today we are experiencing high percentages of residents being vaccinated, see attachment. They want this nightmare to end. We want this nightmare to end.

Although visitation restrictions have protected the physical health of residents, the requirements of shutting down visitations has resulted in an unintended harm. I don't know yet if we really know the extent of the harm.

Residents did experience loneliness, anxiety, and depression due to prolong separation from families and loved ones. In the name of safety, all group dining and group activities were shut down, adding to the

isolation of being alone. Not having your family or your internal facility community open has been so difficult.

The Coronavirus Commission for Safety and Quality in Nursing Homes documented the negative impact on residents being separated from families and said the extent of this unintended harm has not been adequately assessed.

Facilities see firsthand the need to protect and follow all the CMS, CDC, and executive order guidance, but we see the vital need to open up and bring families back together. Just 4 months ago, in one single day reported on the Health Department website we had 1,630 residents and staff with COVID-19. Today we have 5 residents and 30 staff infected.

What got us out of those dark days was diligently following every mitigation strategy. During that time, we still took every step possible to electronically connect families and residents. With 60% of long term care facilities reporting, we recorded 1300 virtual visits in one week. I feel we all recognized the power of human touch and visually being in the same room. Although electronic connections have certainly helped, there is nothing that can replace a grandmother's hug.

Today almost everyone is open, and we have been in this status since January 2021. Based on the revised CMS guidance on visitation this is our current status:

- There are 17 nursing facilities who have had active cases in the last 14 days, which represents 22% of SNF's. The other 78% should be open to indoor visitation.
- Based on the new CMS guidance, best guess when applying the new outbreak testing scenario, if the first round of outbreak testing

within 3 to 7 days of that positive case and it reveals no new cases outside of the 'outbreak' area or unit, 13 of those 17 facilities may partially reopen. There are 4 facilities who appear to have staff or residents who can't isolate their positives to a particular unit and will likely remain closed to indoor visitation until they complete the outbreak testing cycle. It appears from the testing schedule most of these 13 facilities have testing scheduled early this week. This is a very positive change. If you have a single case and it's isolated on a unit, it may not shut down the entire facility.

- The difficult scenario exists with HCW testing positive and facilities trying to determine if it affects visitation for the whole facility or not. Facilities will need more guidance from CMS.
- Of the 134 AL and BC facilities, 13 have an active positive case in the last 14 days. All AL and BC facilities have been open to safe indoor visitation in a designated space. If they have a case, they've had the option to close in resident room visitation but keep open visitation outdoors or in a inside safe designated space. Basic care and assisted living don't need to follow the CMS guidance and are highly recommended to follow the CDC guidance.

The Health Department is seeing additional guidance from CMS on the visitation guidance for nursing homes.

Attached are the CDC guidelines, which the state advices all basic care and assisted living follow. Nursing facilities must follow the CMS guidance and those guidelines are also attached.

As a final note, our State, the Health Department, and the Department of Human Services/VP3 Team were incredible partners in assisting facilities in their response. Providing lab and testing services, emergency staff, PPE and medical equipment and supplies (State Cache), technical assistance and support and weekly tactical calls kept everyone updated and deeply

engaged. The past year was not easy, but together I think everyone worked continuously and saved lives.

This past year has been tremendously hard on family and residents. We are thankful visitation is open and the dark days of the pandemic are beginning to lessen.

This concludes my testimony, and I would be happy to answer any questions you may have.

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LTC COVID-19 Vaccine Update

Data Submitted Week of 03/10

Caveats:

91.04% Completion (193/212)

Percentage of Residents Vaccinated

	Total Residents	% of Residents vaccinated with 1 dose	% of Residents vaccinated with 2 doses
ALF	2510	93.50%	91.27%
BC	1813	92.11%	89.69%
SNF	4371	87.62%	83.50%
Overall	8694	90.26%	87.04%

Percentage of Staff Vaccinated

	Total Staff	% of Staff vaccinated with 1 dose	% of Staff vaccinated with 2 doses
ALF	1901	52.81%	49.55%
BC	1882	52.92%	49.10%
SNF	9522	54.50%	51.66%
Overall	13305	54.39%	51.00%

LTC All Stars – Staff and Resident at 80% or More Coverage Rate

Facility	% of Residents Vaccinated with 1 dose	% of Staff vaccinated with 1 dose
Crosby - Northern Lights Villa AL	100.00%	100.00%
Devils Lake - Odd Fellows Home BCF	88.89%	86.36%
Fargo - Bethany on 42nd SNF	98.23%	85.61%
Fargo – Bethany on University SNF	82.56	85.66
Fargo – Eventide Fargo AL	98.61%	80.00%
Fargo - Pioneer House Assisted Living for Seniors AL	100.00%	82.76%
Fargo – Villa Maria SNF	84.62%	80.11%
Grafton - Leisure Estates AL	100.00%	100.00%
Hankinson - St. Gerards Community of Care SNF	96.30%	91.89%
Hatton - Prairie Village AL	100.00%	100.00%
Hillsboro - Sanford Health Comstock Corner AL	100.00%	100.00%
LaMoure - Rosewood Court AL	100.00%	100.00%
McClusky	81.82%	91.67%
Northwood - LTC Northwood Deaconess AL	100.00%	100.00%
Oakes - Good Samaritan Society Royal Oakes AL	100.00%	100.00%
Rolla - Park View AL	100.00%	100.00%
Rugby - Haaland Estates AL	89.29%	100.00%
Rugby - Haaland Estates BCF	97.06%	84.62%
Valley City - Hi Soaring Eagle Ranch BCF	100.00%	88.89%
Wahpeton - Siena Court AL	100.00%	80.00%
West Fargo - Eventide at Sheyenne Crossings BCF	86.67%	80.00%
West Fargo - Sheyenne Crossings Care Center TCU SNF	98.41%	87.41%
Williston - Arbor House AL	100.00%	94.12%

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: QSO-20-39-NH

REVISED 03/10/2021

DATE: **September 17, 2020**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Nursing Home Visitation - COVID-19 *(REVISED)*

Memorandum Summary

- CMS is committed to continuing to take critical steps to ensure America's healthcare facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- **Visitation Guidance:** CMS is issuing new guidance for visitation in nursing homes during the COVID-19 PHE, *including the impact of COVID-19 vaccination.*

Background

Nursing homes have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality.[1] The vulnerable nature of the nursing home population combined with the inherent risks of congregate living in a healthcare setting have required aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes.

In March 2020, CMS issued memorandum QSO-20-14-NH providing guidance to facilities on restricting visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In May 2020, CMS released Nursing Home Reopening Recommendations, which provided additional guidance on visitation for nursing homes as their states and local communities progress through the phases of reopening. In June 2020, CMS also released a Frequently Asked Questions document on visitation, which expanded on previously issued guidance on topics such as outdoor visits, compassionate care situations, and communal activities.

While CMS guidance has focused on protecting nursing home residents from COVID-19, we recognize that physical separation from family and other loved ones has taken a physical and emotional toll on residents and their loved ones. Residents may feel socially isolated, leading to

[1] Information on outbreaks and deaths in nursing homes may be found at https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg.

increased risk for depression, anxiety, and other expressions of distress. Residents living with cognitive impairment or other disabilities may find visitor restrictions and other ongoing changes related to COVID-19 confusing or upsetting. CMS understands that nursing home residents derive value from the physical, emotional, and spiritual support they receive through visitation from family and friends. In light of this, CMS is revising the guidance regarding visitation in nursing homes during the COVID-19 PHE. The information contained in this memorandum supersedes and replaces previously issued guidance and recommendations regarding visitation.

Since the release of QSO memorandum 20-39-NH on September 17, 2020, COVID-19 vaccines have received Emergency Use Authorization from the Food and Drug Administration. Millions of vaccinations have since been administered to nursing home residents and staff, and these vaccines have been shown to help prevent symptomatic SARS-CoV-2 infection (i.e., COVID-19). ***Therefore, CMS, in conjunction with the Centers for Disease Control and Prevention (CDC), is updating its visitation guidance accordingly, but emphasizing the importance of maintaining infection prevention practices, given the continued risk of COVID-19 transmission.***

Guidance

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission:

Core Principles of COVID-19 Infection Prevention

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions *about and* observations *of* signs or symptoms), and denial of entry of those with signs or symptoms *or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status)*
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose)
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper 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 areas, hand hygiene)
- Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO-20- 38-NH)

These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for nursing homes, and should be **adhered to at all times**. Additionally, visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear Plexiglass dividers, curtains). Also, nursing homes should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the

core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance.

Outdoor Visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred *even when the resident and visitor are fully vaccinated* against COVID-19*. Outdoor visits *generally* pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status) may hinder outdoor visits. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, all appropriate infection control and prevention practices should be adhered to.

**Fully vaccinated refers to a person who is ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons.*

Indoor Visitation

Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times). These scenarios include limiting indoor visitation for:

- *Unvaccinated residents, if the nursing home's COVID-19 county positivity rate is >10% **and** <70% of residents in the facility are fully vaccinated;*[2]
- *Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; or*
- *Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.*

Facilities should consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors. During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room, if possible. 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.

Note: CMS and CDC continue to recommend facilities, residents, and families adhere to the core

[2] The county positivity rate refers to the color-coded positivity classification, which *can be found on the COVID-19 Nursing Home Data site.*

principles of COVID-19 infection, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated. However, we acknowledge the toll that separation and isolation has taken. We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility.

Indoor Visitation during an Outbreak

An outbreak exists when a new nursing home onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). This guidance is intended to describe how visitation can still occur when there is an outbreak, but there is evidence that the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility. To swiftly detect cases, we remind facilities to adhere to CMS regulations and guidance for COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:

- *If the first round of outbreak testing reveals **no additional COVID-19 cases in other areas (e.g., units) of the facility**, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing.[3]*
    - *For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.*
- *If the first round of outbreak testing **reveals one or more additional COVID-19 cases in other areas/units of the facility** (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.*

*While the above scenarios describe how visitation can continue after one round of outbreak testing, facilities should continue all necessary rounds of outbreak testing. In other words, this guidance provides information on how visitation can occur during an outbreak, but does not change any expectations for testing and adherence to infection prevention and control practices. If subsequent rounds of outbreak testing identify **one or more additional COVID-19 cases in other areas/units of the facility**, then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.*

NOTE: In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.

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[3] *Outbreak testing is discontinued when testing identifies no new cases of COVID-19 infection among staff or residents for at least 14 days since the most recent positive result. For more information see CMS Memorandum QSO-20-38-NH.*

*We note that compassionate care visits and visits required under federal disability rights law should be **allowed at all times**, for any resident (vaccinated or unvaccinated) regardless of the above scenarios. Lastly, facilities should continue to consult with their state or local health departments when an outbreak is identified to ensure adherence to infection control precautions, and for recommendations to reduce the risk of COVID-19 transmission.*

Visitor Testing *and Vaccination*

While not required, we encourage facilities in medium- or high-positivity counties to offer testing to visitors, if feasible. If so, facilities should prioritize 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). *Similarly, we encourage visitors to become vaccinated when they have the opportunity. While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation. This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems, as described below.*

Compassionate Care Visits

While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care situations" 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 a visit in these situations would be consistent with the intent of, "compassionate care situations." Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident's needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. *Compassionate care visits, and visits required under federal disability rights law, should be allowed at all times, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak.*

Lastly, visits should be conducted using social distancing; however, if during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following appropriate infection prevention guidelines, and for a limited amount of time. *Also, as noted above, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility.* Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits.

Required Visitation

Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f) (4) (v). A nursing home **must** facilitate in-person visitation consistent with the applicable CMS 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), and the facility would be subject to citation and enforcement actions.

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.

Access to the Long-Term Care Ombudsman

As stated in previous CMS guidance QSO-20-28-NH (revised), regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid- certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. During this PHE, in-person access may be limited due to infection control concerns and/or transmission of COVID-19, *such as the scenarios stated above for limiting indoor visitation*; however, in-person access may not be limited without reasonable cause. We note that representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If in-person access is deemed inadvisable (e.g., the Ombudsman has 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 Section 483.10(f)(4)(i)(E) and (F) requires the facility to 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). P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to "investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe the incidents occurred." 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes "the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person." 42 CFR § 51.42(c); 45 CFR § 1326.27.

Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).

For example, if a resident requires assistance to ensure effective communication (e.g., a qualified

interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention. *Any questions about or issues related to enforcement or oversight of the non-CMS requirements and citations referenced above under this section subject heading should be referred to the HHS Office for Civil Rights, the Administration for Community Living, or other appropriate oversight agency.*

Entry of Healthcare Workers and Other Providers of Services

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 showing signs or symptoms of COVID-19 after being screened. We note that EMS personnel do not need to be screened, so they can attend to an emergency without delay. We remind facilities that all 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 COVID-19 testing requirements.

We understand that some states or facilities have designated categories of visitors, such as "essential caregivers," based on their visit history or resident designation. CMS does not distinguish between these types of visitors and other visitors. Using a person-centered approach when applying this guidance should cover all types of visitors, including those who have been categorized as "essential caregivers."

Communal Activities and Dining

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Residents may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). Facilities should consider additional limitations based on status of COVID-19 infections in the facility. Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering (except while eating). Facilities may be able to offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.

Survey Considerations

Federal and state surveyors are not required to be vaccinated and must be permitted entry into facilities unless they exhibit signs or symptoms of COVID-19. Surveyors should also adhere to the core principles of COVID-19 infection prevention, and adhere to any COVID-19 infection prevention requirements set by state law.

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance at 42

CFR § 483.10(b), F550.

- For concerns related to a facility limiting visitors without a reasonable clinical and safety cause, surveyors should investigate for non-compliance at 42 CFR § 483.10(f)(4), F563.
- For concerns related to ombudsman access to the resident and the resident's medical record, surveyors should investigate for non-compliance at 42 CFR §§ 483.10(f)(4)(i)(C), F562 and 483.10(h)(3)(ii), F583.
- For concerns related to lack of adherence to infection control practices, surveyors should investigate for non-compliance at 42 CFR § 483.80(a), F880.

Contact: Questions related to this memorandum may be submitted to: DNH_TriageTeam@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers, and the State/CMS Locations within 30 days of this memorandum.

/s/
David R. Wright

cc: Survey Operations Group

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Mom's vaccinated:

WHEN CAN I VISIT HER NURSING HOME?

It is so great that your mom, dad or other loved ones have received their COVID-19 vaccine. This is an important step towards protecting their health, achieving herd immunity and returning to normal life.

Both CMS and CDC recognize the importance of visiting your relatives as part of staying healthy. You can now visit your loved ones inside when the positivity rate in your nursing home's county is less than 10%. In addition, if the positivity rate in your nursing home's county is more than 10%, and less than 70% of residents in the facility are fully vaccinated, then only residents who are fully vaccinated should receive visitors.

In the case of an outbreak at a facility, indoor visitation is still possible, as long as COVID-19 transmission is contained to a single area of the facility.

If your loved one is fully vaccinated, they can choose to have close contact (including touch) with you as long as they are wearing a well-fitting face mask.

Outdoor visits are also safer when weather is good. You can check with your nursing home or local health department to find out more information on visiting your loved one. More information on CMS' visitation guidance can be found **here**, including compassionate care visits and visitor vaccination.

We are constantly weighing the risks of spreading COVID-19 with the risks of expanding visitation. There are a few more steps before nursing homes can allow even more visitors.

Some nursing home residents and staff are not vaccinated or haven't received their second doses. **So, not everyone in a nursing home is protected from COVID-19 yet and could be infected by visitors.**

Also, **although a vaccinated person may not "feel" sick from COVID-19, they could be infected and/or spread the virus to others**. For example, if a vaccinated resident contracts the virus from a staff member or visitor, that resident will likely be protected from the disease, but could put an unvaccinated resident or staff member at serious risk.

For now, nursing home staff, patients, residents, and visitors need to **continue practicing the 3 W's: Wear a mask, Wash your hands, Watch your distance**. And, nursing homes must continue to implement all current CDC **infection control guidance** and adhere to CMS' regulations and guidance for **testing**. **As vaccination increases and COVID-19 cases decrease, we look forward to more visitation and social interaction among residents, friends, family, and loved-ones.** We will continue to learn and make updates to visitation over the coming months.

So what can you do in the meantime? Get the vaccine when it's available to you. And do what you can to slow the spread of COVID-19. If you are vaccinated, then if asked, explain why you chose to be vaccinated.

The sooner we have more people vaccinated and fewer people getting sick, the sooner we can visit and hug the nursing home residents we love.

FOR MORE INFORMATION, VISIT:

https://www.cdc.gov/vaccines/covid-19/toolkits/long-term-care/downloads/answering-residents-loved-ones-questions.pdf

March 2021

COVID-19 Guidance for Shared or Congregate Housing

Updated Dec. 31, 2020 Print

The following guidance was created to help owners, administrators, or operators of shared (also called "congregate") housing facilities – working together with residents, staff, and public health officials – prevent the spread of COVID-19.

For this guidance, shared housing includes a broad range of settings, such as apartments, condominiums, student or faculty housing, national and state park staff housing, transitional housing, and domestic violence and abuse shelters. Special considerations exist for the prevention of COVID-19 in shared housing situations, and some of the following guidance might not apply to your specific shared housing situation.

People living and working in this type of housing may have challenges with social distancing to prevent the spread of COVID-19. Shared housing residents often gather together closely for social, leisure, and recreational activities, shared dining, and/or use of shared equipment, such as kitchen appliances, laundry facilities, stairwells, and elevators.

Be sure to consider the unique needs of your residents, such as people with disabilities, cognitive decline, or no access to technology. This guidance does not address infection prevention and control in healthcare settings. If your facility offers healthcare services, please consult CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

There may also be specific guidance for certain types of shared housing, such as homeless shelters, that may apply to your facility.

State, territorial, local, and tribal public health departments can give you specific information on COVID-19 transmission and policies in your community, which can help you decide when and if you need to scale up or loosen prevention measures.

Plan and prepare

Review, update, and implement emergency operations plans (EOPs)

Some shared housing facilities have already experienced an outbreak of COVID-19, others have a handful of cases, and others have not yet had infection introduced. Regardless of the status of a facility, the most important thing is for all facilities to plan **and prepare**. No matter the level of transmission in a community, every shared housing facility should have a plan in place to protect residents, workers, volunteers, and visitors from the spread of COVID-19. This should be done in collaboration with state and local public health departments, housing authorities, local or state regulatory agencies, and other relevant partners. Focus should be on components, or annexes, of already-existing plans that address infectious disease outbreaks. If your shared housing facility does not have an emergency operations plans (EOP), now is the time to develop one.

Reference key resources while developing, reviewing, updating, and implementing the EOP

- Multiple federal agencies have developed resources on emergency preparedness, which may be helpful for administrators of shared housing facilities.
  - The National Multifamily Housing Council (NHMC) provides guidance on emergency preparedness and response resources for the apartment industry. HUD also provides guidance for public health disaster readiness and preparation .

- CDC has specific consideration for people with disabilities as they may be at higher risk of getting COVID-19 or having severe illness.
- Additionally, FEMA's Planning Considerations for Organizations in Reconstituting Operations During the COVID-19 Pandemic outlines key considerations for planning to resume operations while protecting the well-being and safety of employees and communities.

Planning strategies to include:

- Informing residents, workers, volunteers, and visitors about COVID-19. Develop information-sharing systems that are tailored to the needs of your setting. For instance, administrators can support residents who have no or limited access to the internet by delivering print materials to their residents. Printable materials for community-based settings are available on the CDC website.
- Promoting healthy behaviors that reduce spread, maintaining healthy environments and operations, and knowing what to do if someone gets sick.
- Taking action to prevent or slow the spread of COVID-19. This includes limiting the number of non-essential visitors to workers, volunteers, and visitors who are essential to preserving the health, including the mental health, well-being, and safety of residents.
- Consider identifying residents who have unique medical needs and behavioral health needs and encourage them to develop a plan for if they or their primary caregiver(s) become ill.

To maintain safe operations

- Review the CDC guidance for businesses and employers to identify strategies to maintain operations and a healthy working and living environment.
- Develop flexible sick leave policies. Require staff to stay home when sick, even without documentation from doctors. Use flexibility, when possible, to allow staff to stay home to care for sick family or household members or to care for children in the event of school or childcare dismissals. Make sure that employees are aware of and understand these policies.
- Create plans to protect the staff and residents from spread of COVID-19 and help them put in place personal preventive measures.
- Clean and disinfect shared areas (such as exercise room, laundry facilities, shared bathrooms, and elevators) and frequently touched surfaces using products from EPA's List N: Disinfectants for Coronavirus (COVID-19) more than once a day if possible.
- Identify services and activities (such as meal programs, religious services, and exercise rooms and programs) that might need to be limited or temporarily discontinued. Consider alternative solutions (e.g., virtual services) that will help programs continue while being safe for residents.
- Identify a list of healthcare facilities and alternative care sites where residents with COVID-19 can receive appropriate care, if needed.

Encourage staff and residents to prepare and take action to protect themselves and others

- Follow the guidance and directives on community gatherings from your state and local health departments.
- Encourage social distancing by asking staff and residents to stay at least 6 feet (2 meters) apart from others and wear masks in any shared spaces, including spaces restricted to staff only.
- Consider any special needs or accommodations for those who need to take extra precautions, such as older adults, people with disabilities, and people of any age who have serious underlying medical conditions.
- Limit staff entering residents' rooms or living quarters unless it is necessary. Use virtual communications and check ins (phone or video chat), as appropriate.
- Limit the presence of non-essential volunteers and visitors in shared areas, when possible.
- Use physical barriers, such as sneeze guards, or extra tables or chairs, to protect front desk/check-in staff who will have interactions with residents, visitors, and the public.
- Provide COVID-19 prevention supplies for staff and residents in common areas at your facility, such as soap, alcohol-based hand sanitizers that contain at least 60% alcohol, tissues, trash baskets, and, if possible, masks that are washed or

discarded after each use.

- Consider any special communications and assistance needs of your staff and residents, including persons with disabilities.
- Suggest that residents keep up-to-date lists of medical conditions and medications, and periodically check to ensure they have a sufficient supply of their prescription and over-the-counter medications.
- If possible, help residents understand they can contact their healthcare provider to ask about getting extra necessary medications to have on hand for a longer period of time, or to consider using a mail-order option for medications.
- Make sure that residents are aware of serious symptoms of their underlying conditions and of COVID-19 symptoms that require emergency care, and that they know who to ask for help and call 911.
- Encourage residents who live alone to seek out a "buddy" in the facility who will check on and help care for them and safely make sure they are getting basic necessities, including food and household essentials.

Note: Surgical masks and N-95 respirators are critical supplies that must continue to be reserved for healthcare workers and other medical first responders, as recommended by current CDC guidance. All staff and residents should wear a mask covering when in shared areas of the facility and maintain social distancing to slow the spread of the virus.

Communicate to staff and residents

Identify platforms such as email, websites, hotlines, automated text messaging, newsletters, and flyers to help communicate information on:

- Guidance and directives from state and local officials and state and local health departments.
- How your facility is helping to prevent the spread of COVID-19.
- How additional information will be shared, and where to direct questions.
- How to stay healthy, including videos, fact sheets, and posters with information on COVID-19 symptoms and how to stop the spread of germs, how to wash your hands, and what to do if you are sick.
- How staff and residents can cope and manage stress and protect others from stigma and discrimination.
- Identify and address potential language, cultural, and disability barriers associated with communicating COVID-19 information. Communications may need to be framed or adapted so they are culturally appropriate for your audience and easy to understand. For example, there are resources on the CDC website that are in many languages.

Considerations for common spaces in your facility, to prevent the spread of COVID-19

- Consider how you can use multiple strategies to maintain social (physical) distance between everyone in common spaces of the facility.
- Consider cancelling all public or non-essential group activities and events.
- Offer alternative methods for activities and social interaction such as participation by phone, online, or through recorded sessions.
- Arrange seating of chairs and tables to be least 6 feet (2 meters) apart during shared meals or other events.
- Alter schedules to reduce mixing and close contact, such as staggering meal and activity times and forming small groups that regularly participate at the same times and do not mix.
- Minimize traffic in enclosed spaces, such as elevators and stairwells. Consider limiting the number of individuals in an elevator at one time and designating one directional stairwells, if possible.
- Ensure that social distancing can be maintained in shared rooms, such as television, game, or exercise rooms.
- Make sure that shared rooms in the facility have good air flow from an air conditioner or an opened window.
- Consider working with building maintenance staff to determine if the building ventilation system can be modified to increase ventilation rates or the percentage of outdoor air that circulates into the system.
- Clean and disinfect shared areas (laundry facilities, elevators, shared kitchens, exercise rooms, dining rooms) and frequently touched surfaces using products from EPA's List N: Disinfectants for Coronavirus (COVID-19) more than once a day if possible.

Considerations for specific communal rooms in your facility

Shared kitchens and dining rooms

- Restrict the number of people allowed in the kitchen and dining room at one time so that everyone can stay at least 6 feet (2 meters) apart from one another.
  - People who are sick, their roommates, and those who have higher risk of severe illness from COVID-19 should eat or be fed in their room, if possible.
- Do not share dishes, drinking glasses, cups, or eating utensils. Non-disposable food service items used should be handled with gloves and washed with dish soap and hot water or in a dishwasher. Wash hands after handling used food service items.
- Use gloves when removing garbage bags and handling and disposing of trash. Wash hands

Laundry rooms

- Maintain access and adequate supplies to laundry facilities to help prevent spread of COVID-19.
- Restrict the number of people allowed in laundry rooms at one time to ensure everyone can stay at least 6 feet (2 meters) apart.
- Provide disposable gloves, soap for washing hands, and household cleaners and products from EPA's List N: Disinfectants for Coronavirus (COVID-19) for residents and staff to clean and disinfect buttons, knobs, and handles of laundry machines, laundry baskets, and shared laundry items.
- Post guidelines for doing laundry such as washing instructions and handling of dirty laundry.

Recreational areas such as activity rooms and exercise rooms

- Consider closing activity rooms or restricting the number of people allowed in at one time to ensure everyone can stay at least 6 feet (2 meters) apart.
- Consider closing exercise rooms.
- Activities and sports (e.g., ping pong, basketball, chess) that require close contact are not recommended.

Pools and hot tubs

- Consider closing pools and hot tubs or limiting access to pools for essential activities only, such as water therapy.
  - While proper operation, maintenance, and disinfection (with chlorine or bromine) should kill COVID-19 in pools and hot tubs, they may become crowded and could easily exceed recommended guidance for gatherings. It can also be challenging to keep surfaces clean and disinfected.
  - Considerations for shared spaces (maintaining physical distance and cleaning and disinfecting surfaces) should be addressed for the pool and hot tub area and in locker rooms if they remain open.

Shared bathrooms

- Shared bathrooms should be cleaned regularly using products from EPA's List N: Disinfectants for Coronavirus (COVID-19) , at least twice per day (e.g., in the morning and evening or after times of heavy use).
- Make sure bathrooms are continuously stocked with soap and paper towels or automated hand dryers. Hand sanitizer could also be made available.
- Make sure trash cans are emptied regularly.
- Provide information on how to wash hands properly. Hang signs in bathrooms.
- Residents should be instructed that sinks could be an infection source and should avoid placing toothbrushes directly on counter surfaces. Totes could also be used for personal items to limit their contact with other surfaces in the bathroom.

If a resident in your facility has COVID-19 (suspected or confirmed)

- Have the resident seek advice by telephone from a healthcare provider to determine whether medical evaluation is needed.

- Residents are not required to notify administrators if they think they may or have a confirmed case of COVID-19. If you do receive information that someone in your facility has COVID-19, you should work with the local health department to notify anyone in the building who may have been exposed (had close contact with the sick person) while maintaining the confidentiality of the sick person as required by the Americans with Disabilities Act (ADA) and, if applicable, the Health Insurance Portability and Accountability Act (HIPAA).

- Provide the ill person with information on how to care for themselves and when to seek medical attention.
- Encourage residents with COVID-19 symptoms and their roommates and close contacts to self-isolate – limit their use of shared spaces as much as possible.

- - If possible, designate a separate bathroom for residents with COVID-19 symptoms.
  - Consider reducing cleaning frequency in bedrooms and bathrooms dedicated to persons with COVID-19 symptoms to as-needed cleaning (e.g., soiled items and surfaces) to avoid unnecessary contact with the ill persons.
  - Follow guidance on when to stop isolation.

- Minimize the number of staff members who have face-to-face interactions with residents who have suspected or confirmed COVID-19.
- Encourage staff, other residents, caregivers such as outreach workers, and others who visit persons with COVID-19 symptoms to follow recommended precautions to prevent the spread.
- Staff at higher risk of severe illness from COVID-19 should not have close contact with residents who have suspected or confirmed COVID-19, if possible.
- Those who have been in close contact (i.e., less than 6 feet (2 meters) with a resident who has confirmed or suspected COVID-19 should monitor their health and call their healthcare provider if they develop symptoms suggestive of COVID-19.
- Be prepared for the potential need to transport persons with suspected or confirmed COVID-19 for testing or non-urgent medical care. Avoid using public transportation, ride-sharing, or taxis. Follow guidelines for cleaning and disinfecting any transport vehicles.

Accepting new residents at facilities that offer support services

First, review and follow the guidance and directives from your state and local officials.

If your situation is not restricted by their guidance and directives, then consider the following guidance:

- - At check-in, provide any new or potential resident with a clean mask and keep them isolated from others. Shelters can use this tool to screen for symptoms at entry.
  - Medical evaluation may be necessary depending on the symptoms.

- If your facility is full, your facility space is inadequate to maintain physical distancing (such as is recommended in the guidance for homeless shelters), or you do not have the resources (staff, prevention supplies) to accept additional residents, reach out to community- or faith-based organizations to help meet individuals' needs, including:
  - A safe place to stay
  - Ability to obtain basic necessities, such as food, personal hygiene products, and medicine
  - Access to any needed medical or behavioral health services
  - Access to a phone or a device with internet access to seek out resources and virtual services and support

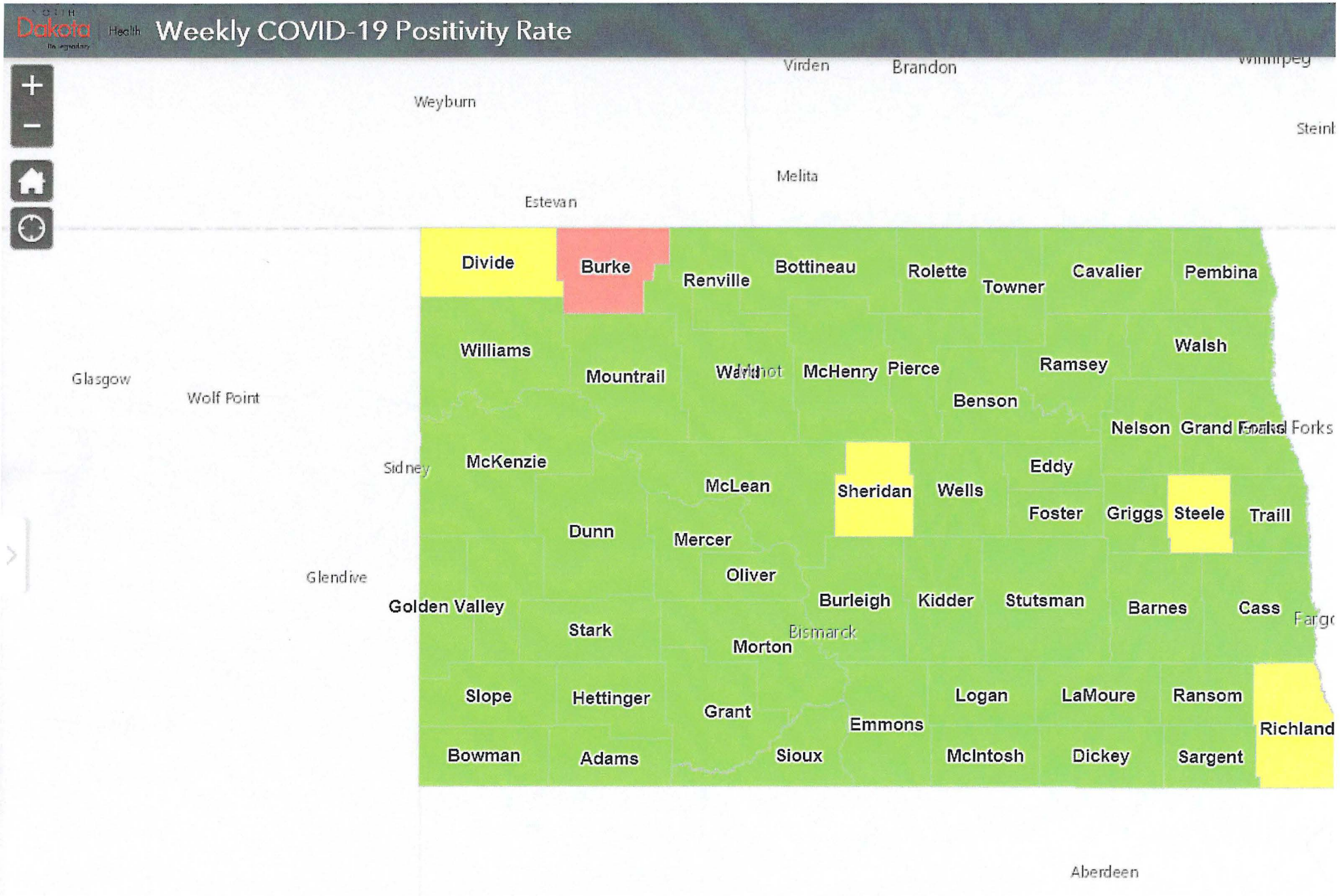
Additional CDC resources to help prevent spread of COVID-19 in shared or congregate housing settings

More detailed guidance is available for specific types of facilities. Some of the information in these guidance documents is applicable to that specific type of facility only, and some of the information would be applicable to other congregate housing facilities.

- Assisted living facilities

- Retirement communities and independent living
- Homeless shelters
- Community- and faith-based organizations
- Colleges and universities
- Households with suspected or confirmed COVID

Last Updated Dec. 31, 2020


North Dakota Health
Weekly COVID-19 Positivity Rate
Virden
Brandon
Weyburn
Melita
Estevan
Divide
Burke
Renville
Bottineau
Rolette
Towner
Cavalier
Pembina
Williams
Mountrail
McHenry
Pierce
Ramsey
Walsh
Benson
Nelson
Grand Forks
Glasgow
Wolf Point
Sidney
McKenzie
McLean
Sheridan
Wells
Eddy
Foster
Griggs
Steele
Traill
Dunn
Mercer
Oliver
Glendive
Golden Valley
Burleigh
Kidder
Stutsman
Barnes
Cass
Stark
Bismarck
Morton
Slope
Hettinger
Grant
Emmons
Logan
LaMoure
Ransom
Richland
Bowman
Adams
Sioux
McIntosh
Dickey
Sargent
Aberdeen

North Dakota Long Term Care Association
Assisted Living, Basic Care, Nursing Facility Death Data

	2017	2018	2019	2020
January	192	247	224	241
February	195	203	174	219
March	197	191	183	242
April	185	179	217	230
May	183	176	200	201
June	184	158	180	160
July	150	147	164	158
August	169	140	186	152
September	168	172	203	215
October	219	200	195	306
November	191	188	205	348
December	193	211	201	230
	2226	2212	2332	2702

Please Note:

1. 2017, 2018, 2019 Death Data from Vital Records/DOH.
2. 2020 Data based on survey of assisted living, basic care and nursing facilities.
3. The data for 2020 is preliminary and not complete. Data for 2020 will not be final until reported by Vital Records in July 2021.
4. This data only includes residents who died in long term care facilities. It does not include residents that died in a hospital.
5. 20 assisted living, 13 basic care and 1 nursing facility did not report 2020 deaths for January - October.
6. 30 assisted living, 23 basic care and 11 nursing facilities did not report November and December 2020 Deaths.
7. In 2020 there are approximately 700 fewer residents in long term care than in 2019.
8. Cause of death is not tracked in this survey, in 2020 this data reflects all deaths not just COVID-19.

North Dakota Long Term Care Association

updated 02-11-2021