Testimony on SB 2145
Senate Human Services Committee
January 18, 2021

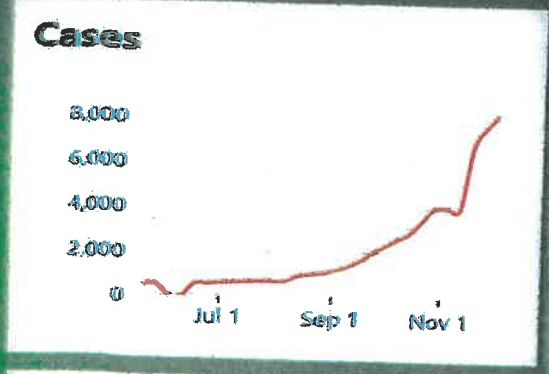
Good morning Chairman Lee and members of the Senate Human Services Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We represent 211 assisted living, basic care, and skilled nursing facilities in North Dakota. I am here to testify in support of the legislation before you.

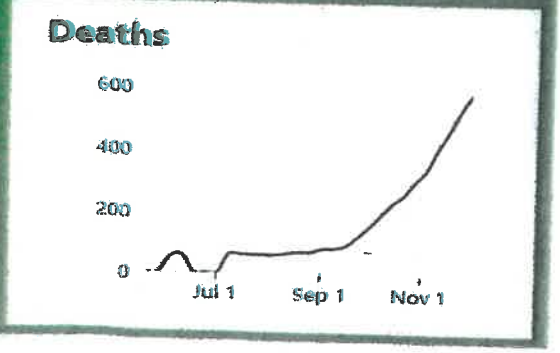
The global outbreak of COVID-19 has been traumatic unlike anything any of us have probably ever experienced. Now in the tenth month of the COVID-19 pandemic, the toll of physically separating residents from family has impacted everyone involved, including the dedicated facility staff members who are doing everything in their power to provide the best possible care in an extremely difficult situation.

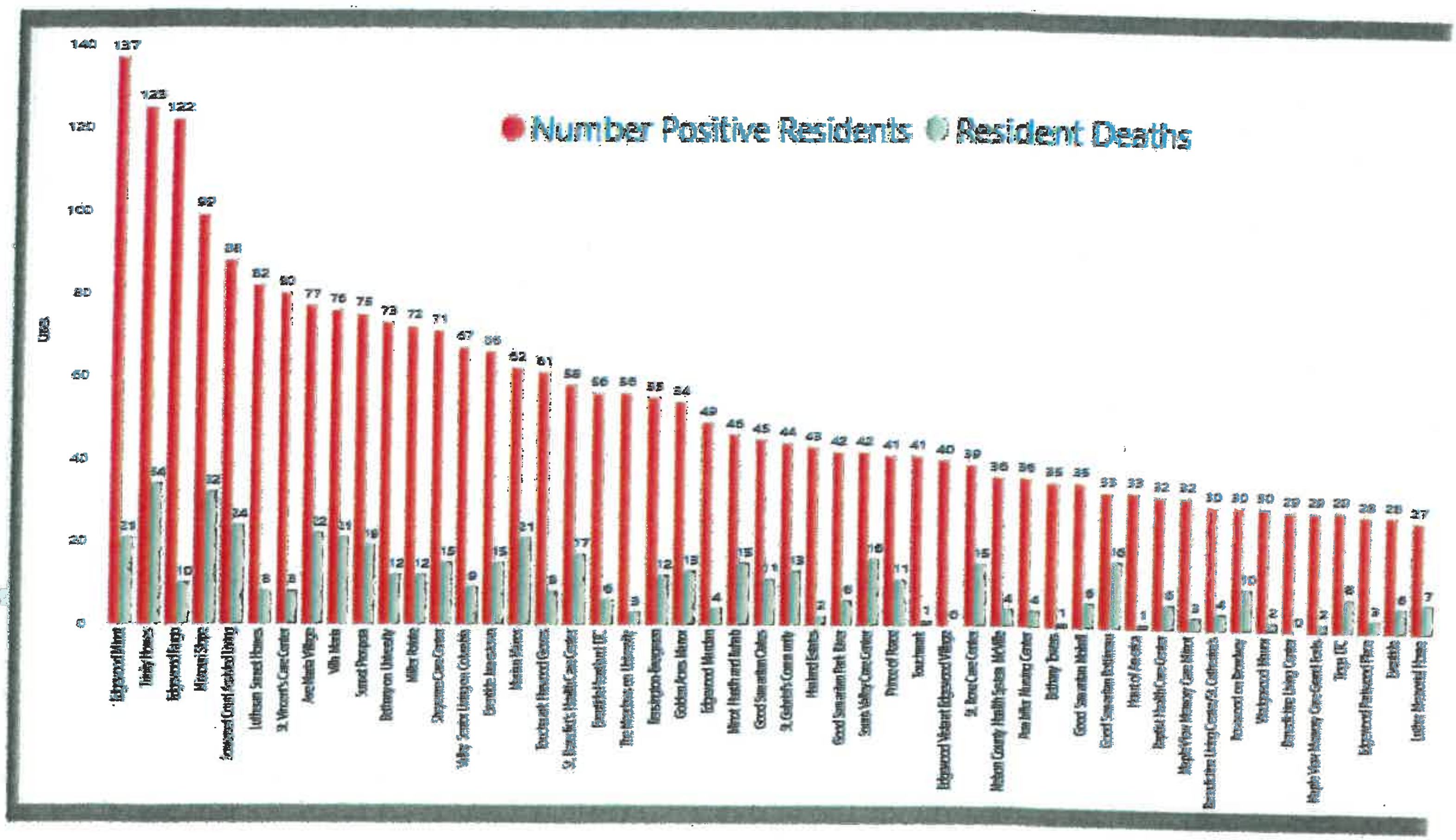
Long term care facilities have emerged as hotspots for COVID-19 outbreaks. In the United States nursing homes, residents and staff represent 8% of COVID-19 cases yet bear 41% of COVID-19 deaths based on data reported in August 2020. In North Dakota in December 2020, the total long term care cases represented 10% of all the cases, sadly 60% of all deaths.

ND LTC Cases and Deaths through 12/8/20

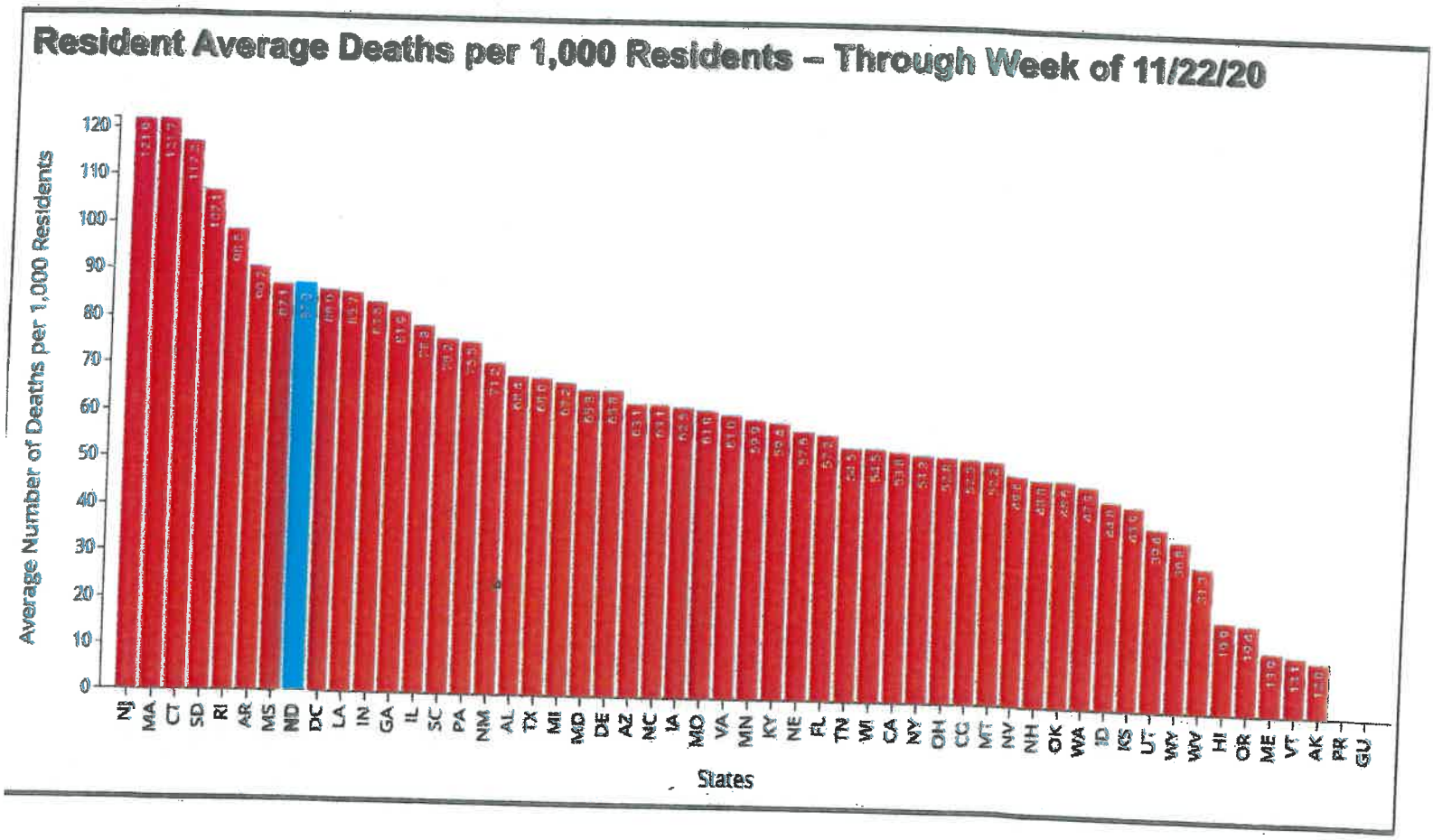
Cases and Deaths	Number (%)
Total Cases in ND	83,324
Total Cases in LTC (%)	8,471 (10%)
Staff	4,692
Residents	3,779
Total Deaths in ND	1,022
Total Deaths in LTC	613 (60%)







Number Positive Residents
Resident Deaths
140
120
100
80
60
40
20
0
Trinity Homes
Edgewood Fargo
Missouri Slope
Lutheran Sunset Home
St. Vincent's Care Center
Ave Maria Village
Villa Maria
Sunset Prospera
Bethany on University
Miller Pointe
Cheyenne Care Center
Valley Senior Living on Columbia
Marian Manor
Touchmark
St. Rose Care Center
Bethany Towers
Heart of America
Wedgewood Manor
Trinity LTC
Luther Memorial Home


Resident Average Deaths per 1,000 Residents – Through Week of 11/22/20
Average Number of Deaths per 1,000 Residents
120
110
100
90
80
70
60
50
40
30
20
10
0
NJ
MA
CT
SD
RI
AR
MS
MD
DC
LA
IN
GA
IL
SC
PA
NM
AL
TX
MI
MD
DE
AZ
NC
IA
MO
VA
MN
KY
NE
FL
TN
WI
CA
NY
OH
CO
MT
NV
NH
OK
WA
ID
KS
UT
WY
WV
HI
OR
ME
VT
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States

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	n/a
December	193	211	201	n/a
	2226	2212	2332	2124 YearToDate

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. 20 assisted living, 13 basic care and 1 nursing facility did not report 2020 deaths.
4. The data for 2020 is preliminary and not complete. Data for 2020 will not be final until reported by Vital Records in July 2021
5. This data only includes residents who died in long term care facilities. It does not include residents that died in a hospital. A large number of COVID deaths to long term care residents occur in a hospital.
6. In 2020 there are approximately 700 fewer residents in long term care than in 2019.
7. 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 11-30-2020

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. In March, prior to the declaration of the public health emergency, 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 have dictated what we should and must be doing during this pandemic. And 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 over 800 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. It has been tremendously difficult to lose each resident.

Residents do not want to die. Statewide we are experiencing high percentages of residents being vaccinated. 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.

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. I recall not so long ago, in one single day reported on the Health Department website we had 1,630 residents and staff with COVID-19. That was just two months ago. Today we have 120 residents and staff infected. As a result of those low numbers long term care facilities have been able to open up visitations.

What got us out of those dark days was diligently following every mitigation strategy, including very little visitation. During that time, we still took every step possible to electronically connect families and residents. But electronic connection, as outlined in the Coronavirus Committee for Safety and Quality in Nursing Homes final report, has limitations: "Virtual visitation often provides an insufficient substitute to address resident needs. The gap between in-person and virtual visitation is even more acute when combined with limitations due to differing physical and cognitive abilities; resident, family, and/or staff unfamiliarity with proper equipment use and functionality and equipment and internet availability."

In North Dakota with 60% of long term care facilities reporting, we recorded 1300 virtual visits in one week. Some families even reported better communication and connection with their loved ones. 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 mother's hug.

Long term care facilities look forward to seeing the reconnecting of families and many have been allowed to open up on a limited basis. But many mitigation strategies are still in place. With our lower numbers and vaccinations occurring we asked the question, when can we see a change in the mitigation strategies including visitation restrictions. The response was that discussion is premature and no changes are envisioned in the near future.

We are supportive of the amendment to provide for family and facility participation in the development of the protocols.

I have attached some of the most recent guidance from the State Health Department and the current guidance from the VP3 Plan. I have not attached the CMS requirements because I did not want to overwhelm you with information.

Our only concern in this legislation is that families might feel with the passage of this legislation that long term care facilities will suddenly be able to open up visitation. This legislation does not take away any of the existing requirements, facilities must still follow the VP3 Plan, the CMS QSO guidance and all recommendations from the Health Department as they are based on CDC guidance.

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

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LONG-TERM CARE GUIDANCE

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Skilled nursing, basic care, and assisted living facilities across North Dakota have faced countless impacts as a direct result of COVID-19. Nonetheless, as community spread has continued to transpire, there has also been a direct parallel with increased cases occurring amongst both healthcare workers and residents whom are residing within these facilities where our states most vulnerable population resides. The following document serves as reopening guidance for North Dakota's skilled nursing, basic care, and assisted living facilities. The skilled nursing facility visitation and service guidance, which can be found below, was developed in alignment with the federal requirements outlined in memo QSO-20-39-NH as mandated by the Centers for Medicare and Medicaid Services. All skilled nursing facilities must comply with the guidelines set forth in QSO-20-39-NH. A slightly modified visitation and service guidance for basic care and assisted living facilities was established by the state (see below) with collaboration and input from key stakeholders, including The Reuniting Families Taskforce, The North Dakota Long-Term Care Association, The North Dakota Department of Health, and The North Dakota Department of Human Services (VP3 taskforce).

Congregate living settings have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality. The vulnerable nature of this 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 ongoing spread of COVID-19 within these settings.

Core Principles of COVID-19 Infection Prevention

The following core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for congregate living settings and should always be adhered to. These core principles reflect best practices that have been shown to effectively reduce the risk of COVID-19 transmission:

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g. temperature checks, questionnaire about signs or symptoms, etc.) and denial of entry of those individuals with any signs or symptoms.
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Clean face covering or mask (covering both the mouth and nose)
- Social distancing of 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 clean 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. partitioned care area with a separate entrance and dedicated staff)
- Resident and staff testing conducted as required via the associated facility testing structure algorithm (see below)

Key Factors to Evaluate

Factors that should be routinely evaluated for skilled nursing, basic care, and assisted living facilities, include:

Case status in the county: Based on weekly COVID-19 county positivity rate (**Red, Yellow, or Green**) on the statewide testing map that is updated weekly on Monday's. Refer to the statewide map for your county's current designation.

Case status in the facility: There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing.

Adequate ability to screen: Implementation of screening protocols for all staff, each resident, and all persons entering the facility, such as vendors, volunteers, and/or visitors.

Universal source control: Visitors and staff will at a minimum wear a clean, cloth face covering or face mask, maintain social distancing, and perform appropriate hand hygiene upon entrance to the facility. Direct care staff should continue to utilize a surgical mask per CDC recommendations. If a visitor or staff is unable or unwilling to maintain these precautions (such as young children), facilities may offer an alternative (i.e. full face shield), otherwise their ability to enter the facility will be restricted. Restrict the amount of visitor and staff movement throughout the facility at a given time to mitigate potential spread of COVID-19 (e.g. eliminating visits in common areas or dining rooms, establishing visitor thresholds, modifying employee break rooms, etc.).

Access to adequate Personal Protective Equipment (PPE): All staff and visitors will wear appropriate PPE when indicated and have facility defined par levels on-hand to appropriately care for COVID-19 residents.

Resident Rights: Basic care and assisted living facilities will also be given the flexibility and discretion to adopt more stringent guidelines if they so choose, but not practice less leniency. **Nonetheless, it is vital that the level of stringency exercised by facilities does not infringe upon a resident's right. For instance, the resident may leave the congregate living setting, while understanding it comes with the inherent risk of enhanced infection control measures upon return, including the potential for isolation.**

Compassionate Care Visits: May occur in all levels of care in accordance with the definition provided by CMS in QSO 20-39-NH.

CONTACTS IF YOU HAVE QUESTIONS

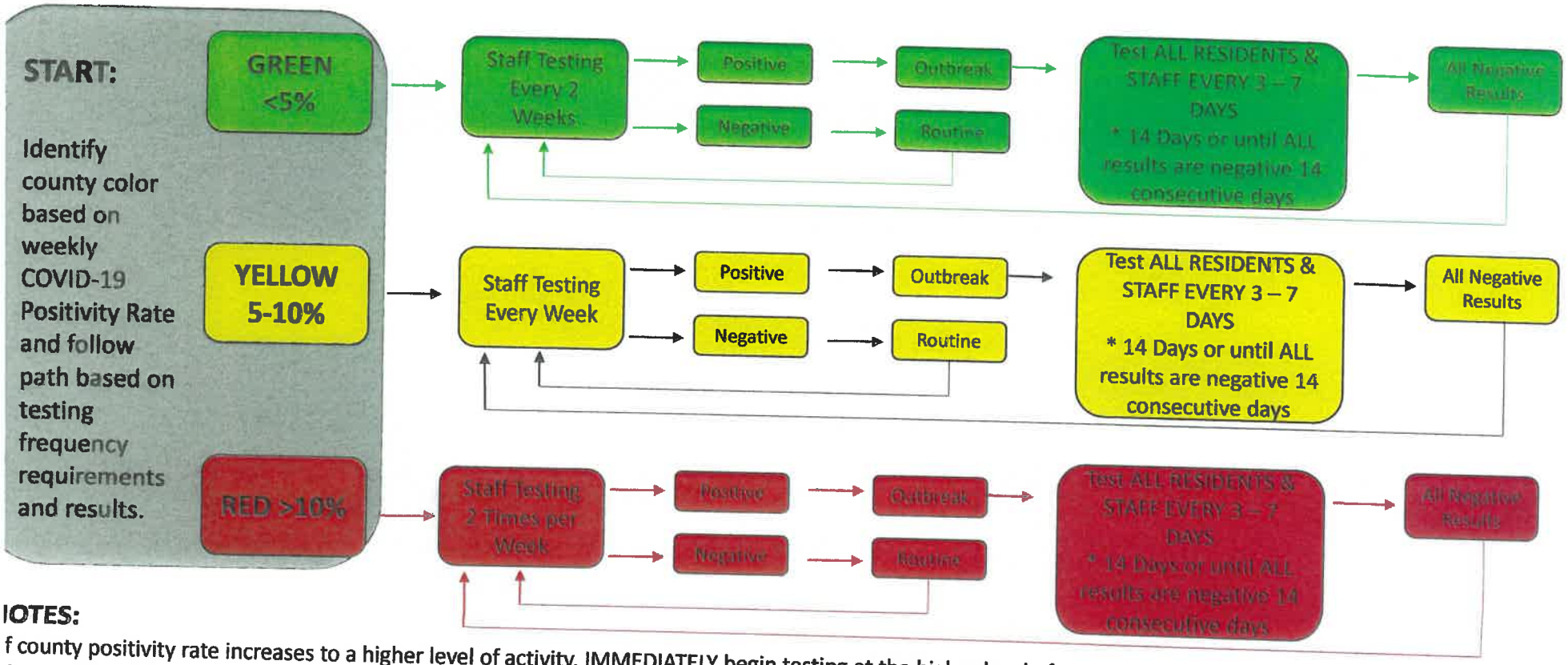
If you have any facility specific questions, please reach out to one of the VP3 State Regional Coordinators during normal business hours at the number or email provided below:

- Rosanne Schmidt – (701) 328-8234 or rosschmidt@nd.gov
- Seth Fisher – (701) 328-8232 or sefisher@nd.gov
- Jan Kamphuis – (701) 328-8239 or jkamphuis@nd.gov

VISITATION & SERVICE GUIDANCE FOR SKILLED NURSING FACILITIES 10-22-2020

STEP 1: IDENTIFY COUNTY WEEKLY COVID POSITIVITY RATE	**STEP 2:** IDENTIFY FACILITY STATUS: ROUTINE OR OUTBREAK	**Indoor/in Room Visitation**	**Outdoor or Safe designated space per weather conditions**	**Communal Dining**	**Activities**	**Resident Screening**	**Entry of Health Care Workers who are non-employees**
GREEN <5%	Routine	* limited and scheduled visit time * 1 -2 persons per resident at a time *limit # of total visitors in facility	Yes	*Tables 6 feet apart * 1 per table or 2 if roommates or close associate outside of mealtimes	Group activities with social distancing, mask wearing, and hand hygiene	* 2x per day * Screening Questions *Temperature and Oxygen Sats	* All staff providing services tested per facility policy * Other Non essential personal follow visitation guidelines
	Outbreak	No indoor visitation	Yes	*If staff positive, dining continues as in routine * If resident positive, no communal dining until return to routine status	*If staff positive, activities as in routine * If positive reisdent, limited group activities with 10 or less residents	* 3x per day * Screening Questions *Temperature and Oxygen Sats	* All staff providing services tested per facility policy * Other Non essential personal follow visitation guidelines
YELLOW 5 - 10%	Routine	* limited and scheduled visit time * 1 -2 persons per resident *limit # of total visitors in facility	Yes	* Tables 6 feet apart * 1 per table or 2 if roommates or close associate outside of mealtimes	Group activities with social distancing, mask wearing, and hand hygiene	* 2x per day * Screening Questions *Temperature and Oxygen Sats	* All staff providing services tested per facility policy * Other Non essential personal follow visitation guidelines
	Outbreak	No indoor visitation	Yes	*If staff positive, dining continues as in routine * If resident positive, no communal dining until return to routine status	*If staff positive, activities as in routine * If positive reisdent, limited group activities with 10 or less residents	* 3x per day * Screening Questions *Temperature and Oxygen Sats	* All staff providing services tested per facility policy * Other Non essential personal follow visitation guidelines
RED >10%	Routine	No indoor visitation	Yes	* Tables 6 feet apart * 1 per table or 2 if roommates or close associate outside of mealtimes	Limited group activities with 10 or less	* 2x per day * Screening Questions *Temperature and Oxygen Sats	* All staff providing services tested per facility policy * Other Non essential personal follow visitation guidelines
	Outbreak	No indoor visitation	Yes	No Communal Dining	Individual resident activities only	* 3x per day * Screening Questions *Temperature and Oxygen Sats	* All staff providing services tested per facility policy * Other Non essential personal follow visitation guidelines

FACILITY TESTING STRUCTURE FOR SKILLED NURSING FACILITIES



IOTES:

f county positivity rate increases to a higher level of activity, IMMEDIATELY begin testing at the higher level of activity

f county positivity rate decreases to a lower level of activity, CONTINUE testing at the previous level of activity until positivity rates remain at the lower level for at ast 2 weeks

TESTING OF SYMPTOMATIC RESIDENTS OR STAFF SHOULD OCCUR AT ANY TIME - if positive results, continue at "Outbreak" and follow required testing frequency

)UTBREAK" ***is defined as any positive HCW or resident in the facility***

VISITATION & SERVICE GUIDANCE FOR BASIC CARE & ASSISTED LIVING FACILITIES

11/5/2020

*** A safe designated space per weather conditions may include one internal location with univeral source control measures and monitoring**

*** Cohorting is defined as keeping all positives in a partioned space with a separate entrance and designated staff**

*** If any positive results, outbreak testing of all residents and staff occurs weekly for 14 days or until no new COVID cases for 14 days**

STEP 1: IDENTIFY COUNTY WEEKLY COVID POSITIVITY RATE	**STEP 2:** IDENTIFY FACILITY STATUS: ROUTINE OR OUTBREAK	**Indoor/In room Visitation**	**Outdoor or Safe designated space per weather conditions**	**Communal Dining**	**Activities**	**Resident Screening**	**Entry of Health Care Workers (non-employees)**
GREEN <5% - Staff testing monthly	Routine	* Limited and scheduled visit times * 1-2 visitors per resident at a time * Limit # of total visitors within facility	Yes	* Tables 6 feet apart * Max of 4 per table	* Group activities with social distancing, mask wearing, and hand hygiene.	* 1x per day * Screening Questions * Temperature and Oxygen Sats	* All staff providing services tested per facility policy. * Other non-essential personal follow visitation guidelines.
	Outbreak	No in room visitation	Yes	* If staff positive, dining continues as in routine. * If resident positive, dining dependent on cohort ability.	* If staff positive, activities as in routine. * If positive resident, limited group activities with 10 or less residents.	* 2x per day * Screening Questions * Temperature and Oxygen Sats	* All staff providing services tested per facility policy. * Other non-essential personal follow visitation guidelines.
YELLOW 5-10% - Staff testing every other week	Routine	* Limited and scheduled visit times * 1 -2 persons per resident at a time * Limit # of total visitors within facility	Yes	* Tables 6 feet apart * 1 per table or 2 if roommates or close associates outside of mealtimes.	* Group activities with social distancing, mask wearing, and hand hygiene.	* 1x per day * Screening Questions * Temperature and Oxygen Sats	* All staff providing services tested per facility policy. * Other non-essential personal follow visitation guidelines
	Outbreak	No in room visitation	Yes	* If staff positive, dining continues as in routine. * If resident positive, dining dependent on cohort ability.	* If staff positive, activities as in routine. * If positive resident, limited group activities with 10 or less residents.	* 2x per day * Screening Questions * Temperature and Oxygen Sats	* All staff providing services tested per facility policy. * Other non-essential personal follow visitation guidelines.
RED >10% - Staff testing weekly	Routine	No in room visitation	Yes	* Tables 6 feet apart * 1 per table or 2 if roommates or close associates outside of mealtimes.	* Limited group activities with 10 or less	* 1x per day * Screening Questions * Temperature and Oxygen Sats	* All staff providing services tested per facility policy. * Other non-essential personal follow visitation guidelines.
	Outbreak	No in room visitation	Yes	No Communal Dining	* Individual resident activities only	* 2x per day * Screening Questions * Temperature and Oxygen Sats	* All staff providing services tested per facility policy. * Other non-essential personal follow visitation guidelines.

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RECOMMENDATIONS TO PREVENT AND RESPOND TO COVID-19 IN LONG TERM CARE, BASIC CARE, & ASSISTED LIVING FACILITIES

Daily prevention measures:

Recommendations to prevent COVID-19 in skilled nursing facilities, basic care, and assisted living facilities include:

- Post visual alerts (e.g., signs, posters) in strategic places (e.g., waiting areas, elevators, cafeterias) to provide instructions about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include wearing a cloth face covering (for visitors) or facemask for source control, and how and when to perform hand hygiene.
- Prepare your facility for a wing or section of rooms away from other residents to be used for new admits and residents that are suspect or confirmed COVID-19 cases.
    - Have a plan in place to provide dedicated staff for these areas.
- All staff should wear face masks. Face masks are preferred over cloth face coverings for all staff because they offer both source control and protection for the wearer against exposure to splashes and sprays of infectious materials from others. Cloth face coverings are not personal protective equipment (PPE).
    - HCP should remove their respirator or facemask and put on a cloth face covering when leaving the facility at the end of their shift (cloth face coverings are recommended for all people when outside the home).
    - If HCP must touch or adjust their facemask or cloth face covering, hand hygiene should be performed immediately before and after touching.
- Review training with staff for isolation protocols, donning and doffing of PPE, hand hygiene, and cough etiquette.
    - Ongoing auditing should be in place for PPE use and hand hygiene with immediate feedback and retraining as needed.
    - Make hand sanitizer and necessary PPE available in areas where resident care is provided. Put a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room, or before providing care to another resident in the same room.
- Screen healthcare personnel (HCP) at beginning of their shift for fever, all symptoms and risk of COVID-19.
    - Actively take their temperature and document symptoms and ask that HCP also regularly monitor themselves for fever and other symptoms.
    - If HCP develop symptoms while at work, they should immediately put on a face mask (if not wearing one under universal masking), inform their supervisor, and leave the workplace.
    - HCP who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.
- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill HCP to stay home. Remind HCP not to report to work when ill.

- Mask donning and doffing training should be provided. Mask use with hand hygiene should be monitored.
    - If mask shortage, HCP can be given 5 masks to use on a daily rotation basis, storing masks in individual paper bags with names on them. Please see NDDoH reuse guidance.
    - If gloves and/or gowns are used with each resident encounter, ensure they are being discarded between residents and hand hygiene is performed after gloves are discarded.
- Follow visitor allowance and service guidance according to the re-opening guidance of your facility.
    - If visitors do come in, screen visitors for fever and all COVID-19 symptoms, or for known exposure to someone with COVID-19 before they enter the facility. If fever or COVID-19 symptoms are present, or there is a known exposure to COVID-19, the visitor should not be allowed entry into the facility.
    - Visitation for compassionate care reasons, such as end-of-life situations, can be permitted in all re-opening Guidance.
        - If visitors are for confirmed COVID-19 or presumptive cases, HCP needs to assist them with donning and doffing full COVID PPE. Do NOT give N95 mask as they are not fit tested.
        - Educate not to touch eyes, adjust mask, etc. with gloved hands.
        - Have hand sanitizer available so HCP can perform HH when assisted doffing is completed. Have visitor complete hand hygiene and don clean mask before exiting through facility.
    - Post signs at the entrances to the facility advising that no visitors may enter the facility without entry screening for fever and symptoms, and visitors should wear a cloth face covering while in the facility. Visitors using their own face coverings should be assessed. Assess for cleanliness and that it is free of rips or tears. Facilities may choose to issue cloth face coverings for all visitors.
- To address asymptomatic and presymptomatic transmission and to help prevent transmission from infected individuals who may or may not have symptoms of COVID-19, cloth face coverings should be considered (if tolerated) and worn for all patients and visitors during duration of time in the facility, regardless of symptoms.
    - Cloth face coverings are not considered PPE because their capability to protect healthcare personnel (HCP) is unknown. **HCP should wear facemasks rather than cloth face coverings.**
    - Visitors
        - Essential visitors could wear their own cloth face covering (see comments above regarding personal face coverings). If not, they should be offered a cloth face covering or facemask (as supplies allow).
        - They should be instructed that if they touch or adjust their face covering, they should perform hand hygiene immediately.
        - Cloth face coverings should not be placed on young children under age 2 or anyone who has trouble breathing.
    - Residents
        - Cloth face coverings should not be placed on anyone who has trouble breathing or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
            - A faceshield may be considered if facemasks are not tolerated by the resident.

        - Residents may remove their cloth face covering when in their rooms but should put them back on when leaving their room or when others (e.g., HCP, visitors) enter the room.
        - Implement a laundering process for the residents' cloth masks.
- Limit residents from leaving the facility for non-medical reasons when a facility is in re-opening phase 1 and/or cases in community.
    - Residents going to the Emergency Room (ER) or Clinic:
        - Residents should wear a mask if tolerated.
        - Assess resident twice a day for 14 days for fever and new onset of symptoms.
        - Consider placing residents on transmission-based precautions if they were in ER or comparable setting for more than 24 hours.
    - Residents leaving the facility for family outings/events should be placed on enhanced precautions and closely monitored for 14 days. If they do not reside in a private room, the curtain should be pulled between residents at all times during the 14 days and roommate should be assessed for signs and symptoms as well.
        - Educate resident and family on the importance of source control.
        - See Holiday Recommendations for Resident Outings
        - Consider testing 5-7 days after outing.
        - If the outing is greater than 24 hours, the resident should be placed in a private room upon return and quarantined for 14 days.
- Limit and monitor entry points to the facility.
- Allow group activities, communal dining, and outside trips in accordance with the re-opening guidance of the facility with appropriate source control practices and county positivity rate guidance.
- Screen residents for symptoms and fever, according to re-opening guidance or as otherwise directed
    - Residents with a temp ≥100.4 F (people 70 or immunocompromised may have fever at 99.6 F) or repeated low-grade temps (>99 F) or symptoms should be placed in a single room, if possible, and placed in isolation precautions using personal protective equipment (PPE) including gown, gloves, and N95 or higher respirator (facemask if respirator is not available) with face shield or goggles for eye protection pending further evaluation. These residents should be tested for COVID-19 if clinically indicated.
        - Dedicate equipment to these residents and disinfect between use.
        - Resident should remain in the single room and HCP should wear the PPE listed above while awaiting COVID-19 test results.
    - Residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
    - Document daily screening results.
- Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas and make sure sinks are well-stocked with soap and paper towels for handwashing.
- Make tissues and face masks available for coughing people. Consider designating staff to steward those supplies and encourage appropriate use by residents and staff.

- Notify the NDDoH at 1-888-391-3430 about any residents with severe respiratory infection or if the facility identifies ≥3 cases of respiratory illness among residents and/or HCP within 72 hours of each other.
    - These situations should prompt further investigation and testing for COVID-19.
- When a resident or HCP with suspected or confirmed COVID-19 is identified, facilities should be instructed to notify the NDDoH immediately at 1-888-391-3430. Notification should occur regardless of re-opening phase status.
- If a resident needs to leave the facility for routine medical care, advise them to wear a clean, cloth face covering or face mask (if cloth face covering is unavailable).
- Ensure all residents are up-to-date for routine immunizations, including influenza and pneumococcal vaccines.

New Admission and Readmission Recommendations:

COVID-19 Status is Unknown:

- A new admission that is **not** suspected of having COVID-19 or a confirmed case should be placed in a private room, with droplet precautions including an N95 mask if possible the resident should wear a mask or cloth face covering for source control, for 14 days. If the individual remains asymptomatic, then he/she can be moved to another room with a roommate.
    - Assess the resident twice a day for symptoms and fever for 14 days.
    - Keep the door to the resident room closed.
        - Attempts should be made to have these residents cohorted with dedicated staff.
    - If a resident becomes symptomatic, then he/she should be tested for COVID-19.
        - Increase monitoring of residents for worsening of symptoms.
        - If transfer to an acute hospital needs to be made due to worsening condition, without testing or before test results are known, call ahead to make arrangements and notify the facility and transfer crew that the resident may have COVID-19.
- If the resident has not already been tested for COVID-19 due to being a close contact, consider testing the resident for COVID-19, ideally 7-10 days from a known exposure to a confirmed case and again on day 14.
        - Close contacts may be removed from quarantine after 14 days from last contact with a COVID-19 case.
    - Suspect, or Confirmed COVID-19 Case:
- If a new admit is a confirmed or suspect case, prior to admission, they should have been in isolation until at least 10 days have passed since symptom onset and it has been 24 hours since last fever without the use of fever-reducing medications and improvement in symptoms OR 10 days have passed since the date of their first positive COVID-19 test (if asymptomatic).
    - For positive COVID-19 cases with severe or critical illness or severely immunocompromised^, duration of isolation for at least 10 days and up to 20 days after symptom onset or after first positive COVID-19 test for severely immunocompromised patients who are asymptomatic, may be warranted. Consider consultation with infection control experts.
    - The test-based strategy is no longer recommended to determine when to discontinue isolation, except in rare circumstances.

- If a new admit is suspected of having COVID-19 prior to admission, the individual should be tested. If negative, follow guidance above for new admissions. Consider testing residents who are an admit from a hospital at the end of their 14-day quarantine period to increase certainty that the resident is not infected.

Our Facility has Identified a COVID-19 Case in a Resident or Staff:

Mitigation and Prevention Recommendations

- Consider having pregnant or immunocompromised staff assigned to other areas in the facility.
- If the resident is having mild symptoms, you can keep them in your facility as long as their clinical care needs can be met.
- Place in private room or cohort COVID-19 positive residents together (COVID Unit), ideally placed 6 feet apart. Space should be dedicated to care for residents with COVID-19 such as a floor, unit, or wing in the facility or a group of rooms at the end of the unit.
    - Consider multi-drug resistant organism (MDRO) infection/colonization status when making resident placement decisions. Staff must change their gown after working with residents infected or colonized with a MDRO.
- Place resident(s) in droplet precautions, with the addition of an **N95** mask for PPE.
    - Staff should have been fit tested for use of N95 masks and perform self-seal checks **each** time mask is donned.
    - The same mask and eye protection can be used for multiple residents that are cohorted, but gown and gloves should be changed between residents and hand hygiene performed. Mask should be discarded at the end of each shift or before if soiled/contaminated.
    - Same gown may be considered if supply is low but residents MDRO history has to be identified and staff trained on individual gown use for those residents.
    - Eye protection should be disinfected, adhering to contact time, when visibly soiled and at end of shift and stored between shifts. Eye protection should be labeled with name and dedicated to a single person for use.
    - Please do not discard N95 masks. There are several processes available to decontaminate the masks and a number of hospitals have this capability. The CDC recommends that users store used N95 masks in a breathable container, that is well marked (to prevent accidental use), and according to the manufacturer's recommendations for temperature and moisture.
    - Cloth face coverings should NOT be worn in place of face masks or N95 respirators.
    - If N95 masks are not available or HCP are not fit tested, a surgical mask and face shield can be worn.
    - Additional PPE may be ordered at hanassets.nd.gov.
- Keep the door to the resident room closed.
- Dedicate equipment to these residents and disinfect between use.
- A log should be kept of all staff going in and out of room. Include family if end of life visits were to occur.
- Increase monitoring for worsening of symptoms.
- Monitor staff for proper use of PPE and hand hygiene.

- Have dedicated staff care for the resident(s).
- See CDC's Strategy to Mitigate Healthcare Personnel Staffing Shortages.
- Positive COVID-19 residents and staff should remain in isolation until at least 10 days have passed since symptom onset and it has been 24 hours since last fever without the use of fever-reducing medications and improvement in symptoms OR 10 days have passed since the date of their first positive COVID-19 test (if asymptomatic).
    - For positive COVID-19 cases with severe or critical illness or severely immunocompromised^, duration of isolation for at least 10 days and up to 20 days after symptom onset or after first positive COVID-19 test for severely immunocompromised patients who are asymptomatic, may be warranted. Consider consultation with infection control experts.
    - The test-based strategy is no longer recommended to determine when to discontinue isolation, except in rare circumstances.
- If resident worsens, arrange for transport and admission to acute care, calling ahead to make arrangements and notify both services of diagnosis.
- Nursing staff should organize their work and take on the duties of environmental cleaning to decrease number of staff entering room.
    - Environmental staff are usually not fit tested for N95 masks.
- If nursing staff from the unit are working with residents other than COVID-19 confirmed or suspected residents, separate PPE, including masks should be used for working with residents who are not suspect or COVID-19 positive.
- Masks used with these residents should be discarded if resident is receiving nebulizer or other aerosolized therapy, after each treatment.
- Disinfect face shields adhering to contact time if resident is receiving nebulizer or other aerosolized therapy, after each treatment.
- Provide notification to resident's families/guardians when there is a case of COVID-19 identified in your facility.
- Conduct facility-wide testing of all residents and staff according to NDDoH Congregate Setting Testing Strategy and Centers for Medicare and Medicaid Services (CMS).
- Once residents have recovered from COVID-19 they may return to their rooms and facility activities and dining. Continue to monitor daily once they have returned to their baseline.

Additional Facility Mitigation Actions

- Consider temporarily halting admissions to the facility, at least until the extent of transmission can be determined and interventions implemented. Avoid internal transfers to the affected area/unit.
- Consider cohorting quarantined close contacts together.
- Separate PPE needs to be used when moving between New admit/hospital return quarantine, close contact quarantine and negative/status unknown residents in addition to the COVID Unit.
- Restrict healthcare personnel movement from areas of the facility affected to non-affected areas.
- Restrict all residents to their room to the extent possible. Once the scope of transmission can be determined, these precautions can be prioritized to affected areas/units.
- Restrict visitation to affected areas/units, except for compassionate care situations.

- Restrict communal dinning, group activities, non-essential trips outside of the building to affected areas/units.
- Post signs at facility entrances notifying visitors of the restrictions and include where the restrictions are implemented. If restrictions are isolated to affected areas/units, post clear signage indicating the restricted access at each entry point.
- Consider implementing restrictions facility-wide until the scope of transmission can be determined.
- Adhere to CDC recommendations for Testing and Management for Nursing Home Residents with Acute Respiratory Illness when COVID-19 and Influenza Viruses are circulating.
- Even though residents are recovered and are not tested for 90 days unless they develop a new onset of symptoms, source control is still to be in place due to risk of reinfection. A person's immunity time frame is uncertain and is not to be perceived as 90 days due to testing recommendations.

For additional information, please review guidance from the Centers for Disease Control and Prevention for preventing the spread in long-term care facilities.

Guidance subject to change based on state and facility PPE supply and capacity. See CDC's PPE Optimization Strategies for healthcare settings.

Definitions:

- **Healthcare Personnel (HCP)**: HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).
- **Source Control**: Use of a cloth face covering or facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are talking, sneezing, or coughing. Facemasks and cloth face coverings should not be placed on children under age 2, anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
- **Enhanced Barrier Precautions:** expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:
    - Dressing
    - Bathing/showering
    - Transferring
    - Providing hygiene
    - Changing linens
    - Changing briefs or assisting with toileting
    - Device care or use of a device: central line, urinary catheter, feeding tube, tracheostomy
    - Wound care: any skin opening requiring a dressing

Gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to Standard Precautions. Residents are not restricted to their rooms or limited from participation in group activities.

- **Contact isolation precautions:** used for infections, diseases, or germs that are spread by touching the patient or items in the room (examples: MRSA, VRE, diarrheal illnesses, open wounds, RSV). Healthcare workers should: Wear a gown and gloves while in the patient's room.
- **Severe Illness**: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- **Critical Illness**: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.
- **Severely Immunocompromised**: Some conditions, such as being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions. Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions. Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

^ *Patients with severe to critical illness or who are severely immunocompromised:*

- At least 10 days and up to 20 days have passed *since symptoms first appeared* ***and***
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications ***and***
- Symptoms (e.g., cough, shortness of breath) have improved

For ***severely immunocompromised*** patients who were ***asymptomatic*** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test.

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North Dakota Department of Health COVID-19 Screening for Healthcare Employees

Our goal is to keep workforce intact while protecting staff and the public we serve.

This form should be used if an employee has signs or symptoms commonly associated with COVID-19 or has been exposed to someone with COVID-19

Employee Name:	Employee Phone Number:
Classification/Job Title:	Date/Time:

1.	Does the employee have a fever ≥ 100.4° Fahrenheit (38°C) (note, people 70> or immunocompromised may have a fever at 99.6° F)	Yes	No
2.	Does the employee have at least 1 symptom of new onset of viral illness: cough, congestion/runny nose, sore throat, muscle/body aches, headache, fatigue, shortness of breath, chills, new loss of taste/smell, nausea/vomiting, or diarrhea?	Yes	No
3.	Did employee have close contact* with a person who has been diagnosed with COVID-19 or is under investigation for COVID-19? ** Being within approximately 6 feet or within the room or care area for a prolonged period of time defined as 15 minutes (e.g. healthcare personnel, household members) while not wearing any personal protective equipment or not wearing a facemask or respirator OR having direct contact with infectious secretions of a COVID-19 case (e.g., being coughed on).*	Yes	No
4.	Did the employee, who did not have a mask or eye protection, have contact with a person who has been diagnosed with COVID-19 or is under investigation for COVID-19, and that contact was within 6 feet and less than 15 minutes in duration and the employee did not have direct contact with the infectious secretions of the a COVID-19 case (e.g., wasn't coughed or sneezed on)?	Yes	No

For an individual answering "Yes" to questions 1 or 2, immediately provide the staff member with a mask and refer them to their medical provider or occupational health, calling ahead. The medical provider should assess the individual for COVID-19 infection and submit a specimen for testing, if indicated. If tested for COVID-19, the individual should be sent home until test results are obtained. If not tested but COVID-19 is suspected, the individual should be sent home until recovery defined as resolution of fever without the use of fever-reducing medications in the past 24 hours **and** improvement in symptoms **and**, at least 10 days have passed since symptoms first appeared. If diagnosed with another illness that doesn't require exclusion, the employee may return to work. See the NDDoH Healthcare Worker Return to Work full guidance for more detailed information.

For an individual answering "Yes" to question 3, The employee should be furloughed for 14 days (from their last known exposure) and be quarantined at home. At this time, the CDC and Centers for Medicare and Medicaid (CMS) recommend 14-day quarantine for healthcare employees. See the NDDoH Healthcare Worker Return to Work full guidance for more detailed information regarding essential workers and optional reduced quarantine.

For an individual answering "Yes" to questions 4, The employee may work, but must wear a mask at ALL times (a N95 mask is preferred for fit tested employees), and be screened for symptoms and fever at arrival to work for 14 days. If working 12 hour shifts, suggest screening for symptoms twice a shift. Consult with your facility's infection prevention program on all possible exposures.

Completed by:

Printed Name: _____ **Date/Time:** _____

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HEALTH CARE WORKER (HCW) RETURN TO WORK GUIDANCE

HCW Diagnosed with Covid-19 (positive test result)

The North Dakota Department of Health (NDDoH) recommends following CDC guidance for return to work criteria for health care workers. Except for rare situations, a test-based strategy is no longer recommended to determine when to allow HCW to return to work.

Symptom-based Strategy:

HCW with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms have improved

HCW with severe to critical illness or who are severely immunocompromised:

- At least 10 days and up to 20 days have passed *since symptoms first appeared*
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms have improved
- Consider consultation with infection control or infectious disease experts

Time-based Strategy:

HCW who is asymptomatic:

HCW who are **not severely immunocompromised** and were **asymptomatic** throughout their infection may return to work when at least 10 days have passed since the date of their first positive viral diagnostic test for current infection.

HCW who are **severely immunocompromised** but who were **asymptomatic** throughout their infection may return to work when at least 10 days and up to 20 days have passed since the date of their first positive viral diagnostic test for current infection.

A test-based strategy is no longer recommended (except in rare situations) because, in the majority of cases, it results in excluding from work HCW who continue to shed detectable SARS-CoV-2 RNA but are no longer infectious.

Test-based Strategy:

HCW who are symptomatic:

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in symptoms (e.g., cough, shortness of breath), **and**

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

HCW who are not symptomatic:

- Results are negative from at least two consecutive respiratory specimens collected ≥24 hours apart (total of two negative specimens) tested using an FDA-authorized molecular viral assay to detect SARS-CoV-2 RNA. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV).

HCW With Symptoms but Never Tested for COVID-19

The HCW may return to work when the following criteria have been met:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms have improved.

If a HCW has an alternative diagnosis (e.g., influenza, strep throat), criteria for return to work should be based on that diagnosis. HCW should refer to their facility's policy for returning to work for the specific diagnosis.

HCW With Symptoms and a Negative COVID-19 Test Result (PCR or Antigen)

If the HCW has symptoms and received a negative antigen test, it is recommended to collect another specimen for confirmatory RT-PCR (reverse-transcriptase polymerase chain reaction) testing. The HCW should remain isolated while awaiting test results.

For HCWs who were suspected of having COVID-19 and had it ruled out (negative test or clinical decision with testing not indicated), then return to work decisions should be based on their suspected or confirmed diagnoses (i.e., influenza).

If the HCW has no other diagnosis, follow general return to work guidelines according to your facility policy. Generally, the HCW may return to work when the following criteria have been met:

- At least 1 day (24 hours) have passed **and**
- Recovery defined as resolution of fever without the use of fever-reducing medications for 24 hours **and**
- Improvement in symptoms

If the HCW is someone currently being monitored and under quarantine because they are a household or close contact to a confirmed case, then they need to remain quarantined until they meet release criteria. They still could be incubating the virus so one negative earlier on in their quarantine does not absolve them from getting sick and testing positive later in their quarantine.

HCW is a Household or Close Contact to a COVID-19 Case in a non-Healthcare Setting

The HCW may return to work when the following criteria have been met:

- Is asymptomatic (does not have any symptoms suggestive of COVID-19 infection) **and**

- It has been 14 days from their last known exposure to a confirmed COVID-19 case.

Household contacts to a COVID-19 case have ongoing exposure while they remain in the household. The 14-day quarantine period begins once the COVID-19 case is determined to be non-infectious.

At this time the CDC and Centers for Medicare and Medicaid (CMS) recommend HCWs, especially those in LTC, quarantine for 14 days from their last exposure. If not possible (i.e., staffing shortages), consider quarantining following CDC's options to reduce quarantine. REMEMBER: if working because an essential worker or with reduced quarantine, the HCW must remain symptom-free, continue to monitor twice a day for symptoms, and wear an N95 mask (if fit tested) to decrease potential of transmission during the full 14-day monitoring period.

Return to Work Practices

After returning to work, HCWs should wear a facemask for source control at all times in the facility until all symptoms are completely resolved or at baseline. Follow facility policy after baseline obtained. HCWs should self-monitor for symptoms, and seek re-evaluation from occupational health if symptoms recur or worsen.

Definitions:

Mild Illness: Individuals who have any of the various signs and symptoms of COVID 19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

Severely Immunocompromised:

- Some conditions, such as being on chemotherapy for cancer, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and require actions such as lengthening the duration of HCW work restrictions.
- Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect occupational health actions to prevent disease transmission.
- Ultimately, the degree of immunocompromise for HCW is determined by the treating provider, and preventive actions are tailored to each individual and situation.

In some instances, a test-based strategy could be considered to allow HCW to return to work earlier than if the symptom-based strategy were used. However, as described in the Decision Memo, many individuals will have prolonged viral shedding, limiting the utility of this approach. A test-based strategy could also be considered for some HCW (e.g., those who are severely immunocompromised) in consultation with local infectious diseases experts if concerns exist for the HCW being infectious for more than 20 days.

Updated: 12/11/2020