2021 SENATE HUMAN SERVICES

SB 2145

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2145
1/18/2021

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities in case of a declaration of disaster or emergency; and to declare an emergency.

Madam Chair Lee opened the hearing on SB 2145 at 9:00 a.m. Members present; Senator Lee, Senator K. Roers, Senator Hogan, Senator Clemens, Senator Anderson. Senator O. Larsen joined the hearing virtually at 9:01 a.m.

Discussion Topics:

- Federal requirements with assisted and long term care
- CMS (Centers for Medicare & Medicaid Services) guidelines
- Death rate in long term care facilities V.S. other states
- Outbreak testing
- Nursing home in-person visitation
- How to make a complaint against a long term care facility in regards to visitation
- Compassionate and at-home care in rural counties
- Long Term Care Facility death rate due to COVID-19
- Implementation plan
- CMS requirements V.S. Executive order 2020.21.1

[9:01] Senator K. Roers, District 27. Introduced SB 2145 and provided testimony #987 & #1128 in favor.

[9:06] Senator Dever, District 32. Provided testimony #1060 in favor.

[9:12] Chris Jones, Director, Department of Human Services. Provided neutral testimony #1099.

[9:23] Bridget Weidner, Director, Division of Health Facilities, North Dakota Department of Health. Provided testimony #1100 in favor.

[9:41] Roza Larson, Minot, North Dakota. Provided testimony #1145 in favor.

[9:54] Tessa Johnson, Executive Director, CountryHouse residence. Provided testimony #962 in favor.

[10:00] Beth Sanford, Registered Nurse, North Dakota citizen. Provided testimony #1083 in favor.

[10:12] Laurie Scholser, Bismarck, North Dakota. Provided oral testimony in favor.

[10:18] Karla Backman, Long-Term Care Ombudsman, North Dakota. Provided testimony #1182 in favor.

[10:23] Barbara Johnson, Arnegard, North Dakota. Provided testimony #968 in favor.

[10:29] Lisa Buchweitz, Langdon, North Dakota. Provided testimony #1043 in favor.

[10:36] Amber Vibeto, President, North Dakota Conservative Political Action Committee. Provided testimony #1172 in favor.

[10:38] Deann Stanley, Harvey, North Dakota. Provided testimony #1048 in favor.

[10:47] Shelly Peterson, President, North Dakota Long Term Care Association. Provided testimony #1001 in favor.

[11:02] Josh Askvig, State Director, AARP North Dakota. Provided testimony #1052, #1053, #1054 in favor.

Additional written testimony: (9)

Sherri Miller (BS, BSN, RN), Executive Director, North Dakota Nurses Association. Provided testimony #961 in favor.

Lisa Moldenhauer, Minot, North Dakota. Provided testimony #904 in favor.

Sharon Nelson, Registered Nurse. Provided testimony #967 in favor.

Sierra Heitkamp, North Dakota Right to Life. Provided testimony #1007 in favor.

Eldon Johnson. Provided testimony #1046 in favor.

Bea Streifel. Provided testimony #1074 in favor.

Kristine Medeiros, Watford City, North Dakota. Provided testimony #1090 in favor.

Laurie Heick, Dickinson, North Dakota. Provided testimony #1503 in favor.

Evonne Hickok, Williston, North Dakota. Provided testimony #1504 in favor.

Madam Chair Lee closed the hearing on SB 2145 at 11:06 a.m.

Justin Velez, Committee Clerk

North Dakota Senate

State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505-0360

Senator Kristin Roers
District 27
4240 31st Avenue South
Fargo, ND 58104-8725

C: 701-566-0340
kroers@nd.gov

Committees:
Government and Veterans Affairs
Human Services

Madam Chair, Senator Kristin Roers, District 27.

Today, I am here to introduce Senate Bill 2145, relating to establishing a Designated Caregiver for residents in Long Term Care. We are all aware of the brutal toll that COVID-19 has taken on our elderly population – but I would posit that the isolation that they have endured is equally brutal.

I want to start by thanking the Department of Health, the Department of Human Services, the Vulnerable Population Protection Plan taskforce, the Reuniting Families Taskforce, the Long Term Care Ombudsman, and the Long Term Care Association for working so diligently to protect those among us that are most vulnerable. They were assigned a nearly impossible task of trying to keep an aggressive virus out of the population it most devastated. As they started their work, we knew that we needed to protect this population, and we knew how we didn't want to do it, as we had seen some states fail in ways we could not allow to happen in North Dakota. With the benefit of hindsight, we know that the information they had was minimal, and yet they created a plan that has helped to save hundreds, if not thousands of lives. So again, I say thank you.

We are now nearing the 1-year mark when we learned that this virus was in the US, and in North Dakota. Many things have been learned in that year – we know better how the virus is spread, we have better therapeutics, and we also know that we have adequate PPE to care for all of the residents in our healthcare facilities – and we also, thankfully, have vaccines!

The Federal government, through the Centers for Medicare and Medicaid Services (CMS), have created a protocol for allowing indoor visitation in LTC that includes meeting 2 thresholds: 1) no positive test results in the previous 14 days for either staff or residents and 2) your county positivity rate must meet a certain rate. Thankfully, we are now in a place were most facilities are able to meet these two thresholds.

The time has come to ensure we mitigate the effects of isolation in Long Term Care. We want to look forward to identify what we can do to ensure that all residents are afforded their rights – the right to see their loved ones being at the forefront – to give and receive hugs, to talk, and to make that human connection.

North Dakota Senate

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To be honest, my hope is that this bill is completely and totally unnecessary – that we can ensure that all facilities who are eligible for indoor visitation by the CMS guidelines, are allowing that visitation – but I also want to make sure that we have these standards in place for the future.

This bill is relatively simple at its heart – it basically says, as long as the Feds haven't specifically limited visitation, no facility may deny visitation for a Long Term Care resident by their designated caregiver or caregivers. The facilities may create protocols for that visitation, but they need to allow it – these protocols may include PPE requirements, screening, or other steps – but I would believe that the loved ones of the resident would jump through all of those hoops, and then some, just for the chance to make that connection.

The numbers of letters, emails, and calls that I have received lead me to believe that this bill is necessary. And the content of those messages are beyond heartbreaking.

As many of you know, I worked with COVID and non-COVID patients in the hospital over the last few months and saw this isolation in person. It made me sad that people had to be hospitalized to be able to get a visitor. I had coworkers who are experiencing moral distress from having to be the one standing between their patient or resident and their loved ones. I had friends relay stories to me about residents begging them to end their lives – not to let them die, but to kill them. The lasting effects on our families, our residents, and our healthcare workers will not be seen fully for years, but I fear that much of this damage cannot be undone.

The time has come to allow for this visitation and I hope that this bill can help to be a vehicle to get us from where we are today to where we want to be – and to prevent this isolation from happening again in the future.

I have a few friendly amendments suggested by the LTC Association as well as some of the advocates that I hope will be helpful to make this bill become even more effective. I will present them after all of the testimony is complete in the interest of time.

Thank you for your consideration – I know that there are many who would like to testify after me and I would like to give them as much time as possible, but I am available for questions at any time.

Roers, Kristin

From: galsters@ndsupernet.com
Sent: Sunday, January 17, 2021 3:31 PM
To: Roers, Kristin
Subject: SB 2145 -please pass

My father has been a resident in a skilled nursing facility since October 2019 and the past 10 months have been horrifying to his mental well-being, his physical health and to his overall emotional state.

Please understand how devastating the isolation has been on these older people. they are near the end of life and the only things they look forward to are visits from family and friends, to be able to see and hug their grandchildren and to know that they are not alone, left to die. But due to the virus that is exactly what has happened and when I go to see my father through his window and reaches his hand out to me and cries "help me, help me" and there is nothing that I can do. Do you know and understand how heartbreaking it is. I call him on the phone and he tells me "I don't like being alone".
The family members that are in charge of their parents care as POA cannot even see them in person, to see how frail they have become, due to the limitations of nursing home staffing and the CDC regulations more and more elderly people are dying. not because they have gotten the virus but as victims to the consequences from the virus.
It should be every family members right to protect and care for their loved one in person, not through a window or a zoom meeting.
Please give these people their right to a life back. they do not deserve to be isolated like the most dangerous criminals on earth in prisons.

I would love to come and testify in person on behalf of dozens of friends who are in the same situation and many have already lost their parents to this dreadful fight; but I must be here to stand outside my father's window each and every day to help him find peace and the will to go on until we can be together again in person.

Thank you.

LeeAnn Galster, Dickinson, ND 701-290-4382
My father is at St Benedict's Health Center

Roers, Kristin

From: Deb Leingang <debleingang@yahoo.com>
Sent: Saturday, January 16, 2021 5:22 PM
To: Beth Sanford; Jones, Chris D.; Burgum, Doug; Peterson, Shelly; Roers, Kristin
Subject: Resident letter

On behalf of my Mom,Virginia Geist, 2425 Hillview ave, Bismarck, as told to me,Debra Leingang, 409 Keidel Trail Sw, Mandan:This is her true & sworn statement.

My life in 2020 started out with losing my husband of almost 60 yrs on Jan 22.We shared a room in a skilled nursing facility for almost 3 yrs.My daughters visited me daily to help me through the loss.

Then in March 2020,the facility was "LOCKED DOWN"!I not only lost my husband but now my family!

We have had very few video visits, very few outdoor visits - visits with no privacy & over a fence,few window visits because the window is on roommates side with her bed along the window.

I am VERY LONELY, DEPRESSED,have a hard time getting out of bed daily for What?! No activities, no socialization, NO FAMILY! I feel like I'm in jail,on my last leg of living.The door is closed most of the time,all meals(not always hot either) in room,only getting out for baths & therapy when provided, but mostly that in room also.No fresh air ,no sun.THIS IS NO QUALITY OF LIFE!!

I've had to go through all The FIRSTS AFTER LOSING A SPOUSE BY MYSELF! I'm missing out on the great grandkids growing up & their birthdays- ages 2 1/2 to 6 1/2!I NEED MY FAMILY TO TOUCH & HUG!

This is my last home & I want QUALITY of life in my last days however long that may be.

PLEASE OPEN UP THE FACILITIES & LET US BE WITH ALL OF OUR FAMILIES!

Sent from Yahoo Mail on Android

Roers, Kristin

From: Kim Johnston <steve2kim@hotmail.com>
Sent: Saturday, January 16, 2021 3:18 PM
To: nd.bethsanford@gmail.com; Roers, Kristin
Subject: Isolation is HeartBreaking....

My Mom is being locked away from her family and loved ones now for 10 months and counting...why and when will this end.
My Mom has been the center of our Family... Wife, Mother, Grandma and now she sits alone away from the family visits and waits for
a scheduled window visit that in itself is frustrating as she has cataracts and unable to see distances and not allowed to be pushed closer
to window as a policy/rule set in place states she can't....So she can't see clearly and hearing is always a struggle can't read lips to help her
understand as she and the visitor are having to wear masks...So a visit is overwhelming for her and she cries for the ones she longs to see..
My Mom is not the same Mom you have locked away from us...She is lonesome ,sad, depressed and cries because she is all these things,
she is broken and has physically declined in these past 10 months....With no fault of her own but because of restrictions keeping her isolated
from Family.....
I have asked over and over WHY the PPE staff is using to protect the residents, WHY can't a family member be able to use THAT EXACT PPE
to be in contact with a resident?? It makes absolutely NO SENSE to me and countless others ....Tell me WHY can't this happen!
What is the reason...
If Its approved PPE and good enough for staff daily contact, there should be no reason it's not for a Family member?
One family member accessed to a loved one can't be out of the question...If so, please explain Why.
My Mom has more life behind her ,than she has in front of her,
she doesn't want to spend the days left to her, alone and isolated from the Family
she has spent her life loving.
This is so cruel, please reconsider this isolation and lockdown of our elders....

Kim Johnston,
Loved Daughter of Lola

Senators, K. Roers, Mathern, Patten, and Representatives Keiser, Rohr, and Westlind, thank you for introducing Senate Bill 2145. Thank you for letting me share my story.

On a cold March day, it would be the last time I would sit with my mom during her noon meal, encouraging her to eat, and sharing family stories and laughs. Providing this companionship and joy for her was all she had. I did not know it would be the last time to help her brush her teeth, help the CNA take her to the bathroom, wash her hands, give her a big hug, tuck her into bed for an afternoon nap, and tell her how much I love her. I waved goodbye that day as she smiled her beautiful smile back at me and said, "I love you Sharon! I wish you could stay!" I smiled back through tears, "I will see you tomorrow mom, I will be back." The next day, the unexpected call came, that no visits could take place. The doors of the long-term care facility were locked. A sign on the door stated No Visits Allowed. They had a contracted employee test positive for COVID-19.

I always visited my mom, almost daily, because I knew she was not getting the basic care she deserved. Basic care! To be taken to the bathroom throughout the day, to be helped at mealtimes, to be provided with a call light, and to have her teeth brushed, because she would pocket food in her mouth, from not chewing and swallowing so well anymore. No one would wash her hands before meals and after meals, or after being helped in the bathroom. I witnessed this daily when I could visit. So, I would provide as much care as I could. I would brush her teeth, wipe off the narrow dirty metal shelf that was her place in the shared bathroom to keep her toothbrush. I would position the toothbrush in a way that I could tell if someone moved it or took the time to brush her teeth. Every day, the toothbrush was in the same place, dry and stiff, un-used. How disappointing. I took my concerns to every care conference for my mom, with nods of heads from managers and care takers, saying it would be taken care of. It was not!

She was in lock down now. I could not physically help her, so I made phone calls to the facility to double check that her plan of care was being followed, that she was taken to the bathroom every 2 hours. I worried about her skin and the breakdown that would occur if she sat in urine all day. Again, I was told, it was taken care of. I was not there to advocate for her, to be with her, and care for her. Who was going to do this? Adequate staffing was needed.

I continue to worry, because on several occasions she had fallen, trying to go to the bathroom herself. More than once she ended up at the emergency room. A deep open cut in her forehead, needing several stitches, and pain medication. A black eye engulfed her face. She has now fallen several times trying to get to the bathroom. I panic every time the phone number comes across my phone. Now what happened? Is my mom okay? Is she safe? I asked the facility director if I could come in and volunteer and help in any way. I am a nurse and educator. I am screening for COVID-19, I have minimized my risks, and would follow policies and protocols. I just want to help and be an extra set of eyes and hands and sit and visit with my mom and any residents that would enjoy a visit. The answer was, "No." The director said, "If you want to be here, then apply for a nursing position. We need nurses."

With the doors locked and new guidelines in place, and no visits allowed, I signed up for Facetime visits with my mom, so I could see her and check in. She would look so lost and bewildered and would wonder why I was not there. She did not understand why I could not be with her. When I would see her on the screen, I would be devastated. Her glasses were crooked, her hair not brushed, food and juice down her face, and food on her shirt. I told her stories and comforting words, I told her I loved her, trying to catch a smile. Her teeth were covered in food. No sweater or light jacket on, as I requested, because she was always cold. Did anyone notice or care? What is happening? My mom cared for her son, my brother with disabilities, for over 50 years, and now it was her time to be cared for. When we moved my mom in to the facility, I was told by the nursing director of the unit that she is in a good place and that they would take good care of her. She told me" don't worry, she is in good hands." Why are they not providing the care they promised? Why is the mission and vision statements of their facility, that are placed on the walls and website, not being followed? Where is the accountability? They are caring for my mother. She is not only a mother, but grandmother, and great grandmother and a beautiful and loving woman. She dedicated her life to care for her son with disabilities. She was a caretaker herself.

In November, she acquired COVID-19. Facility acquired COVID-19! No updates were given except for the initial call, "Your mom has COVID, and has been moved into the COVID unit." Over 30 residents died of COVID-19 there in a few short months. COVID was brought to them. My mom survived. I was told I could visit at her window. Standing again in the cold, I came to her window, she was eating her lunch, alone in the room. She saw me and cried and motioned for me to come in! She continued to motion to come in and all I could do was say, "I'm sorry, I can't." She has been declining these past months, and after finishing her quarantine and getting through COVID-19, she continues to decline. How long do I need to wait to see her? How much does she have to decline before I can be with her? Until she is dying? I am her POA and would love to be her "designated caregiver." She deserves the presence of her family, so does every resident in a long-term care facility in the state of North Dakota. Other states have figured this out, including Minnesota, and recognize the critical role family members and others have in the care and support of their loved one. Efforts that have been made to protect residents have failed to consider the physical and psychological impact of separation from those that matter most. I urge you to help pass SB 2145, so that my mother and all of our community members in long term care facilities, in North Dakota, can have the comfort and support of a "designated caregiver" now, when they need them most.

Thank you for introducing SB 2145.

Respectfully, Sharon Nelson, Ph.D., RN

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Thank you for introducing SB 2145.

Respectfully, Sharon Nelson, Ph.D., RN

Roers, Kristin

From: June Lundstrom <leostrong3120@gmail.com>
Sent: Friday, January 15, 2021 5:18 PM
To: Roers, Kristin
Subject: Elder neglect in nursing homes

Hello Kristin,

I was given your contact as I was told your are gathering information regarding neglect; abuse and other items happening in nursing homes.

Bethany University in Fargo:
My mother, Judith Meyers "Judy", entered Bethany September 25, 2020 - due to there actions and LACK of, they euthanized her by December 18, 2020.

Prior to entering Bethany she was living and caring for herself with little assistance. She was independent in everything for the exception of her macular degeneration eyesight.

Bethany:
- refused to release her to go to dr fir her regularly scheduled eye injections that would SLOW her macular degeneration.
- refused to release her to have her hearing assessment fir hearing aids.
- refused to release her to ANY dr appointments; one being a specialist in non invasive management of her mitral valve and A-fib and others
- refused to discuss her cares or ANY aspect of her cares, meds, appointments etc etc etc
- refused to clarify medications, especially care plan for "fluid" weight (to safely reduce and get fluid off); and "restless leg" syndrome.
- placed in Lasix for fluid (dangerously extreme high doses) causing EXTREME side affects such as: dangerously morbid depletion of potassium and other "life survival" electrolytes. Causing increased exacerbation of restless legs, that kept her up without sleeping WHY WOULDn't they send her for dialysis to help with fluid overload???? WHY could Sanford be able to reverse this affect in 3 days and Bethany KILLED my mother in 3 months!!!! With that 50 pound weight gain; electrolyte imbalance including anemia!!!!
- refused to manage prescribed diet for health conditions
- Refused to allow referrals; second opinions etc

- Judy express concerns for them "not doing anything"; "not getting answers"; " they didn't tell me, I know nothing" etc etc etc.
- Judy was extremely concerned with her weight. They said it was "fluid".
-Judy complained about all the meds she was on and didn't know what they were for.

NOTE: Judy stated she was up 50 pounds the week she passed away.

Dawn Hummel, Director called and VERBALLY ABUSED; INTIMATED; BULLIED and THREATENED me, inly days after my mother's death, as I tried to retrieve a Christmas tree and emoji towels that Bethany had MISPLACED and was not among my mother's belongings.

In stead of assisting with resolving the tree and towels, Dawn attacked me re: not being rehire-able and she VAGUELY and insinuated an incident 10 years ago.

'id remind her that that incident was Bethany refusing and delaying care of a resident that sustained an OPEN hip acture more that 24 hours AFTER it happened.

I.e. incident about 10 years ago
- resident fall
- resident was accepted by dr
- dr called ER and ER was accepted resident
- I faxed accepting physician orders to both ER dr and Ambulance
- waited for Bethany Administrator to call back and approve sending resident into ER per physician orders etc.
- Bethany Administrator REFUSED to send resident in.
- over 24 hours later; upon arrival at work (Bethany); Resident has JUST been sent for medical treatment; her husband called later and stated it was an open hip fracture but because Bethany had fed her, she still couldn't have the surgery for hours because Bethany had fed her.
- when I have report yo night shift; the orientee spoke with me privately and stated; her preceptor didn't check on the resident who had fallen until around 4am; the wound on the hip was indeed open, the bandage over the wound was "very bloody"; but the nurse only steri stripped it, rebadged it; gave her Tylenol for pain. AGAIN resident was NOT sent in.

I wrote this incident up and placed it in the unit manager's desk. Next Dawn Hummel and HR met with me. Dawn asked if I reported it to the state; "are you going to report it to the state"; "your in nursing school aren't you"; "if you value your nursing license you won't tell the state". I tried tell her, that I reported it to management; that it's there job to review what happened and make changes in the process. Dawn again in a louder more threatening tone "you better not report this to the state"... next I was being walked to get my things snd out the door.

ack to what happened when I was trying to retrieve the Christmas tree and towel. Dawn continued to badger me. She stated that "we pulled your file...."I finally told her... "Dawn.... my mother is dead, I was here to simply retrieve the tree and towels my daughter so thoughtful was trying to get to her grandma but it never got there.... and your talking to me like this?"

By Dawn's statement; her tone; her INTIMIDATION, her BULLYING THREATENING manner is NOT isolated to me but to AlL those around her. That by her stating "we pulled your file" I believe Dawn's PERSONAL FEELINGS about me, INTERFERED with ANY staff doing there job for my mother, Judith Meyers. I believe the staff were filling DAWN's "orders" and euthanasia groups my mother.

Please assist me in creating CHANGE in nursing homes. I've worked in them, they are not all what has happened to me, my family and my mother. But with leadership like Dawn, her behaviors filter into a toxic detrimental environment, that breeds mismanagement of cares.

Thank you for your time and reading some of my experiences. While I mourn what has happened to my mother, that strains my family relationships as Bethany drove a huge wedge and played family members against family members. Help break these cycles. We never know how much time our loved ones have left. We should NOT be spending any time like my family and my mother did, those last 3 months.

I whole heartedly believe if she has NOT been at Bethany, she would still be alive and living independently.

ncerely,

June Lundstrom

1511 34th Ave S
Fargo, ND. 58104
Leostrong3120@gmail.com
701-446-6103

Roers, Kristin

From: Craig & Kristi Thomas <crkrthomas@gmail.com>
nt: Friday, January 15, 2021 3:55 PM
o: Roers, Kristin
Subject: SB2145

Dear Senator Roers,

My name is Kristine Thomas. I am a nursing student. Our family experienced the unexpected death of our daughter in May 2020, due to a brain tumor while she was in a North Dakota hospital. Our grief has been exponentially compounded by the fact that my husband and I were prevented from appropriately being together with our children and extended family members as we prayed for a miracle during the five days that she lay comatose in the hospital. Finally, due to our insistence, our children and their grandmother were permitted to come and see their sister/granddaughter briefly for the last time as it was clear that our daughter was not going to survive.

As a nursing student, I recognize that COVID is a serious illness, and I understand the difficult position that care facilities are in. I also know from my studies that nurses are called to take a holistic approach to healthcare. People need their loved ones, especially during difficult times. It is inhumane to keep people in long-term facilities from their loved ones. That is why I support SB2145.

Thank you for your time.

Sincerely,
Kristine Thomas

I am asking for your support of Senate Bill No. 2145.

Having a designated caregiver during a declaration of disaster or emergency is a win/win situation for all.

Watching and communicating with my father and staff through a window for nine months was not pleasant. My father passed away on Thanksgiving Day. He was Covid free, and right up to the end we were not allowed to be with him. Many of these facilities are short staffed and they are not able to give the care required to residents. Residents are so sad and lonely, and starving for attention. If staff did give my dad 30 seconds of their time, I could see the sparkle in his eyes that someone communicated with him and gave him some attention.

Having a designated caregiver would be helpful in so many ways. It would free up time for staff. One day a worker was in the room for a half hour trying to get an oxygen reading on my dad, as their checker never seemed to work properly. That is something so simple a caregiver could help with. Loved ones can help with meals. They could make sure the oxygen is in their nose, instead of as I witnessed when I would call and ask the nurse to put it back in, she would say "Well, he keeps taking it out!" A caregiver could give quality, one on one time to their loved one, reading, conversing, simple physical and occupational therapy, and giving human touch, something they all need.

We were almost glad when he went to the hospital during the past nine months and we could be in the hospital with him. We gave him a haircut, fixed his wheelchair, brought him an ice cream cone, etc. It was amazing to see how clear his head was and the good mood he was in when family was with him. There were also some sad things we discovered during a couple of hospital visits. One was his toenails had not been cut for 2 ½ years. Yes, 2 ½ years! During one of his last trips to the hospital, I saw his bed sores firsthand in ER. Blood running down his butt, raw in another area, and a larger area that was red and purple, bruised looking. Absolutely no reason for a person to get bed sores of this magnitude! Residents are not being checked, turned or tended to. A crucial reason a caregiver needs to be with their loved one.

My dad fiercely loved his kids. Having him motion to you every day through the window to come in, and every day telling him we can't come in, and watching him deteriorate as the months went by, is indescribable and unforgiveable. He, as well as many of the residents in these homes, would much rather have a family member with them than to be alone and/or die alone in isolation.

Being in a facility that was rated in the top five worst in the state, it was crucial that we be there by his side every day. Pre-Covid, my siblings and I spent around seven hours every day with him, and during Covid, around five hours every day outside his window.

If a family member could be with their loved one, they are going to take every precaution to protect them. It is a disgrace to have tortured so many of these people with making them spend their final time on earth alone, when all they wanted was to have their family beside them.

I ask you to please support Senate Bill 2145.

Lisa Moldenhauer
8200 66th Ave SE
Minot, ND 58701

I am writing in support of SB2145.

Our mother, grandma, great grandma lives in the Horizon Assisted Living in Watford City.

She is 91 years old, witty and good natured. She has an amazing spirit and has worked hard to make the best of this lock down and tried not to let it get her down. Despite her good attitude she has declined significantly during the months of lock down, both physically and mentally.

She is fortunate to have 4 children & their spouses, several grand and great grandkids very close to visit and be part of their lives. The outdoor visits worked ok for her although hardly ideal. Depending on the weather, distance and face masks made it very difficult to communicate along with poor hearing.

Despite being completely isolated from her loved ones, she still contracted Covid 19. So, after months of not being able to be with her we had to life flight her to Fargo for her to be alone for another couple weeks. God granted her the strength to get through and she is now recovering, on oxygen, at her home at the horizon. Fortunately, we are able to see her 2 people at a time with precautions. If that were to be taken away due to surge in cases or whatever, she wouldn't last long there. Without family interaction and help she would soon be in the nursing home.

As good as employees can be (and that's in fortunate cases) they can not replace the everyday needs that a family member can provide. Just the connection with the rest of the family, opening mail together, taking care of business, sorting & changing out seasonal clothing to name a few. Everyday things that keep us all getting up in the morning makes a huge difference in their mental and physical wellbeing. Also, as much as we would like to think all facilities are looking out for them, things fall between the cracks and if they can't speak for themselves how far can it go and how quickly can they decline? There needs to be someone to be their advocate.

This has been so terribly hard on families. I can't even imagine being kept from my spouse when you know you have little time left anyway. There is NO WAY that can be in anyones best interest.

SB2415 provides connection with family. The restrictions of the designated family member are as stringent or more than the employees caring for them. I often wonder how taking a CNA course magically makes one less contagious than a loved one who will go through any measure to be safe and still not be able to even enter the building. Thank God for the CNAs and all healthcare workers, but they get off work, go on with their daily lives and then come back to work the next day. There are no guarantees they are disease free, there is risk of exposure for all. The numbers prove that.

Limiting exposure is good. But being 100% isolated from family/caregiver is never good and should not be allowed. SB2145 would guarantee they have the simple right to a personal representative!

Respectfully,

Jennifer Sorenson
701-770-6858
12652 22nd St NW
Watford City, ND 58854

Roers, Kristin

From: Rosemary Ames <rosemarycames@gmail.com>
Sent: Thursday, January 14, 2021 11:52 AM
To: Roers, Kristin
Subject: SB2145

Dear Senator Roers,
I am emailing about the lack of being able to visit our loved ones in LTC from March 2020-Present. My Mother has been in Memory Care in a LTC in Fargo. It has been difficult to visit my Mother during this time without being hackled to get a test even though I have never had the virus and also restricted on how long I could visit. From March-May the faciility was completely closed to visitors of any kind. In August my Father passed away due to complications from knee surgery. I have 3 other sibilings and they live out of state, and I live 3 hours away from Fargo. When my Father passed away on a Monday, my sister flew in so we could be with our Mother, which was on Wed. We were almost not let in to visit, even though my sister had cleared it with the social worker. After getting the running around for an hour we finally got the go ahead to visit, but had to leave by 6:00. We had the same experience the following day on Thursday with having to leave again at 6:00. On Friday our Mother asked us if she could come help pick out our Father's casket, and we said as far as we were concerned she could, but sought permission(this broke my heart to hear her ask and beg if she could). She was cleared to do so and we picked her up and we went to take make funeral arrangements for our dad, her husband. Again we had to have her back by 6:00, and they took her straight to quarantine, despite she was only with myself, sister, brother and the funeral director. Our plan was to visit our Mother everyday through the day of the funeral, but we were not allowed by the Administrator to visit on Saturday and Sunday. Come Monday, the day of the funeral we took our Mother out for the funeral, and again had to have her back by 6:00. Again when bringing her back, they immediately took her to quarantine and were going to test her 2x week during this quarantine period. As of today my Mother has never had the virus! A month later in mid September I was able to visit during a 1 hour window(1 hour only). From after that date in September until now I have not been able to visit my Mother. Unless you are heckled to TEST, TEST, TEST! We have lost a whole year due to a virus that has a 99.9% recovery rate! My Mother has dementia, and we have lost a whole year of being with our loved ones, who we have entrusted to these facilities to care for loved ones! We have no idea when God will call us to our forever home and as I said she has dementia is nearly 83 years old! Time to open up to being able to visit our loved ones anytime we want! My Mother isn't getting any younger and God could call her home anytime and I have lost valuable time with my Mother! If you want to know more, feel free to contact me.

Sincerely,
Rosemary Ames

Roers, Kristin

From: Rhonda Larson <nyylover@srt.com>
Sent: Wednesday, January 13, 2021 10:08 PM
To: Roers, Kristin
Subject: SB 2145

Dear Senator Kristin Roers,

I have not had contact with my Mom, who is a resident in a Long Term Care Facility, for 10 months. During this time she has developed depression and sadness, she has not walked for 4 months, she has had numerous falls, I lost count after 15, her dementia has worsened, and she contracted COVID-19 from a staff member at this facility. The federal and state mandated visitor restriction are a violation of her rights by locking her up and isolating her against her wishes. She is a resident in a Long Term Care Facility which is her home, yet these federal and state mandated visitor restrictions are inhumane and abuse. She has rights that cannot be taken from her for any reason.

My Moms home was invaded with COVID-19 that started with a staff member. According to a CMS report about this facility 35 residents contracted COVID-19 and recovered, 10 residents contracted COVID-19 and died, and 25 staff members contracted COVID-19. This facility has 50 licensed beds with a daily average of 37 residents. According to this data there should now be minimal risk to my Mom and other residents but the lockdown and isolation continues. Why? These federal and state mandates cannot be a one size fits all approach. Anyone who has a loved one living in a Long Term Care Facility or provides care to these residents knows how important it is to them to have consistent and routine contact with their loved ones. My Mom should not be suffering in isolation when her risk or the risk to others is minimal at this point.

The constant and continuing response I receive from staff and administrators at this Long Term Care Facility is "We don't like it either but our hands are tied. We have to follow the Governor's Executive Order", or "We have to do this or we will lose Medicare funding", or "this is what the Department of Health and Human Services or the Department of Health says we have to do." I am fed up with everyone passing the buck and not taking responsibility for the things they can control to improve the quality of life and ending this lockdown and abuse that is killing my Mom and so many others whose home happens to be in a Long Term Care Facility.

For the most part of the past 10 months the news of a vaccine has always been the solution to ending this pandemic and the lockdowns. My Mom has received the first dose and will get the second dose in the next week. I am hoping to be vaccinated as soon as I am allowed to get it. Now I am told that vaccinations will not end the lockdown of my Mom's home and visitor restrictions will continue. The CDC and other government bureaucracies have not provided any guidelines for Long Term Care Facilities post-vaccination other then all precautions should continue to protect this population.

It is shameful how this population has been locked away and forgotten with no regard for their human rights, dignity, and emotional well-being. Isolation and loneliness also kills not just COVID. This needs to end now!

Sincerely,
Rhonda Larson
20300 Hwy 83 South
Max, ND. 58759
701-204-3609

Roers, Kristin

From: Tami <tstew5@midco.net>
Sent: Wednesday, January 13, 2021 10:23 AM
To: Roers, Kristin
Subject: LTCFACILITIES

***** CAUTION: This email originated from an outside source. Do not click links or open attachments unless you know they are safe. *****

My Name is Tamara Stuhlmiller & Live in Bismarck ND. My Mother(89 years old) lives in an Assisted Living Facility also in Bismarck. I along with My Siblings Moved her 2 years ago their, & I have been her Main Caregiver Daily since the First Day Living their. I have done many cares & things Daily, 7 Days a Week, so to keep her their & Not in a Nursing Home. Which I will Not have her live in. I have been Locked out since 3/12/2020.
It is Now 1/2021, & STILL LOCKED DOORS!! PLEASE HEAR MY VOICE!! These Facilities NEED to Unlock & Allow Family In to their Private Home!! Society can go to Stores, Restaurants, etc.., Staff comes & goes!! What is WRONG with this?!!!! We are Killing our Elderly from Isolation & Depression and their Dignity is GONE!! My Mom Eats all Meals in her Room ALONE, they seldom take or do activities with my Mom. Thank GOD She has a Ground Level Home so I sit outside her Window off & on Every Day, Her Words are-"Come In, Come In"!! This has Broken my Heart over & over, I am exhausted!! We are allowed In Door Visitation Mon.-Fri., 10am-4pm, designated areas. No Weekends, No Holidays, due to Short of Help!!!! This is NOT MY FAULT they won't Hire enough Staff!! They have been Vaccinated & Test for COVID Weekly, still NO CHANGE!! PLEASE TELL ME WHY? Protecting Elderly- THIS IS NOT!! I also have been Locked out of In-laws Facility, We Lost my Husbands Father 3 Days before CHRISTMAS & My Mother In-law is still in Hospital, they both contacted COVID from Staff!!!!! We ALL know COVID IS HERE, WE ALL KNOW IT'S ALSO HERE TO STAY, OPEN UP THESE LTC FACILITIES!!!! End of Story!! I also want to know about State Funded Ventilation System for LTC Facilities?!!
Sent from my iPhone

Roers, Kristin

From: Glen/Lisa <glschmidt@bis.midco.net>
Sent: Wednesday, January 13, 2021 9:36 AM
To: Roers, Kristin
Subject: Long term care plea

***** CAUTION: This email originated from an outside source. Do not click links or open attachments unless you know they are safe. *****

Hello! Our dear mother was recently put in a nursing home. She was separated immediately from me and I wasn't even able to say goodbye and give her her things, after spending 3 grueling days in a hospital with her after she fell in her home. It was very traumatic and I had to stand in a snowbank outside her window in tears to say goodbye. This was down right mean and the nurses and workers even told me the policies are terrible for these precious elderly loved ones.

After this, she was quarantined. She had just had a negative covid test that very day and it made no sense. Rightly so, she started calling us, her loved ones, on the phone many times a day as she was so alone!

The confusion came a couple of days later when they called me saying she had a doctors appointment and that I could meet her at the clinic. I replied that I thought she was quarantined? They told me she "has the right to her health care" and they make exception for doctors appointments. I thought to myself, "Why can't she have just 2 or 3 family members come visit her, hug her, and sit with her then for her mental health?" Don't they have a "right" to that?

So, the supposed "quarantine" is of none effect because I went to her appointment with her and hugged on her and she was exposed to the public

These rules have no common sense and our elderly are dying alone of loneliness and neglect! Please, change these laws! Our dear mother would rather die of covid than not see her children and grandchildren!

Respectively,
Lisa Schmidt

Roers, Kristin

From: kim johnston <steve2kim@icloud.com>
Sent: Wednesday, January 13, 2021 1:16 AM
To: Roers, Kristin
Subject: Isolation & Depression

My Mother has been locked away from her family for now going on 10 months .... She has lived her whole life up until this lockdown with Family.. now 83 years old and each day brings her closer to her end of life and she without any choice of her own is locked away .. She cries she is not happy and her smile is not there ... she needs family she needs our hugs as we need hers.. She has spent her life raising her children loving her Grandchildren and Great-children ..
There is no reason that the same PPE that the staff is required to wear to protect the residents , that Family can't be able to be in contact with their loved ones using the same PPE. This is cruel to be locked away and families kept away while staff are in and out going to Walmart, Grocery stores,family get together etc. and then ok to enter and tend to my Mother with the PPE and I am not offered the same to enter wearing the same PPE ??? None of this is ok and has gone on way to long with no resolve... I can't get this time back with my Mom ... her days left are getting fewer ...and I want to be near her, there for her,as she has been for me... Thank you for your consideration.....
"Let Us In"
Loving Daughter of Lola,
Kim Johnston

Sent from my iPhone

My name is Debra Leingang, address is 409 Keidel Trail Sw, Mandan,ND.58554 & this is my true & sworn statement.

To say that 2020 was a challenging year doesn't even begin to describe the Hell that everyone is going through that has a loved one in a long term care facility.

My Dad passed away Jan 22,2020.He shared a room with my Mom.I did daily visits with her to help her through this very difficult time-losing a spouse of almost 60 years.Then March comes around & the facility goes on "lockdown."NO VISITS! She had to go through all the firsts: first holidays, Dads birthday, their anniversary- ALL ALONE!Very few video app visits which she cries every time because we can't be there in person,very few outside visits - over a fence,NO PRIVACY,also cries because we can't hug.Very few outside window visits because the window is on her roommates side & cries when we say goodbye.

She is stuck in a tiny room,no activities,no socialization- her days are watching tv,coloring,putting puzzles together or just sleeping.Her mind isn't as sharp as it used to be & she dwells on things of the past.She is depressed,lonely & is losing muscle tone because of inactivity. She's missing out on grandkids & great grandkids,which range from 2&1/2 to 6&1/2: All who haven't been able to visit!

She had to put off medical care because she was told they couldn't let anyone in or out & didn't even get therapy for awhile.

She has stated numerous times that this isn't Quality of life.She would rather run the risk of getting the virus than not see family.

ALL the covid cases have been brought in by staff.It angers me because the staff is allowed to have other part-time jobs outside of Healthcare or frequent bars or restaurants, where we the family won't put ourselves at risk so we can visit!

I finally told her to make & go to her dr appointments even if she is quarantined afterwards because she has been anyways for most of the year.

She is stuck in her room,with a roommate that barely speaks, has all meals in her room & never gets any fresh air,activities or socialization. WHAT KIND IF LIFE IS THAT!

The vaccine isn't an option right now because of reactions to others & no studies have been done on people with crohns,parkinsons or have had strokes.

She is to the point of going out of her room with a mask on because "SHE HAS RIGHTS & IS GOING TO EXERCISE THOSE RIGHTS!"

So PLEASE OPEN UP & LET the Families in to SPEND WHATEVER TIME OUR LOVED ONES HAVE LEFT TOGETHER!

THANK YOU,

DEBRA L LEINGANG

To: All members of the North Dakota State Legislature

From: Mary Kaye Hjelle
1809 Heritage Avenue
Bismarck ND 58501
701-400-6954

I am writing to request that your body will enact a measure or measures that would help alleviate the extreme isolation that thousands of our elderly , residents of care facilities, are being forced to endure now, as well as in the past months, since the pandemic caused these facilities to cut off most contact from family and loved ones.

These people, many who do not understand why, have been denied the comfort and solace that in -person physical contact with those they love can provide. In many cases this has caused great emotional distress and severe depression. This lack of contact can even accelerate cognitive loss.

I was able to have a handful of indoor 30 minute visits with my 88 year old mother at one point this past summer which since have been discontinued. In addition we were able to visit face to face once or twice a week outdoors for 30 minutes when the weather was nice and no physical contact was permitted. Now that winter has arrived I am forced to visit her at her ground floor window when the weather allows, which now is difficult and in a normal ND winter would be impossible. Those who do not have accessible ground floor windows are even more severely isolated.

When she sees me at her window she's all smiles and motions for me to come in, I get her on the phone and tell her "mom I can't because of the virus". It is heartbreaking to see the wind go out of her sails when I tell her I can't come in yet. Or when I call her from my home to say hi and check on her, she will tell me to come over later and visit. I tell her I will but I have to visit at the window. She says there is no excitement or anything to look forward to any more.

I do not take issue with the care my mother has received, but personal access to her room to comfort her with my touch and words of love, as well as family news would make a huge difference in her mental as well as physical health.

I would ask that at least one "essential care giver" (a family member and one backup person) should be designated for each resident. Someone allowed to enter their room at any given time, with appropriate PPE and monitoring, in order to provide the comfort I have described, as well to maintain and monitor their physical health and the condition of their room and possessions.

I know that these essential caregivers would use at least as much caution, IF NOT MORE, when outside these facilities to avoid infection than those employed by the institutions.

My good friend was recently allowed a compassion visit with her elderly mother, who wouldn't stop crying, in a Bismarck facility. When her mother saw her she said "Where have you been, I thought you forgot about me." IS THIS HOW WE WANT THOSE WHO BUILT OUR STATE TO PASS THEIR FINAL MONTHS OR YEARS?

I think not, and am sure you agree. You can do something about it, I can't. PLEASE HELP!!!

I, Mary Kaye Hjelle, state that this is my sworn testimony, January 9, 2021

Roers, Kristin

From: Terri LeGrand <tlegrand5@icloud.com>
nt: Tuesday, January 12, 2021 3:33 PM
: Roers, Kristin
Subject: Bill 2145

Greetings Senator Roers,
I am writing in support of your bill soon to be heard. I have a mother in the Sheyenne Care Center in Valley City and have been in numerous conversations with the administrator, Craig Christianson since March. He dug his heels in right away and has continued to not be willing to hear my concerns or budge. Mr. Christianson has often told me that he has to follow what the VP3 task force is telling him and has also stated that his hands are tied by CMS because his actions can affect funding.
They have been in lock down a large part of the time since the pandemic was declared in March. My mother was failing by the week, not being able to have me there to spend time with her and to advocate for her. While the rest of the world was trying to return to normalcy, residents at Sheyenne Care Center were at the mercy of Mr. Chrisitianson's decisions. As more and more staff were testing positive for Covid, the rest of us were kept out of the facility. They did go through a period of breakout with both staff and residents in November, shortly after I took my Mom out for a therapeutic leave.
I could not stand to see what was happening with my mother and begged for there to be at least allowance for one essential caregiver to be able to come in. I was willing to follow whatever testing and following of masking, etc. procedures necessary to just be with her in her room. There was no concession on the care center's part, so on Nov. 4, I ok my Mom out and we have been paying a bed hold daily fee since. I did my best to provide the care she needed, as ifficult as it has been.
On Christmas Eve, she fell at my home and broke her leg. At 90 years of age, she chose not to have surgery and has been in the hospital in Fargo since. About a week and a half ago, I moved her to the Sanford Hospice House (still in the hospital setting) because in this setting, I am allowed to be with her and she can have two other visitors each day. So, with an added daily expense, at least I can be with her and still be her advocate.
I cannot take her home with me again and therefore, she needs to return to the care center. We are looking at a return date of Jan. 18. She has to be in bed and there is probably at least another 2 months of healing left for her. After having her with me the months of November and December and after now being with her around the clock since being admitted to the hospital after her fall, it is hard to imagine not being to do anything but see her through her nursing home window! I cannot put my life on hold anymore, but without her being able to have me visit her, i am so torn!
I have talked with the Ombudsman representative for Sheyenne Care Center, Mark Jesser, to be an advocate for me for allowance for compassionate care visits. He was in conversation with Mr. Christianson today and again, no willingness on Mr. Christianson's part to allow even compassionate care visits.
I will be calling Mr. Christianson again myself tomorrow. I am so frustrated with all of this! CMS has stated in their guidelines that compassionate care visits should be allowed.
Thank you for introducing this bill. I do hope my mother lives long enough for me to see this situation resolved.
Terri LeGrand

#1060

Testimony for Senate Bill 2145

Senator Dick Dever

January 18, 2021

Madam Chair, members of the committee, I am Dick Dever, Senator from District 32 here in Bismarck. I was asked by one of the advocates for this bill to provide testimony in support of the bill.

The reality of the coronavirus has demonstrated itself no more prominently than as it has raced through our long-term care facilities. According to yesterday's DOH dashboard, of the 1,384 deaths in North Dakota, 820 have been in those facilities.

While we have gone to great lengths to protect our most vulnerable, those efforts have been frustrated by the virus. The residents have not left the facilities. Their families have not been allowed to visit. As of yesterday, there were 48 residents tested positive and 78 staff members across the state.

It is time that we recognize that no one is more concerned about the health and welfare of the long-term residents than their families. All along, the question in my mind has not been if the families should be able to visit, but how they should.

SB 2145 provides the how. The proper protocols are included to allow for the safety of the residents. Together with rapid testing and the fact that most residents have received the first vaccine, the risk of transmitting the virus is less than other health conditions.

It is time to get back to living. I encourage your favorable consideration of the bill.

Testimony #1099

Senate Bill 2145 – Department of Human Services

Senate Human Services Committee

Senator Judy Lee, Chairman

January 18, 2021

Chairman Lee, members of the Senate Human Services Committee, for the record my name is Chris Jones, Executive Director of the Department of Human Services. I am here today to provide pertinent background information and associated content surrounding Senate Bill 2145. The Department is remaining neutral on this bill.

Since the declaration of a national emergency in March, skilled nursing, basic care, and assisted living facilities across North Dakota have faced great impacts as a direct result of COVID-19. Throughout the pandemic's duration, North Dakota has worked diligently to thread the delicate needle between ensuring resident's safety by saving lives and maintaining individual's psychosocial well-being within our states 215 skilled nursing, basic care, and assisted living facilities. Immediately after Governor Burgum issued executive order 2020-22 on April 6th to restrict visitation in these facilities, discussions proactively begin on how to best manage the COVID-19 response within these entities where our states most vulnerable population resides, including how safe reunification of residents and families could transpire. In short order, the state of North Dakota formulated the Vulnerable Population Protection Plan (VP3). The VP3 is composed of clinical professionals with immense experience in both the long-term care and acute care realms, in order to help facilitate that a safe, resident centered, and

evidenced based approach governed these congregate living settings during the COVID-19 pandemic. The VP3 team employed a multi-faceted methodology in order to assist our states facilities with responding to and effectively mitigating the spread of COVID-19. Key mitigation strategies that were imperative to this effort, included:

- Participation in rapid response calls
- Deployment of professional cleaning services
- Coordination of staffing needs via the distribution of CNA's, LPN's, and RN's to fill open shifts
- Providing advisement, consultation, and support services to facilities navigating a COVID-19 outbreak
- Securing of grant funds to help facilities install Halo Air Purification systems to assist with removing virus infected particles from the air

As a direct result of these proactive measures, North Dakota was able to pave the way in allowing for the safe resumption of visitation within these congregate living settings, nearly three months earlier than any federally issued easing of visitation restrictions occurred. On June 5th Governor Burgum officially amended executive order 2020-22, resulting in the allowance of visitation to resume within these facilities in accordance with the states VP3 plan and associated North Dakota Smart Restart Long-Term Care Reopening Guidelines. This phased reopening approach allowed North Dakota to be a national leader in the early reunification of residents with their families via progressively lifting restrictions in skilled nursing, basic care, and assisted living facilities across the state. Initial lifting of restrictions focused on an internal approach in

phase 1 and ultimately evolved to incorporate external components in phases 2 and 3. A vast array of factors were evaluated when determining entrance for gating criteria into the three tiered plan, including: COVID-19 case status in the county, COVID-19 case status in the facility, adequate staffing levels, access to testing, ability to screen residents/visitors, adherence to universal source control measures, availability of adequate PPE, and local hospital capacity. Over the summer months, facilities across the state steadily progressed through the various phases and ultimately most were able to graduate from outdoor to internal visitation. In doing so, numerous residents and families across the state were able to partake in visitation months ahead of our sister states and the entire nation. Furthermore, it is important to note that facilities maintained the ability to be more stringent if they deemed it necessary to safeguard the residents entrusted to their care.

Nonetheless, as community prevalence of COVID-19 rose in mid-Fall, there was a direct correlation with increased cases amongst both healthcare workers and residents who reside within these congregate living settings where our states most vulnerable population resides. Sadly, to date there has been 830 North Dakotan's who have lost the battle to COVID-19 within our states skilled nursing, basic care, and assisted living facilities (456 from skilled nursing facilities and 374 from basic care/assisted living). With that being said, the states approach to keeping all levels of care under the same guidance has been vital to mitigating the spread of COVID-19 amongst our whole vulnerable population, largely due to its robust testing strategy and associated visitation/service guidelines. This unified approach was further supported and praised

by Dr. Deborah Birx, Coronavirus Response Coordinator for the White House COVID Task Force, during her visits to North Dakota. Since many of our state's facilities house multiple service lines within a single building, historically this approach has also avoided having to differentiate restrictions by level of care, which would be an extremely daunting task to successfully achieve for administration. Both Minnesota and South Dakota have also opted to maintain visitation guidance that is consistent between skilled nursing and their assisted living communities, even though CMS doesn't govern assisted living.

In light of the guidance released by the Centers for Medicare & Medicaid Services (CMS) related to visitation for nursing homes in QSO 20-39-NH on September 17th, key North Dakota stakeholders had been working with CMS to request modifications to align more closely with our current visitation plan (N.D. was far less stringent than the new Federal requirements). Unfortunately, CMS verified on October 16th that North Dakota would have to conform to the new guidelines and communications then ensued to notify the public that North Dakota would be tightening up their visitation for skilled nursing facilities effective immediately. Nonetheless, as the state ultimately holds oversight of basic care and assisted living entities, we were able to modify these guidelines to promote the allowance for some form of indoor visitation to occur within all these facilities since early November. To reiterate that point, all basic care and assisted living facilities which are overseen by the state, from the states perspective can have indoor visitation in either a safe, designated indoor space or in their own room depending on the facilities status today (current data reflects that 85%

can have in-room visitation, with only 19 facilities having to engage in indoor visitation within a safe, designated indoor space due to either the county positivity rate or having a COVID-19 case within the past 14 days). In contrast, both Minnesota and South Dakota have elected to mirror the stringency within CMS QSO 20-39-NH for skilled nursing facilities and apply this directly to their assisted living communities as well. In fact, Minnesota goes as far to specifically state in their assisted living visitation guidance that, "In an effort to be consistent with CMS guidance, MDH will consider essential caregiver visits as a type of compassionate care visit". Alas, an approach that North Dakota avoided and as a result has been able to safely achieve the more open visitation scheme shared above. Therefore, our existing guidance allows for more than a "essential caregiver" and we are unsure of how the proposed legislation would further enhance the existing guidelines without superseding federal regulation and potentially causing a false public perception of increased hope surrounding visitation changes.

I would be happy to answer any questions that you may have.

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Senate Bill 2145
Human Services
January 18, 2021, 9:00 a.m.

Good morning Chairman Lee and members of the Human Services Committee. My name is Bridget Weidner and I serve as the Director of the Division of Health Facilities for the North Dakota Department of Health (NDDoH). I am here to provide testimony in order to offer information related to the Centers for Medicare and Medicaid Services (CMS) current visitation guidelines in nursing homes during the COVID-19 public health emergency.

Nursing homes certified by CMS are required to follow federal requirements. These guidelines only apply to nursing homes, not basic care or assisted living facilities as these entities are not regulated by CMS. In March 2020, CMS issued a memorandum providing guidance to facilities on restricting visitation for all visitors and non-essential health care personnel, except for certain compassionate care situations. In May 2020, CMS released Nursing Home Reopening Recommendations which provided additional guidance on visitation for nursing homes as states and communities progressed through the phases of reopening from COVID-19. In September 2020, CMS issued QSO-20-39-NH Nursing Home Visitation-COVID-19. The intent of this guidance was to provide reasonable ways a nursing home could facilitate in-person visitation to address the psychosocial needs of nursing home residents.

In the September 2020 memorandum, CMS provided core principles of COVID-19 Infection Prevention, consistent with the Centers for Disease Control and Prevention (CDC) guidance, which must be adhered to during any visitation. CMS indicated all visits should be held outdoors whenever practicable as outdoor visits pose a lower risk of transmission. The memo outlined that aside from weather considerations, an individual resident's health status, or a facility's outbreak status, outdoor visitation should be facilitated routinely. Facilities were to create accessible and safe outdoor spaces for visitation.

CMS also stated facilities should accommodate and support indoor visitation when there is no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing. In addition, facilities are to use the COVID-19 county positivity rate to determine how to facilitate indoor visitation. If the county positivity rate is greater than ten percent, indoor visitation should only occur for compassionate care situations according to the core principles of COVID-19 infection prevention and facility policies. If a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is less than 10 percent, a nursing home must facilitate in-person visitation consistent with the regulations. Failure to allow visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of resident rights. Failure to adhere to infection control practices would constitute a potential violation of infection prevention and control. Unfortunately, around the time of the September 2020 memo, North Dakota (ND) began to see a rise in COVID-19 cases and most facilities had positive residents and/or staff and their county positivity rate was greater than ten percent which did not allow for regular indoor visitation. ND was also beginning with our change in seasons which made outdoor visitation difficult.

In this memo, CMS stated they do not distinguish between essential caregivers or designated caregivers and other types of visitors and that these guidelines cover all types of visitors. They also encouraged facilities to test visitors but were clear to say that visitor testing is not required.

In summary, CMS has attempted to balance infection prevention and control with resident rights regarding in-person visitation. The memo issued in September was to provide reasonable ways to facilitate in-person visitation. Nursing home facilities certified by CMS are required to follow these requirements regardless of state and local laws and regulations.

This concludes my testimony. I am happy to answer any questions you may have.

#1145

January 17, 2021

SB 2145 – providing for access to long-term care facilities

Chairperson Lee and members of the committee,

My name is Roza Larson. I'm here today in speak in favor of SB 2145. I'm not here to vilify long-term care administrators, nurses, aides or other staff, who I believe have been acting with the best interests of all concerned in these unprecedented times.

I'm here to talk to you as a daughter of a loved one in long-term care. My story is much like many I'm certain you have heard. April 6, 2020 was the day my 90 year old mother's life changed forever. April 6, 2020 was the day she fell and shattered her wrist. Until that day she was living independently, in her home on the farm. Until that day she had the ability to visit people, call people, drive to town. I lived 3 hours away in Minot and am the State's Attorney. When I got the call that she had fallen, my husband and I went down right away and got her to the hospital. The next day she had surgery. It was at that time she was assess and it was determined she could not live alone. She needed supervision 24/7. She did not qualify for assisted living, but rather, she needed a higher level of care.

So on April 10, 2020 I had to tell mom, she would not be going home to live. That she would be staying in the hospital until her quarantine time was over and then moved into the Good Shepherd home. Because of the protocols put in place, that was the last time I got to visit her face to face, the last time I got to touch her until the middle of July when for a brief 2 or three week period of time, family members were allowed to go inside the home and visit their loved ones in their room.

This isolation exasperated her confusion. I would attempt to talk to her on the phone, but often times that was difficult. Her phone line didn't seem to work properly, she claimed she didn't know how to use her phone, others were calling me telling me there were issues with her phone as well. The nurses were wonderful in bringing her to the station to talk. The problem was she wanted to tell me something private she felt she could not, "they are all listening" There were things she wanted to tell me about her care that she didn't like. Concerns she had about what was happening to her, that she felt she couldn't tell me on the phone because people were listening. I wasn't allowed to go inside, go into her room to help figure out what was going on with the phone. I wasn't allowed to go inside and have a private conversation with her to try to figure out what was going on that was making her feel uncomfortable and anxious. I was allowed window visits. Visits over the Ipad, visits with her sitting in a hallway where others were ~~wondering~~ wandering around. We were allowed patio visits with a staff member sitting nearby who could hear what we were talking about.

When I was able to go into her room and visit her privately in July, she finally told me what her concerns were. It wasn't until July that I was able to find out what was going on and get it changed.

Until then, mom was not able to have visitors in her room. She was not able to visit other residents in the home, and she has to eat her meals alone in her room. Yet at the same time, she would see other residents were allowed to eat in the dining room, other residents were allowed to have visitors in their rooms. One of these residents is a lifelong friend of mom's whose room is across the hallway. There were many times mom would get scolded for going over to her friends room and staff chased her out of there. Sometimes her visitors would step in and stop them from chasing her out, as they could tell the visits between them was doing them both good.

It does seem a bit unequal and unfair. Over the months of isolation, mom's condition has worsened and her classification has now changed to compassionate care. I guess at this point I'm thankful it got worse, because now I'm allowed to go inside and visit. Now others are allowed to go inside and visit her in her room as well. But when I think of what it took to get to this point it makes me frustrated and sad.

SB 2145 allows for this type of isolation to be prevented. SB 2145 does not go far enough in that it only applies when the governor declares a disaster or an emergency. It is my hope we will never see another pandemic like this. I would suggest that SB 2145 not be as narrow as to only apply when the governor declares a disaster or emergency. I draw your attention to an incident that occurred at Knife River Care Center in 2018. The facility locked-down due to a significant flu outbreak. Flu outbreaks are common and can pose as big of a health risk to long-term nursing facilities.

Again, my purpose here is not to disparage the hard work of those working in the facilities. Residents have rights, they have a right to have visitors. They have the right to have people who provide physical, emotional, and spiritual comfort come to visit them. They have a right to privacy and to be able to tell or confide to somebody with issues they may be having. This wasn't allowed during this time of pandemic, except for those classified as compassionate care, or sadly end of life. Basic human rights should not be suspended even during a pandemic or a flue break out or other reasons.

SB 2145 would allow a loved one, other trusted designated person to have access to the resident. Allow for those private conversation, allow for that human touch that is so needed all the time, but most especially when a love-one is suffering from dementia, or depression, or confusion…

SB 2145 would allow residents to have a designated person or persons come into their room so they could discuss private matters, somebody they know and trust that will look out for their interests and somebody they trust they can report their concerns too and have them look into it. Like I needed to do for mom when she had concerns. It was nearly 4 months after she had moved into the home before we finally got to have a private conversation in July. She finally got to tell me what was going on. The anxiety she had, we both had in not being able to discuss the problem she was having in private had a profound impact on her mental health.

I mentioned to you, I am the State's Attorney in Minot. Inmates in the Ward County Jail have these rights, even through the pandemic, even when there are other lockdowns or emergencies that restrict visitors or others access to the inmate. They still have the constitutional right to attorneys, they have the constitutional right to privacy in talking to those attorneys in person, they have the ability to report issues, concerns regarding their care and treatment in the jail in person. The residents in nursing homes have not had that right.

SB 2145 does not infringe significantly on administrator's right to keep control of their facility. It allows them to set in place protocols the designated people must follow.

SB 2145 It allows the administrators to suspend access if the protocols are not followed. – Although need to have a grievance process.

SB2145 ensures that residents will not be completely isolated, it ensures residents will have at least one person to be able to visit them privately. It allows the residents continued support emotional and spiritual support by loved ones they know and trust.

#962

January 15, 2021

Dear Senator, Roers,

I am writing today in support of SB 2145, a bill that would assign designated caregivers to long term care residents.

My name is Tessa Johnson, and I am a registered nurse in North Dakota. I am the Executive Director of CountryHouse residence in Dickinson North Dakota. CountryHouse Residence is licensed as a basic care and memory care home. I also serve as the NDNA President.

March 13, 2020 will be a day that I will never forget. That will be the day I did the unthinkable. I locked the doors to our home to keep our family members out. CountryHouse is owned by a family company called Agemark. Agemark is owned and operated by a family and family is a true spirit of who we are and what we do. Whether it is our staff, our residents, or their family members we believe so strongly in the value of family.

All the residents that live in my building have some sort of memory loss such as dementia. Their conditions change rapidly. Sometimes they change by the day sometimes by the week and sadly, sometimes by the minute. Every single minute of time they have is precious to their families. During the last 10 months some of our residents have changed drastically. Some of their family members have not been able to see them at all. Sadly, some of our residents no longer remember their family members from when they got to see them last. As a Director, I have had to make some of the hardest decisions in my life. For an example, I had a gentleman who is in his last hours of life. His wife who still lived on their family farm, was on her last day of quarantine for COVID. I had to make a tough decision was she allowed to come in and say goodbye to her husband or not. Those kinds of decisions will haunt me for the rest of my life regardless of the decisions I make. Most recently I have another resident who is seeing the tolls of dementia and in his last days of life. Just last week I had to kick some of his family members out for him to meet his great granddaughter for the first and last time. These are moments this family should be able to cherish together. These are the moments where we need to remember that these are human beings and that these are human lives. We need to be humans.

In addition, during this pandemic we have been very fortunate in the building in which I work. We have only had two positive residents and they have both recovered well. Although, we have had staff that have been positive. Because we are small, and we only have approximately 30 to 35 staff when we have three full-time staff out with COVID that drastically affects our staffing. We had several family members, who most are elderly, offered to come in and help during these times. It would not be realistic for them to become CNA’s in that short period of time or ask them to go through that training. Although, there could have been many things that they could have done physically, emotionally, and spiritually that could have helped our residents and our staff. And they would have been able to see their own loved ones.

Also, during this time our governor passed to allow asymptomatic positive staff to be able to return into the building to take care of COVID positive patients. I have been publicly speaking out against this. However, I find it very ironic that we were going to allow this to happen although we still are not allowing family members to be appropriately screened and wear the appropriate personal protective equipment and still not be able to visit.

The residents that I care for and the residents across the state in long-term care facilities are precious. They have precious time left with us. We need to find a way to be sure that they can spend those last precious time of their life with those that love them the most. We must be an advocate for them. We must look for a way to move forward and to do that safely.

I strongly believe that the designated caregiver bill will allow us the framework to do this. As an administrator and as a long-term care employee we know that we must start opening our doors. We owe it to our residents our families in our communities. When I move a resident into my building, I make a promise to them and their families to do everything I can to give them the best life and the most joy I possibly can. I can only do so much, the residents in my building deserve to have their loved ones around them and they deserve to see their family.

I thank you for your consideration.

Warm Regards,

Tessa Johnson, MSN, BSN, RN CDP

Executive Director CountryHouse Residence

President, NDNA

President, ND Center for Nursing

tjohnson@countryhouse.net

Madam Chairwoman Lee, Sponsor Senator Kristin Roers, and members of the Senate Human Services Committee, thank you for allowing me to speak this morning on behalf of SB2145 regarding access to LTC facilities by Designated Caregivers.

My name is Beth Sanford.

I am a Master's-Prepared Registered Nurse, born and raised in North Dakota. I got my start in nursing working in my local LTC facility at age 15.

I was a nurse's aide for seven years before obtaining my BSN and then MSN from UND. My specialty is working with vulnerable populations, including a two-year stint in LTC and a memory care unit as a staff nurse and then nurse manager. For the last five and a half years, I have been employed as an assistant professor at a local university; many of the students I teach are currently CNA or LPN working in Long Term Care. Among the courses and content that I teach are public health, leadership, disaster-preparedness, and ethics. I am also a Doctor of Nursing Practice student specializing in Public Health and Policy. Also, specifically related to this bill, I am a former member of the Reuniting Residents and Families taskforce set up by DHS and a co-founder of the family-led organization, North Dakota Advocacy for Long Term Care.

The Guidelines handed down from the Centers for Medicaid and Medicare Services, Executive Order 2020.22-1 and the VP3 guidance impacts approximately 8,000 residents in Assisted Living, Basic Care, and Skilled Nursing facilities, countless family members and staff across the state—an upward estimate of 100,000 North Dakotans.

While I understand there is no playbook for a pandemic, the unintended consequences of these policies have caused a lot of unnecessary suffering.

I testify before you today not only as a 25Y seasoned healthcare professional but as a daughter of North Dakota whose family has been and continues to be deeply impacted by the current visitation policies.

In December of 2019, our 93Y grandmother moved from assisted living to the combined basic care and skilled nursing side of her facility. The facility's recent renovation had cut off her independent access to activities, chapel, and her life-long friends. Other than the fact that she is legally blind and walks with a walker, she is very healthy. Like every family, the visitor restrictions while residing in LTC began to take their toll on her well-being and quality of life, including her cognition, physical & emotional health. She became unable to operate her phone, isolating her from her only living child and daily visitor, our mother. At one point, she was fearful that our mother was in jail.

Her conversational ability strikingly declined, and she was unable to talk about anything but the weather.

She also complained about increased pain, likely from the hours and hours of sitting isolated alone in her room. Our mother visited her daily at the window. Unfortunately, it was a thick-paned glass that was difficult for my grandmother to hear through in addition to her visual impairment.

In July 2020, after an incident where our family was refused a valid compassionate care visit, we removed my grandmother from the LTC facility. She is now being cared for by our mother and a local woman that we have hired as there is no homecare in our county. Our family has a beautiful end to our story; our grandmother came back to life. At the age of 93, she regained some of her cognitive function, emotional health, mobility, and some. She now sings, dances, laughs, tells jokes, lifts weights, exercises, walks three times per day, attends church and bible study, and participates in all family events. She is truly living her best life.

However, not everyone has the means or ability to bring their loved one home. Many of these families kept contacting us from all over the state, asking for help.

In September of 2020, after seeing several other states enact Designated Caregiver legislation, four resident family members and I looked to our hometown Senator, Dale Patten, for help.

We shared our story and informed him of the devastating unintended consequences of the current policy. Thank you to Senator Patten, Senator Roers, and the Humans Services committee for encouraging revision of the existing Executive Order. The family-led organization, North Dakota Advocacy for Long Term Care, was created at this time as an effort to bring families together. The purpose is to provide a supportive environment, to provide resident and family resources, direct people to the State Ombudsman, inform residents and families of their rights under the 1987 Nursing Home Reform Act, and as a venue to discuss overreach and brainstorm creative solutions to recommend to facilitate visitation. To date, over 16,000 North Dakotans have accessed information from our group and page, a confirmation that we are not the only family with a resident that requires advocacy during COVID overreach. At that time, we began to discuss with Senator Roers the need to follow other states which had enacted Designated Caregiver legislation. That brings us to today.

It is nearly one year since the initial lockdown. We have counties that are green without one positive case in the facility that are still not allowing visitation. There are residents and family members who have not visited in-person or touched their loved ones since March 2020; this is unacceptable. One could question whether this could be considered a violation of the 1987 Federal Nursing Home Reform Act Resident Bill of Rights; therefore, a human rights violation. The September 17, 2020 CMS Visitation Guidelines read:

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.

SB2145 would safely allow residents and designated caregivers to reunite, increasing quality of life and emotional well-being for all parties involved.

This law would release staff from policing resident families and be the sole source of emotional support.

This law would allow facilities to safely begin the process of visitation with the backing of state law without fear of unnecessary repercussions.

The hearts of thousands of North Dakotans: residents, family, friends, and staff are broken. Therefore, this law is imperative not just for the days of COVID but will provide checks and balances to the LTC system going forward so that this never happens again.

Please vote in favor of SB2145; Together, let's make North Dakota a good place to grow old in.

This is my sworn testimony. Thank you for your time and consideration.

Beth Sanford

Testimony
Senate Bill 2145 - Department of Human Services
Senate Human Services Committee
Senator Judy Lee, Chairman

January 18, 2021

Chairman Lee and members of the Senate Human Services Committee. I am Karla Backman, State Long-Term Care Ombudsman. Essentially, I am the program administrator for the Long-Term Care Ombudsman Program in North Dakota. I am testifying today in support of Senate Bill 2145.

As the State Long-Term Care Ombudsman, I have the honor and responsibility to advocate to protect the health, welfare, safety, and rights of residents of long-term care facilities. As you are fully aware in response to the public health crisis of the COVID-19 pandemic, both federal and state authorities responded by waiving many rights of the residents of long-term care facilities. One of the rights waived that has had much attention was the right to visitation from individuals of the resident's choosing.

The restrictions on visitation have taken a significant toll, impacting residents' physical, psychosocial, and mental well-being. The ombudsmen have heard the stories of residents who were fully functional, walking, and talking and through the time period of restrictions became withdrawn, lost mobility and muscle tone, and whose communications became disjointed and unclear. The negative effects experienced by many residents illustrates the critical necessity of support and interaction between residents and families and friends.

Designated caregivers can be a part of the solution to reduce the unintended but harmful consequences of prolonged physical separation and social isolation on residents through the in-person engagement they can provide. They can assist with communication with staff, aiding with eating, resident engagement and activities, and basic socializing.

Designated caregivers are also seen as a support to the staff of long-term care facilities. Even during 'normal times' staff are busy attending to the myriad of resident needs. During times of public emergency there is an increased toll on staff caused by additional responsibilities, requirements, and staff shortages.

I support Senate Bill 2145 as it is a step towards restoring to residents of long-term care the right to have in-person contact with designated individuals and protecting this right in the future. I believe Senate Bill 2145 is a step towards moving past crisis response to establishing best practice for residents of long-term care facilities. It honors the rights that residents should not have temporarily lost and is person-centered.

Thank you for your time.

This concludes my testimony, and I welcome questions from the committee.

Members of the Senate Committee

Thank you for the opportunity to share with you why I would like to see House Bill #2145 passed.

Both of my parents live in the Horizon an Assisted Care Facility in Watford City. Prior to Covid-19, they were accepting of their health limitations and for the most part were enjoying living in this facility. Since March of last year I have seen a dramatic change in both parents. For months we could not go in to see them or help them with finances, household issues etc. This became very upsetting to them. They became fearful and anxious. During this period my mother had medical episodes that should have put her in the hospital but because of Covid-19 they sent her back to her apartment with orders for 24 hour care which is not provided. I am their primary support for health care and pleaded to let me go into the apartment to be the 24 hour supervision she needed but they repeatedly said NO. Because of this failure to provide adequate medical care she ended up with complications that put her back in ER. This same thing happened to my father. I do not understand how my coming into their apartment would put any body at more risk than them being taken to the ER and Hospital for Lab work and x-rays that would not have been needed if adequate care had been provided. Assistance was only provided from 8:00-4:30. My parents lived in fear for months during the lockdown afraid that if they did something wrong they would be kicked out of their apartment and they would have nowhere to live. My father had permission to walk the halls with his mask as it is medically necessary to keep his anxiety under control. He was afraid to even do that because he thought someone might see him and tell on him. (Which they did) They have gotten to the point they don't dare do anything without asking. The Facility stresses their wishes in a way to the residents that it intimidates them and makes them fearful.

When the State finally decided that Assisted Living should be separate from LTC. The Staff of the Horizon went in and went over the new regulations with the residents. They pretty much told the residents that they could not make them follow the same rules but for their protection they certainly would STRONGLY suggest they follow them. After repeated times of telling my parents that now they can have company in their apartment and they can have coffee, they still ask. The answer is "We strongly suggest that you don't". I have told them many

times that they can have anyone they want in their apartment and can serve their guests anything they want. It is their home and if they are comfortable with company with no masks coming to have coffee or pizza, they can. They are always fearful of doing the wrong thing. “If we get kicked out of here we won’t have anywhere to go”, is the statement I always get. I have reassured them that they don’t have to worry. They have lived under order for so long they can’t even think on their own.

I have a Second Mother who lives in LTC. She has been in lockdown up until about a month ago when she literally went to bed and decided she just didn’t want to live any more. I received a txt from her daughter one day saying that she had gotten so bad that they were allowing Compassionate Care visits and that I was on the list. The first time I went in the curtains were pulled the lights were off and she was curled up under several blankets. I tried to get her to sit in the chair and visit with me but all she would say is, “There is no use”, “There just isn’t any use”. She was stuck in this place and no one could come see her and it was awful and there was nothing to live for anymore. She would say to me, if I walk out in the hall they just tell me to get back to bed. I tried to reassure her that it would get better now. After a couple of weeks of visitation, she now enjoys having me do her nails and looking through cards and letters and going down to see the birds and walk me out. She knows I will be back and counts on it.

My mother in law died on December 18th after being in the LTC facility in Watford City for three months. Because she was end of life family was allowed in to visit 2 at a time. We were not allowed to talk to any of the other residents while in the facility and could not take her out of her room for a walk or anything. She always told us that she had never broke the law or committed any kind of crime in her life yet “Here I sit in Prison, she would say” She missed seeing her friends and grandchildren who could not come to see her. She had a stroke on December 14 and died on the 18th. She finally got out of her room.

I truly do believe that in all of these cases had Compassion, Care and Common Sense played a part, the outcomes would have been much better. I firmly believe that having just one family member allowed to go into the facility and touch them and give them encouragement, reinforcing that everything is all right and looking

into their eyes would bring life back to these forgotten Legends! Right now, there is no life left in a lot of these Residents eyes.

I have a close friend/sister who is dying as I write this with a brain tumor. We are fighting to keep her out of long term care because we would not be able to see her. When I am there she doesn't know a lot but she does know I love her and what my hug feels like! I will not let them take that away from her or me!

All of the Covid cases that came into the McKenzie County Healthcare Systems came from employees. I would have gladly taken weekly Covid testing to make sure I could be there for my parents. I feel each resident deserves a family member of their choice to come and be with them to fulfill emotional, physical, and spiritual needs.

I also believe that we cannot operate on a one size fits all Bill. There is no way we Operate a facility in ND the way one is run in New York. We also need to take this to the next step and get Federal Restrictions relaxed and on board with letting families have one lifeline.

Thank you for your time and for giving this the consideration it so deserves. These are the people who have formed us, our Community, our State and our Nation. They deserve better.

Barbara Johnson

Madame Chairwoman, and members of this Committee, my name is Lisa Buchweitz from Langdon. I am here today to give my support to SB 2145. I am also here to testify on behalf of my Mother and all others who are residents of long term care facilities. The restrictions that have been forced upon them in the name of "protection" have been over reaching and detrimental.

My Mom is 92 years old. She suffers from dementia. In early March of 2020, her facility went into lock down due to Covid-19, about a week ahead of CMS QSO-20-14 restricting visitation. On April 6th Governor Burgum issued executive order 2020-22 doing the same.
My Mother's condition had been kept somewhat in check by maintaining established routines. Regular visits at approximately the same times helped keep her world predictable and in balance. That was destroyed with the implementation of Covid restrictions. This past year has been a true emotional roller coaster ride for my Mom and so many others. I have had numerous phone calls from her in tears, not understanding why her family has abandoned her, saying that she might as well be dead! My Mom hasn't had a proper hair cut in a year! Can you imagine how that affects her dignity? And no matter how caring staff may be, they cannot replace family. They don't know the residents history or what may drive certain behaviors. . Essentially, I was removed from my Mother's life and the care plan process. And I have been raising hell since March of 2020 to make sure I have as much input as possible in my Mom's care.

I fully recognize the role CMS has played in this situation, but this bill is truly the best place to start to right the wrongs that have been done against our loved ones by the States interpretation of those guidelines.

On June 5th Executive order 2020-22.1 was issued establishing the Vulnerable Population Protection Plan (VP3) covering not only skilled nursing facilities but also basic care and congregate living facilities.

Shortly after, I became involved with the Reuniting Residents and Families Task Force. We had conference call meetings on June 6th, June 10th, June 18th and July 20th. In addition to people like me advocating for their loved one, these calls included Chris Jones, Seth Fisher, Shelly Peterson, and Tim Wiedrich and other officials. Also very much involved is Chris Larson as lead for the family part of the task force. In many ways I feel this task force was partly implemented to "shut

up" the many people like myself who felt that residents rights had been completely overran under the guise of "protecting" them. I feel this way because it quickly became apparent that aside from uttering a few sympathetic words, there was no intention of this team doing anything about any of our concerns. It was their way or the highway, period. As far as I know, only the definition of "compassionate care" was redefined and that alone took way longer than it should have. Yet the Long-term Care Guidance issued by the State says input was used from key stakeholders, including the Reuniting Families Task Force. From my perspective this is not true.

From the beginning I asked to be able to test for Covid-19 in order to be able to visit my Mom. A "pilot program" was initiated at one facility and apparently nothing ever came of it because I have never heard anything about it since. What happened with that? Is it because it did actually work that nothing ever came of this program? In fact, this task force hasn't had a meeting since July 20th! From the get go, we advocated for a designated caregiver to be implemented. Many other states have had this in place for months already and they are under the same Federal restrictions as we are. IT'S NOT THAT DIFFICULT.

I would also like to know why did tens of thousands of rapid tests sit in a warehouse for months after receiving them. And why were nursing home facilities not allowed to use them after receiving them? But now all of a sudden they are supposed to use them, quickly! These tests could have been used to facilitate more family visitation. So much more could have been done for our loved ones!

Today the State mask mandate expired. Except not for basic care nursing homes and assisted living facilities as Executive order 2020-22.1 will still apply. Apparently the Governor and the VP3 Team doesn't feel if you live in a basic care facility or assisted living that you are also a citizen with rights? This is overreach, plain and simple. Let the residents and their families decide what is best for them. The State also should not be issuing guidelines that extend beyond the CMS guidelines and nursing homes should also stick to those guidelines and not go beyond.

In closing, I ask this question of all of you. If you were 92, which would you chose? Spending what time you have left here on this earth with your family? Or

spending hours alone, eating alone, limited contact even with other residents, to be “safe”. I know what my choice would be, and I know what my Mom’s choice would be also.

I am asking the members of the committee to please support this bill. Thank you.

This is my sworn testimony.

Lisa Buchweitz
510 17th Avenue
Langdon, ND 58249
701-370-8513

Thank you Chairwoman Lee and members of the Human Service Committee for the opportunity to testify in support of Senate Bill 2145 – the Essential Caregiver Bill.

My name is Amber Vibeto, from Minot District 3, and I'm here today on behalf of the North Dakota Conservative Political Action Committee representing conservative men and women across the state in nearly all 47 voting districts.

As we have endured the spread of COVID-19 and the government's response to it for the last year with no end in sight, and because we are arguably no longer in a state of emergency, it is clear that it is time to revisit all of the restrictions that have been put in place, including those that have been placed on the North Dakota residents of long-term care facilities and assisted living rental apartments.

Restricted visitation was well-intended to keep residents and staff safe in both long-term care facilities and assisted living rental apartments. However, one of the unintended consequences of this ongoing executive order is the considerable emotional trauma that many of our elderly North Dakota citizens, as well as their family members, have gone through, and continue to go through as we speak. On June 5, 2020 the state outlined a phased approach to resume visitation in long-term care facilities, but to date there are some facilities that have continued to stay closed to visitation even with zero COVID-19 cases. This extended restriction in visitation is due to the executive order (2020.22.1) allowing for healthcare staff to implement more restrictions than what CMS already has in place.

The ND Conservative Political Action Committee would like to go on record as supporters of the Essential Caregiver Bill. We believe that residents should never again be completely cut off from their family members and friends with no end, and therefore, no hope in sight. Having an outside caregiver such as a family member or friend is imperative in providing the holistic and ethical care our elderly citizens deserve. Yes, we should be protecting our vulnerable population from COVID-19, but their mental and emotional health must be taken into considerable consideration. It is a cruel thing to force innocent, law-abiding citizens to isolate for months on end, but particularly when they are living out their last days. What makes the restrictions on our elderly so much worse is that many of these residents fought for your freedom and for mine. The very least we can do is honor their sacrifice by extending back that very freedom and allow them to choose who will be with them to comfort them in their last days. Please vote in favor of Senate Bill 2145 and advocate for the removal of executive order 2020.22.1. Thank you for your time and for allowing me to testify on behalf of this important issue.

Amber Vibeto
Minot, District 3
President, ND-CPAC
ndcwpac.com@gmail.com
701-340-6378

Hello,

My name is Deann Stanley from Harvey, North Dakota. I am writing you in support of Senate Bill 2145. My mother is in Long Term Care in the Harvey Nursing home. It has been a very bumpy road for her since March of 2020. She has dementia/Alzheimer's. We moved my mom in to the nursing home in January 2020. We cared for her for well over a year after my dad had passed away.'

I will start of by saying that pre covid my mom loved the nursing home, we would visit her almost daily and take her out a couple of days. She adjusted well and was making her room her new home. The staff were wonderful and you could see they truly cared.

From March until present she has had emotional, physical and spiritual changes. She has started an antidepressant in summer of 2020 to help cope with her feelings of loneliness and sadness, we had to up the dose in November. She gained quite a bit of weight as she couldn't exercise as much being isolated in her room. She was unable to attend church when on lockdown so she questioned her faith because she could not openly attend services in their Catholic based nursing home. These should be basic things a human has access to: family, exercise or just space to walk and not confined to a room and to be able to attend church.

She missed her son being married in June because she did not want to be quarantined again because she had been locked in her room for so long with the lock down. She felt terrible but isolation in a small room is awful.

Her speech really declined because they did not get out of their rooms the majority of the time and less activities and talking so there fore she wasn't using that area of her brain. She is down a lot because she cannot read or write, she needs assistance dressing, bathing and daily living. It is not good for her to be alone or confined to a room.

We had an instance during a supervised visitation inside when she looked at me and broke down and began to cry because a worker was rough with her dressing and she was very down and hurt about the incident. If I hadn't of been able to visit her and for her to feel safe in my presence I would have never have known. It was addressed and handled. A couple days later visits were stopped and no longer could we see her and my heart sank thinking about her being isolated and what if it happened again? She wouldn't feel comfortable telling me on phone or iPad screen with someone watching. Often times emotion surfaces when we are in the presence of peace and comfort.

My brother took my mom to Mayo in October and she had to be quarantined again just for going to the doctor when she got back. That was where things just started to get hard again and sad. We had to increase her depression medication and she just wanted to get out and see her family. She would call crying. She missed thanksgiving.

She stayed in until after her birthday, December 5. She had a hard couple of days after her birthday. She had to open her cards and gifts alone or at times a worker would read her cards since she can not read. She got a bar of soap and she thought she could eat it and so she did eat some of it and had stomach aches and did not feel well. If one of us could have spent time with her to open gifts and cards that would not have happened and she would have known it was soap because we would have told her. We couldn't comfort her and she felt terrible that she did that. Someone told her it was soap and then she got really down on herself for "being so dumb".

She really went down hill and just wanted to be with our dad (heaven). She called a couple days later just balling and we knew we had to take her out and just love on her because she

was falling apart. We took her out everyday trying to give her a reason to wake up each day, smile, enjoy life a little bit. She did and she loved every minute and wanted to get out everyday. She spent Christmas in her house, with family, decorated her tree, and had everything that mattered in her life at her grasp. The staff gets this same right and a resident should have access to their family in their home. A nursing home is their home, they should be able to have us who cared for them in it.

In January she had a really bad fall and open her head and had a huge hematoma ad bruising on her back and eye. She needed staples and a CT. It was so hard to not be able to see her or just provide her comfort. The next day she fell again and this time she opened the back of her head all the way down to her skull open and needed stitches and another CT and MRI. In these situations which she somehow survived, it is a shame that a familiar family member cannot come in to provide comfort, emotional support and offer care. We could take her out but that puts her more at risk for a fall with these incidents so we cant do her justice either way. Please consider these residents in situations where family is best.

The staff is doing the best they can but it is not doing them justice either. They are not meant to be everything to each resident. It was to be a partnership between family and facility. This is a burden on the staff and that is not right. We are waiting to be able to spend time with our loved ones - we shouldn't even have to ask!

Covid 19 found its way in the nursing home and workers in Harvey and took zero lives, but it still got in so what are we really doing here? They are humans and deserve more than isolation. They have a voice and its time for us to start listening to them. By keeping them "safe" which hasn't been successful, it is damaging them emotionally, mentally, and physically. With anyone with cognitive decline with Alzheimer's or dementia, their good days are limited and they are at their very best today. Let them live their good days surrounded by those who love them.

Thank you,

Deann Stanley

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

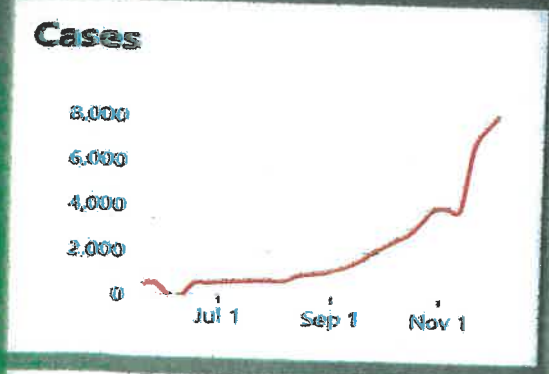
Good morning Chairman Lee and members of the Senate Human Services Committee. My name is Shelly Peterson, President of the North Dakota Long Term Care Association. We represent 211 assisted living, basic care, and skilled nursing facilities in North Dakota. I am here to testify in support of the legislation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

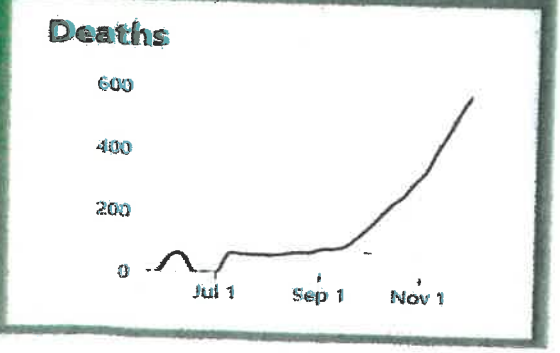
The global outbreak of COVID-19 has been traumatic unlike anything any of us have probably ever experienced. Now in the tenth month of the COVID-19 pandemic, the toll of physically separating residents from family has impacted everyone involved, including the dedicated facility staff members who are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

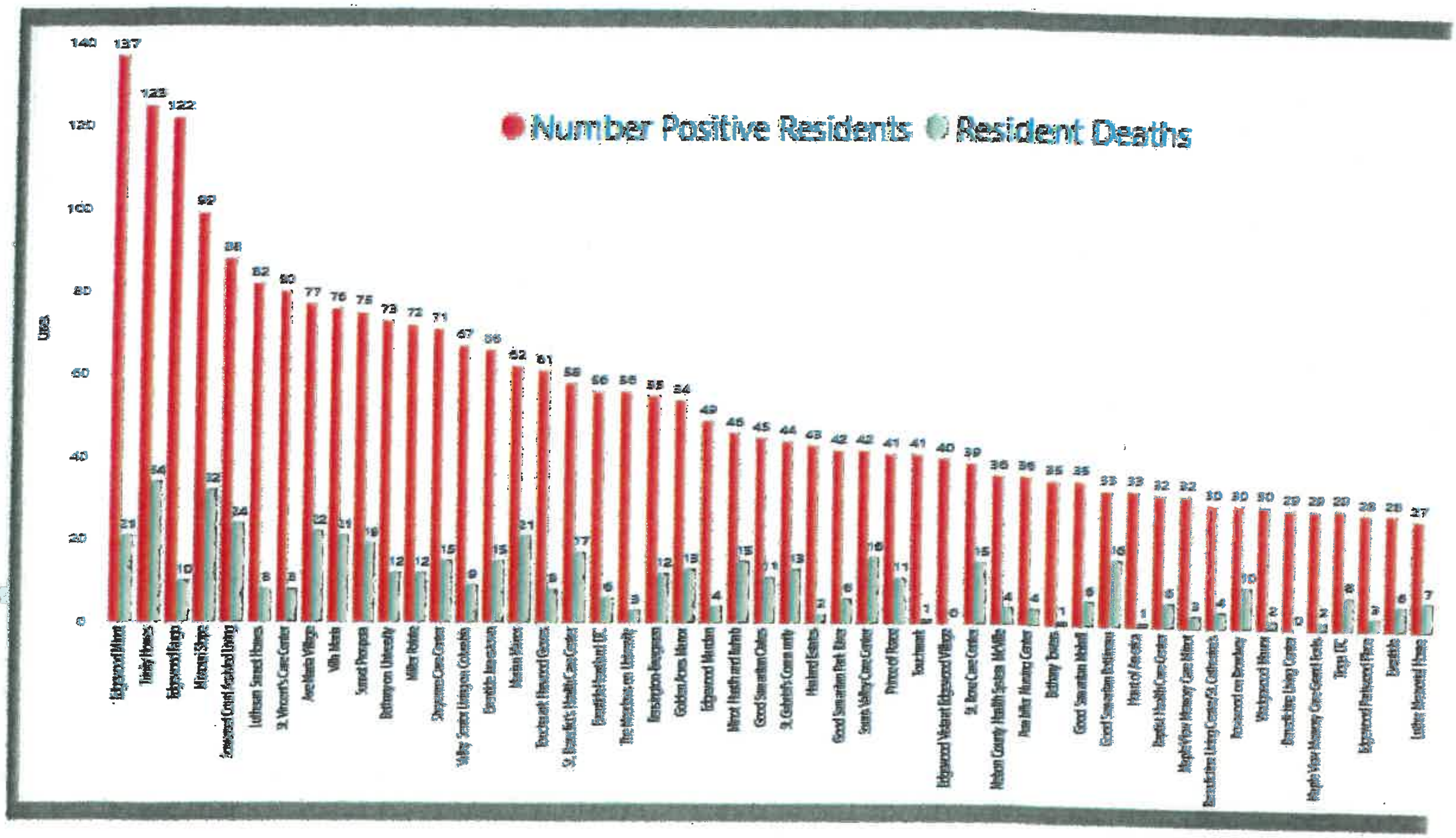
Long term care facilities have emerged as hotspots for COVID-19 outbreaks. In the United States nursing homes, residents and staff represent 8% of COVID-19 cases yet bear 41% of COVID-19 deaths based on data reported in August 2020. In North Dakota in December 2020, the total long term care cases represented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

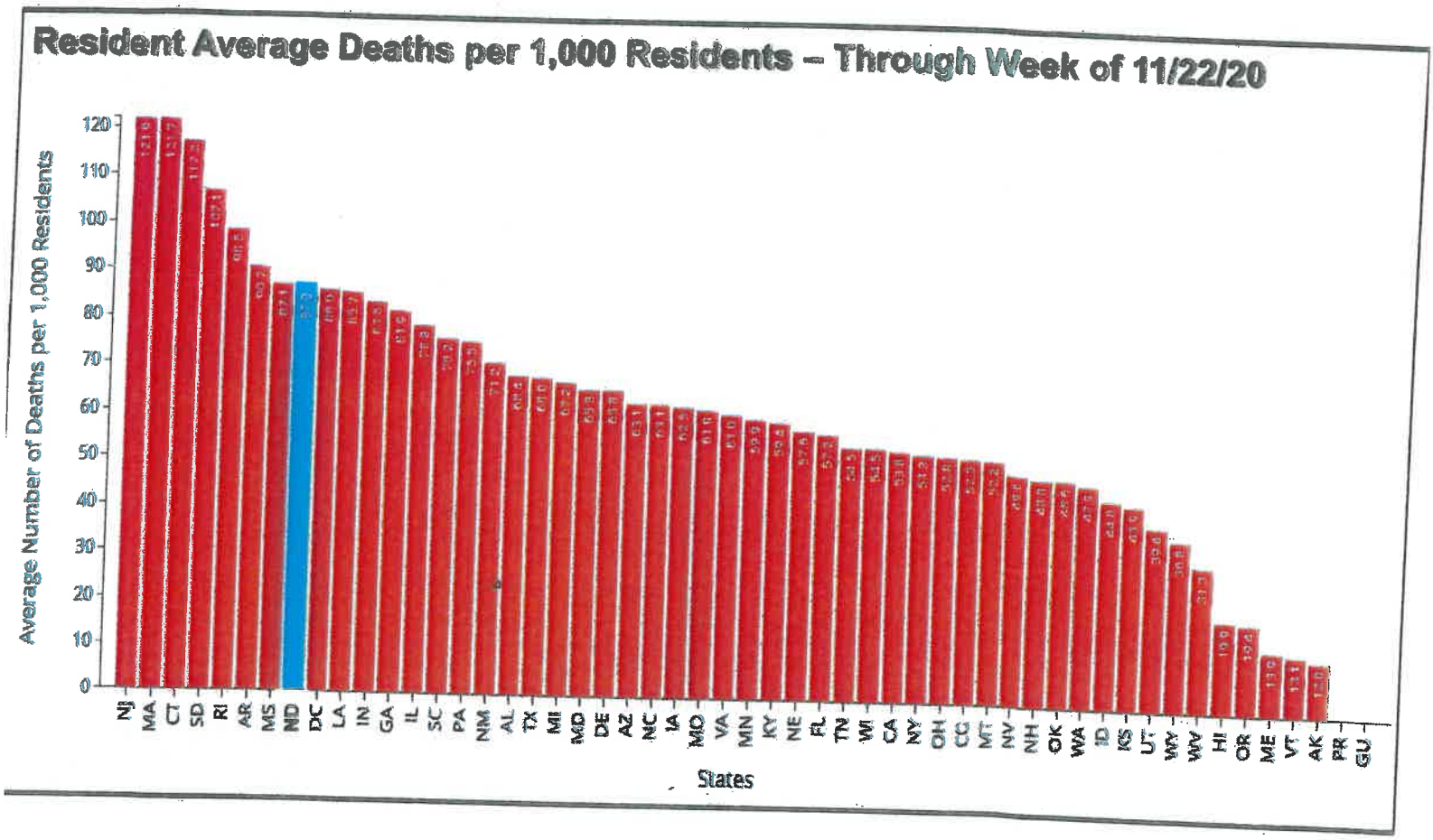
ND LTC Cases and Deaths through 12/8/20

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


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
AK
PR
GU
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.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58501 (701) 222-0660

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

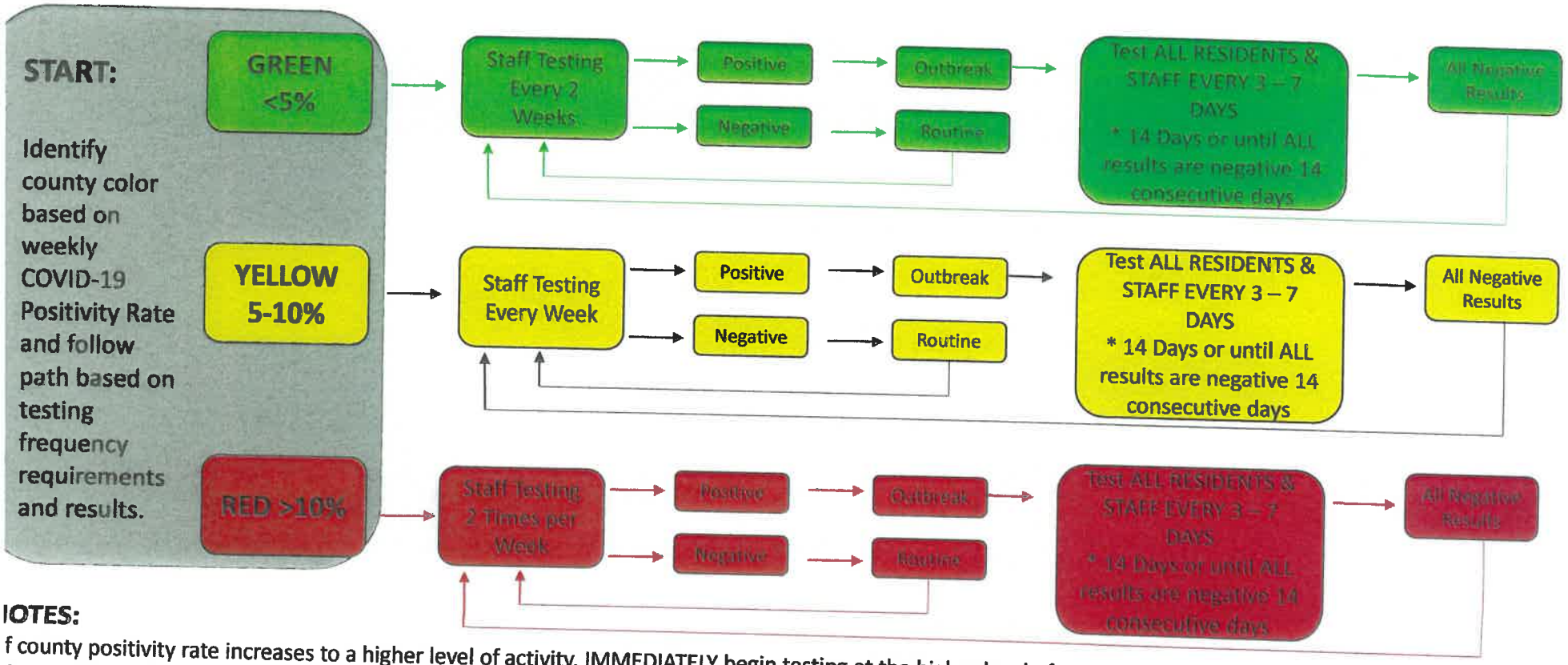
If you have any facility specific questions, please reach out to one of the VP3 State Regional Coordinators during normal business hours at the number or email provided below:

- 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.

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For Immediate Release:
May 28, 2020

Contact:
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Statement from AARP North Dakota Concerning COVID-19 and Long-Term Care Facilities

Gov. Doug Burgum has raised the possibility of soon reinstating visitation in nursing homes and other long-term care facilities – home to more than 5,300 of the state's most vulnerable individuals. As the state determines when and how best to once again allow in-person visitation, AARP North Dakota is urging careful adherence to CMS guidelines to ensure that the health and well-being of residents, staff, visitors, and those in the surrounding communities are protected.

In the meantime, AARP North Dakota urgently repeats its call for virtual visitation and transparency. We ask that the state require all long-term care (LTC) facilities to proactively work to connect residents with their loved ones virtually. North Dakotans living in LTC facilities want to communicate with their families and families are anxious to know what is happening to their loved ones. All LTC facilities should be required to offer *and facilitate* these virtual visits. The state has even been given a grant to facilitate virtual visitation, so there is no reason residents and loved ones should be without virtual visitation. In fact, it should be happening in every nursing home and it's long overdue.

In addition to virtual visitation, AARP North Dakota strongly reiterates our call for increased transparency. Given that the majority of all deaths in North Dakota from COVID-19 have occurred in nursing homes, that there continues to be increasing numbers of LTC facilities reporting cases of COVID-19, including in rural areas, and that the number of confirmed total cases in these facilities (now 478 cases in 63 facilities) continues to grow every day, residents, staff, families and the public deserve to know in which facilities cases have occurred. This transparency is critical for public health and the well-being of residents, staff and the public for their own health decisions and as they consider possible next steps and interventions for their loved ones.

In addition to this critical information, the state should be transparent about the steps all LTC facilities are taking to prevent employees and vendors from bringing the virus into the facility.

For those with a spouse, sibling, parent, or other loved one in a nursing home, AARP recommends asking the facility the following key questions to help keep them safe, remain connected, and stay informed:

1. Has anyone in the nursing home tested positive for COVID-19? This includes residents as well as staff or other vendors who may have been in the nursing home.

2. What is the nursing home doing to prevent infections? How are nursing home staff being screened for COVID-19? What precautions are in place for residents who are not in private rooms?

3. Does nursing home staff have the personal protective equipment and training they need to stay safe and keep their patients safe? If not, what is the plan to obtain personal protective equipment?

4. What is the nursing home doing to help residents stay connected with their families or other loved ones during this time? Will the nursing home set up a regular schedule for you to speak with your loved one by phone or video call?

5. What is the plan for the nursing home to communicate important information to both residents and families on a regular basis? Will the nursing home be contacting you by phone or email, and when?

6. Is the nursing home currently at full staffing levels for nurses, aides, and other workers? What is the plan to make sure the needs of nursing home residents are met if the nursing home has staffing shortages?

For more information on AARP North Dakota's advocacy work on behalf of long-term care residents and their families, go to aarp.org/nd.

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With 85,000 members in North Dakota, AARP is the nation's largest nonprofit, nonpartisan organization dedicated to empowering Americans 50 and older to choose how they live as they age. With nearly 38 million members and offices in every state, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands, AARP works to strengthen communities and advocate for what matters most to families with a focus on health security, financial stability and personal fulfillment. AARP also works for individuals in the marketplace by sparking new solutions and allowing carefully chosen, high-quality products and services to carry the AARP name. As a trusted source for news and information, AARP produces the nation's largest circulation publications, AARP The Magazine and AARP Bulletin. To learn more, visit www.aarp.org or follow @AARP and @AARPadvocates on social media.

AARP Real Possibilities
North Dakota

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August 11, 2020

Karla Backman
State Long-Term Care Ombudsman
1237 W. Divide Ave, Ste 6
Bismarck, ND 58501-1208

Dear Ms. Backman,

AARP North Dakota appreciates the opportunity to comment on the critical issue addressed in your proposals to find creative solutions to ensure residents in LTC (Long-Term Care) facilities remain connected to family and friends as the COVID-19 pandemic continues. Given the serious impact COVID-19 has had on residents in nursing homes, with at least 67 deaths,[1] representing an unimaginable 59 percentage of all COVID-19 deaths in the state, AARP's overarching goal has been and continues to be ensuring the safety and wellbeing of our loved ones who reside in these facilities.

Social interaction with family and friends is critical to the overall health and wellbeing of all LTC residents. Residents and their families have been struggling during these months when in-person visitation in LTC facilities has been effectively prohibited. In addition to the social connectivity and emotional support they provide, visitors are key members of the resident's care team, performing essential hands-on tasks such as feeding, dressing and dental hygiene, and facilitating therapeutic activities that maintain or improve their loved one's cognition and mobility. In addition, family member visitors carefully monitor their loved one's health status and are often the first line of defense, identifying key issues of concern to facility staff.

Regarding your proposals outlined in the 2020 Annual Report for the ND Long-Term Care Ombudsman Program, we encourage your consideration of the following principles to help guide the development of policies related to visitation:

Minimizing Risk: All LTC facilities, their staff and visitors must comply with all required infection control precautions and guidelines established by federal and state governmental entities. This includes screening of visitors (temperature and symptom checks), requiring visitors to properly use masks and other PPE, requiring the use of hand sanitizer, disinfecting visiting areas, and physical distancing.

[1] As of August 10, 2020. See North Dakota Department of Health, *Coronavirus Cases*, available at: https://www.health.nd.gov/diseases-conditions/coronavirus/north-dakota-coronavirus-cases.

Fairness/Universality: All LTC residents should be afforded regular opportunities for in-person visitation, in accordance with guidelines established by governmental authorities. It is not acceptable to deny, restrict, or prioritize visitation based on a resident's cognitive status (e.g., dementia), physical limitations, or inability to verbally express feelings of loneliness or depression. Additional flexibility regarding visitation is appropriate for end-of-life and other compassionate care situations.

Individualized Plan: All residents and their families should be engaged by the facility in developing an individualized visitation plan that is reflective of their wishes and preferences, while adhering to all governmental guidelines. These plans should address visitation schedules, whether one individual or multiple individuals should be designated by the resident for visitation, location of visits (indoor, outdoor, in-room, designated area, etc.) and responsibilities of all parties. These plans should also be reviewed frequently and adjusted to meet changing circumstances and needs. Residents and their families may question or otherwise challenge the individualized visitation plan or any visitation restriction or determination, and they should be provided with Ombudsman assistance in doing so.

Responsibilities of LTC Facilities to Facilitate Visitation: Until LTC facilities can safely allow in-person visitation, and thereafter, facilities should offer virtual visitation as an option for residents and their families. Where possible, we recommend that the facilities prioritize the use of civil money penalties, administrative fines on facilities, or appropriate federal funds to purchase necessary virtual visitation equipment. Some residents, who may or may not need access to the technology, will also need human assistance to use the technology and communicate with their loved ones.

Notification: It is essential that there be clear, regular information from LTC facilities to residents and their loved ones about how visits will be scheduled and facilitated. The state should require that this information be shared with the state LTC Ombudsman, residents, and families on an ongoing basis in the manner best likely to inform them (email, phone, flyers on meal trays, under doors, posting in common areas, etc.).

Residents without Visitors/Outdoor Access: The facility should place a high priority on ensuring that all LTC residents, whether or not they have visitors, are given the opportunity to spend time outdoors, weather permitting, and barring medical contraindications. Similarly, residents who do not have visitors should be provided the same opportunities as residents with visitors to leave their rooms for a change of environment.

Thank you again for allowing us the opportunity to comment on your proposals. Please don't hesitate to reach out if we can be of assistance.

Sincerely,

Josh Askvig
State Director

Cc: Chris Jones, Executive Director, North Dakota Department of Human Services

Senate Human Services Committee
SB 2145
Nursing Home Visitation
January 18, 2021
Josh Askvig, AARP North Dakota
jaskvig@aarp.org – (701) 355-3642

Chair Lee and members of the Senate Human Services Committee, my name is Josh Askvig, State Director for AARP North Dakota. I appreciate your time today and look forward to working with you on an issue that we have been working on since the start of the pandemic.

Before we get into the details of the bill I'd like to spend just a moment reminding you who we are and why we are here. AARP is a nonpartisan, nonprofit, nationwide organization with nearly 38 million members. Over 84,000 of those members live in North Dakota – a staggering number when you consider the overall population of our state.

Our story dates back 60 years, to when our founder, Dr. Ethel Percy Andrus found a former colleague of hers living in a chicken coop. I know we talk about that often, but we think it says a lot about why we fight for what we do. A lot of issues touch older Americans and their ability to live safe, independent and healthy lives.

AARP has worked with state leadership to ensure the strongest response to this pandemic possible. While the tragedy of death and illness from COVID-19 continues to plague the country's nursing homes and other long-term care (LTC) facilities, months-long visitation restrictions are also taking a serious toll[1] on the emotional and physical health of residents and their families.

While we support visitation for essential or designated caregivers, we are advocating for all visitation to resume for all residents in LTC facilities with proper testing, infection control protocols and PPE that ensures the greatest protection for residents and staff. Until that time, AARP continues to encourage the state and LTC facilities to ensure residents have access to the technology, devices and support to remain connected with their families until in person visitation can safely resume. In fact, AARP was one of the early advocates to call for increased virtual visitation to help bridge the gap when facilities are closed to in-person visitation (see attached press release from 2020).

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7205644/

Additionally, when the North Dakota Long Term Care Ombudsman reached out to us last year with a very similar proposal, wherein LTC residents could select an essential caregiver for in person visitation, AARP ND provided detailed comments and included suggestions to improve the proposal at that time. I have attached our August 11, 2020, letter to Karla Backman, State Long Term Care Ombudsman and in that letter you will see the principals we outlined regarding visitation; including Minimizing Risk, Fairness/Universality, Individualized Plan, Responsibilities of LTC Facilities to Facilitate Visitation, Notification, and Residents without Visitors/Outdoor access. We stand by those principles today as well.

As you may know, in September 2020, the Centers for Medicare & Medicaid Services (CMS) issued new guidance for how nursing homes on protocols for safely facilitating visitation. This new guidance, that was issued on September 17, 2020, superseded previous CMS visitation guidance, and was effective immediately for all nursing homes that accept Medicare or Medicaid. The CMS guidance more closely reflects AARP's position that residents should drive how visitation is facilitated as long as it is in line with state protocols.

Additionally, the new CMS guidance calls for visitation that is "person-centered," considering "the residents' physical, mental, and psychosocial well-being. Indoor visitation is allowed if there has been no new onset of COVID-19 cases in the past 14 days and the facility is not conducting outbreak testing per CMS guidelines. The guidance lays out certain core principles of infection prevention that should always be followed and gives other suggestions for how to best adapt visitation for the resident's situation and needs.

The new CMS guidance makes no distinction between essential caregivers and other visitors. Instead, nursing homes now must facilitate in-person visitation for all, consistent with the regulations, as long as there have been no new COVID-19 cases, the county positivity rate is sufficiently low, and there is no other clinical reason to restrict visitation. We are committed to and support movement toward visitation for all residents in LTC again.

Similarly, the CMS guidance clarifies "compassionate care situations" for which special visitation may occur, even when county positivity rates are high and other visitation is restricted. Previously, states and facilities struggled to apply standards for compassionate care and may have been overly restrictive on allowing such visits. Compassionate care visits may be appropriate in end-of-life situations, but also when residents are "struggling with the change in environment and lack of physical family support," "grieving after [a] friend or family member [who] recently passed away," need "help and encouragement with eating or drinking," or are "experiencing emotional distress".

While the CMS guidance makes important advances towards ensuring access to in person visitation, we believe some facilities have been slow to implement this guidance.

While the ability of residents and families to communicate via virtual visitation has greatly improved and virtual visitation is not always ideal, we believe it would be prudent for the state to ensure families and residents have access to this when We encourage the state to consider amending this bill to also include facilitated virtual visitation as a guaranteed option residents and families can rely upon when numbers within a facility or a region preclude the possibility of in-person visitation from taking place.

Nursing home residents continue to bear the brunt of this pandemic, and strong visitation standards can help improve their health and quality of life. We appreciate the time to comment today. Thank you.

NDNA
NORTH DAKOTA NURSES ASSOCIATION

January 15, 2021

Dear Senator Roers,

I am writing today on behalf of the North Dakota Nurses Association in support of SB 2145, a bill that would assign designated caregivers to long term care residents.

For many months, long term care residents and their families have been dealing with the stress and strain of isolation due to efforts to keep them safe from COVID-19. Senate Bill 2145 would allow designated caregivers. It states, "a designated caregiver is an individual, whether a family member or friend of a resident of a long-term care facility, who is designated by the resident or appointed by an individual with decision-making authority for the resident to provide in-person physical, spiritual, or emotional support to the resident during a declaration of disaster or emergency".

The North Dakota Nurses Association supports SB 2145. The designated caregivers could open a well-needed support line. The caregivers would be subject to standardized safety protocols, and individual facilities would have leeway to ask for some additional precautions.

In the facilities where residents have been unable to see family, nursing staff have been the sole caregivers, providing the physical and emotional support for their patients. This could impact nurses with either burnout or compassion fatigue. With these, "commonly reported symptoms include fatigue, illness, headaches, insomnia, disillusionment, emotional instability, anger, sense of hopelessness, and excessive rigidity in interpersonal relations (Epp, 2012; Jenkins & Warren, 2012). "Compassion fatigue has a different source of stress. The stress comes from the nurse's involvement in relationships with patients and families in which the nurse witnesses the trauma or suffering of patients. The cumulative effect causes physical, mental, and spiritual symptoms in the nurse" (Wentzel & Brysiewicz, 2014).

As the mission of NDNA is to advance the nursing profession by promoting professional development of nurses, fostering high standards of nursing practice, promoting the safety and well-being of nurses in the workplace, and by advocating on health care issues affecting nurses and the public, we feel SB 2145 would not only improve the quality of life for our wonderful residents, but also our valuable resource of *nurses*.

Sincerely,

Sherri Miller, BS, BSN, RN
director@ndna.org
Executive Director
North Dakota Nurses Association

I am asking for your support of Senate Bill No. 2145.

Having a designated caregiver during a declaration of disaster or emergency is a win/win situation for all.

Watching and communicating with my father and staff through a window for nine months was not pleasant. My father passed away on Thanksgiving Day. He was Covid free, and right up to the end we were not allowed to be with him. Many of these facilities are short staffed and they are not able to give the care required to residents. Residents are so sad and lonely, and starving for attention. If staff did give my dad 30 seconds of their time, I could see the sparkle in his eyes that someone communicated with him and gave him some attention.

Having a designated caregiver would be helpful in so many ways. It would free up time for staff. One day a worker was in the room for a half hour trying to get an oxygen reading on my dad, as their checker never seemed to work properly. That is something so simple a caregiver could help with. Loved ones can help with meals. They could make sure the oxygen is in their nose, instead of as I witnessed when I would call and ask the nurse to put it back in, she would say "Well, he keeps taking it out!" A caregiver could give quality, one on one time to their loved one, reading, conversing, simple physical and occupational therapy, and giving human touch, something they all need.

We were almost glad when he went to the hospital during the past nine months and we could be in the hospital with him. We gave him a haircut, fixed his wheelchair, brought him an ice cream cone, etc. It was amazing to see how clear his head was and the good mood he was in when family was with him. There were also some sad things we discovered during a couple of hospital visits. One was his toenails had not been cut for 2 ½ years. Yes, 2 ½ years! During one of his last trips to the hospital, I saw his bed sores firsthand in ER. Blood running down his butt, raw in another area, and a larger area that was red and purple, bruised looking. Absolutely no reason for a person to get bed sores of this magnitude! Residents are not being checked, turned or tended to. A crucial reason a caregiver needs to be with their loved one.

My dad fiercely loved his kids. Having him motion to you every day through the window to come in, and every day telling him we can't come in, and watching him deteriorate as the months went by, is indescribable and unforgiveable. He, as well as many of the residents in these homes, would much rather have a family member with them than to be alone and/or die alone in isolation.

Being in a facility that was rated in the top five worst in the state, it was crucial that we be there by his side every day. Pre-Covid, my siblings and I spent around seven hours every day with him, and during Covid, around five hours every day outside his window.

If a family member could be with their loved one, they are going to take every precaution to protect them. It is a disgrace to have tortured so many of these people with making them spend their final time on earth alone, when all they wanted was to have their family beside them.

I ask you to please support Senate Bill 2145.

Lisa Moldenhauer
8200 66th Ave SE
Minot, ND 58701

Senators, K. Roers, Mathern, Patten, and Representatives Keiser, Rohr, and Westlind, thank you for introducing Senate Bill 2145. Thank you for letting me share my story.

On a cold March day, it would be the last time I would sit with my mom during her noon meal, encouraging her to eat, and sharing family stories and laughs. Providing this companionship and joy for her was all she had. I did not know it would be the last time to help her brush her teeth, help the CNA take her to the bathroom, wash her hands, give her a big hug, tuck her into bed for an afternoon nap, and tell her how much I love her. I waved goodbye that day as she smiled her beautiful smile back at me and said, "I love you Sharon! I wish you could stay!" I smiled back through tears, "I will see you tomorrow mom, I will be back." The next day, the unexpected call came, that no visits could take place. The doors of the long-term care facility were locked. A sign on the door stated No Visits Allowed. They had a contracted employee test positive for COVID-19.

I always visited my mom, almost daily, because I knew she was not getting the basic care she deserved. Basic care! To be taken to the bathroom throughout the day, to be helped at mealtimes, to be provided with a call light, and to have her teeth brushed, because she would pocket food in her mouth, from not chewing and swallowing so well anymore. No one would wash her hands before meals and after meals, or after being helped in the bathroom. I witnessed this daily when I could visit. So, I would provide as much care as I could. I would brush her teeth, wipe off the narrow dirty metal shelf that was her place in the shared bathroom to keep her toothbrush. I would position the toothbrush in a way that I could tell if someone moved it or took the time to brush her teeth. Every day, the toothbrush was in the same place, dry and stiff, un-used. How disappointing. I took my concerns to every care conference for my mom, with nods of heads from managers and care takers, saying it would be taken care of. It was not!

She was in lock down now. I could not physically help her, so I made phone calls to the facility to double check that her plan of care was being followed, that she was taken to the bathroom every 2 hours. I worried about her skin and the breakdown that would occur if she sat in urine all day. Again, I was told, it was taken care of. I was not there to advocate for her, to be with her, and care for her. Who was going to do this? Adequate staffing was needed.

I continue to worry, because on several occasions she had fallen, trying to go to the bathroom herself. More than once she ended up at the emergency room. A deep open cut in her forehead, needing several stitches, and pain medication. A black eye engulfed her face. She has now fallen several times trying to get to the bathroom. I panic every time the phone number comes across my phone. Now what happened? Is my mom okay? Is she safe? I asked the facility director if I could come in and volunteer and help in any way. I am a nurse and educator. I am screening for COVID-19, I have minimized my risks, and would follow policies and protocols. I just want to help and be an extra set of eyes and hands and sit and visit with my mom and any residents that would enjoy a visit. The answer was, "No." The director said, "If you want to be here, then apply for a nursing position. We need nurses."

With the doors locked and new guidelines in place, and no visits allowed, I signed up for Facetime visits with my mom, so I could see her and check in. She would look so lost and bewildered and would wonder why I was not there. She did not understand why I could not be with her. When I would see her on the screen, I would be devastated. Her glasses were crooked, her hair not brushed, food and juice down her face, and food on her shirt. I told her stories and comforting words, I told her I loved her, trying to catch a smile. Her teeth were covered in food. No sweater or light jacket on, as I requested, because she was always cold. Did anyone notice or care? What is happening? My mom cared for her son, my brother with disabilities, for over 50 years, and now it was her time to be cared for. When we moved my mom in to the facility, I was told by the nursing director of the unit that she is in a good place and that they would take good care of her. She told me" don't worry, she is in good hands." Why are they not providing the care they promised? Why is the mission and vision statements of their facility, that are placed on the walls and website, not being followed? Where is the accountability? They are caring for my mother. She is not only a mother, but grandmother, and great grandmother and a beautiful and loving woman. She dedicated her life to care for her son with disabilities. She was a caretaker herself.

In November, she acquired COVID-19. Facility acquired COVID-19! No updates were given except for the initial call, "Your mom has COVID, and has been moved into the COVID unit." Over 30 residents died of COVID-19 there in a few short months. COVID was brought to them. My mom survived. I was told I could visit at her window. Standing again in the cold, I came to her window, she was eating her lunch, alone in the room. She saw me and cried and motioned for me to come in! She continued to motion to come in and all I could do was say, "I'm sorry, I can't." She has been declining these past months, and after finishing her quarantine and getting through COVID-19, she continues to decline. How long do I need to wait to see her? How much does she have to decline before I can be with her? Until she is dying? I am her POA and would love to be her "designated caregiver." She deserves the presence of her family, so does every resident in a long-term care facility in the state of North Dakota. Other states have figured this out, including Minnesota, and recognize the critical role family members and others have in the care and support of their loved one. Efforts that have been made to protect residents have failed to consider the physical and psychological impact of separation from those that matter most. I urge you to help pass SB 2145, so that my mother and all of our community members in long term care facilities, in North Dakota, can have the comfort and support of a "designated caregiver" now, when they need them most.

Thank you for introducing SB 2145.

Respectfully, Sharon Nelson, Ph.D., RN

North Dakota Right to Life is dedicated to protecting the lives of every human from conception to natural death. We stand at 2,338 members strong who whole-heartedly believe this mission statement. Every human at every stage of life. I feel that our organization is often associated with our dedication to fighting for the unborn, but I wanted to take this opportunity to talk about the importance of protecting individuals as they age until they experience natural death. Recently, I was reading an article by Wesley Smith in the National Review that discussed the point of view from a doctor in New Jersey. His grandfather, at the age of 103 years old, did not qualify for assisted suicide but wanted to hasten his death due to the isolation he felt during COVID-19. Here is a direct paragraph taken from this article.

> "I described another option to Grandpa: he could voluntarily stop eating and drinking. He'd never considered this possibility (which reminded me again how one's family members and clinicians contribute to inequities in end-of-life care). The option intrigued Grandpa, and during subsequent visits he reinforced his plan to pursue it. I insisted that he first move into my home. I wanted to ensure the quality of his care, knowing that I could enroll him in my health system's hospice program. But I also wished to test his resolve, reasoning that his mind might change once his isolation ended."

To further summarize this article, after the grandfather had moved into his grandson's home, he changed his opinion on starvation and was thriving in his new environment. After a few weeks, he decided to continue forward with death by starvation and to make the decision easier, his grandson sedated him to stop any urges to resist.

The most interesting part of this is the reasoning behind the decision to request physician assisted suicide. Based on a study performed in Canada in 2018 on 112 patients who requested physician assisted suicide, one of the top reasonings for this request was due to loss of purpose they felt in their life or the inability to accept their diagnosis. Given this information, what options do we have to provide hope and comfort to our loved ones who are suffering? Listen to these individuals and find ways to alleviate the physical, mental, or emotional pain that they are feeling. Offer to document preferences and values regarding the patient's end of life care. Understand the important religious or cultural practices that each individual holds in order to remain true to their wishes. And lastly, be there for them to support them in their final days which helps reduce the feelings of isolation experienced by so many.

Let us focus on raising awareness of the danger to our older generations of physician assisted suicide and euthanasia. Please check out the article below which was referenced in this section for further information.

I strongly encourage all to vote in favor of this bill in order to give long-term care patients the ability to have comfort in a designated caregiver during times of a disaster or emergency. Thank you all for your time and God Bless.

Article referenced: https://www.nationalreview.com/corner/suicide-by-starvation-and-expanded-assisted-suicide-promoted-in-new-england-journal-of-medicine/

In my humble opinion, 2020 was the worst year that our great country has endured in almost 100 years. COVID-19 took the world by surprise, and came with a litany of issues that required quick responses from local, state, and federal government officials and agencies. It majorly tested laws, policies, and procedures, many of which are outdated and poorly thought out. Many of these need some amending and tweaking, and others need a major overhaul. Throughout this past year, it has become evident that there are glaring imbalances in the amount of power that many agencies, departments, and individuals in our state possess. Many of these are unelected positions, meaning that they were not chosen by the voters in ND, but simply appointed by the governor. Unilateral decisions were made that had disastrous effects on so many of our citizens. Without a doubt, the most egregious of all of these was committed against the residents of our long term care facilities, and their families.

I can describe my testimony in two words: ONE YEAR.

It has been ONE YEAR since I have been able to be with my 83 year-old father, who has dementia that is worsening by the day. He has been a resident at the Bethel Lutheran Nursing and Rehabilitation Center, in Williston, ND, since August, 2017. It was one of the most difficult decisions our family has ever made, but knowing that we could see him, as often as we desired, made us feel more secure that it was for the best. We loved going to see him. We loved signing him out and going for drives in the country, or taking him home for part of a day so he could sit in his old easy chair and watch his grandchildren play. We all were certainly making the best of a difficult situation.

Almost one year ago, these rights were stolen from us. We could no longer see my dad, period. All for a virus with a 99.98% overall survival rate. Yes, the LTC population obviously is at higher risk than most people, but still enjoys a 95% survival rate. The phrase "Draconian lockdown" only begins to describe the measures that have been taken—and that still exist to this day. I could understand a few weeks…maybe a month. This has dragged on and on, and decisions have continually and erroneously been based on fear, stubbornness, politics, and poor information. They certainly have not been based on good science or even common sense or decency. They took no account of what this complete segregation and isolation from family has had on my dad, or any of the other residents in LTC facilities across the state. The fact that this is still persisting is almost criminal, in my opinion. This can never, EVER happen again.
This virus, though terrible in its own right, did not merit the "all-or-nothing" response that has been instituted.

What frustrates me the most, and tears at my heart, is the fact that the last time I got to be near my dad, he knew who I was. Over the past few "prison visits" through the glass, with masks on, on the telephone, I'm afraid he no longer knows that I am his son. I can never get that back. It was bad enough that we had to be separated by a glass wall, but apparently, the virus could be transmitted through the glass, or possibly through the telephone, which is why we both had to wear a mask? That is absolutely ridiculous, heartless, and cruel, and I fully blame the ND Department of Human Services for this. As I stated above, this can NEVER, EVER happen again, which is why I implore you to pass SB 2145. Thank you very much, and God bless.

Hello Legislators!!!

I have heard so many heartbreaking testimonials of our elderly loved ones suffering!! Please act now to stop the suffering and open up the LTC facilities to families and friends.

Also please end the state of emergency in the state of ND. There is no amount of federal money that is worth the damage this endless state of emergency has brought on we the people of ND. We the people want it ended.

Thank you!

Bea Streifel

#1090

Kristine Medeiros
329 3rd St NW
Watford City, ND 58854
701-770-1296

RE: SB2145

Committee Members:

Thank you for allowing this opportunity to submit my testimony in support of SB 2145.

My name is Kristine Medeiros. I am a mother and grandmother from Watford City, ND. I work as an administrative assistant for our county Emergency Manager.

Almost 8 years ago my oldest son was in a really bad car accident. He suffered a TBI as a result of his injuries sustained in that car accident. He is partially paralyzed on his left side, has little vision, and it has affected his speech. For a while we were able to keep him in his home with his brother taking care of him. Then he moved in with his sister and she became his caretaker. After a few years, we made the agonizing decision that maybe placing him a facility would be the best option. There he would get good healthy meals, be able to socialize, get the therapy he so desperately needs and be close to other family and friends.

Three weeks after we moved him in, Covid-19 hit. The emergency declaration was made the day before my son's 7th anniversary of his accident, One week before his 32nd birthday. Needless to say, we didn't get to celebrate his birthday with him. We got to wish him happy birthday through a window.

My youngest daughter was looking forward to going down to see him and watch wrestling with him like they used to do before the accident. And now she can't. (Emotional support) He was supposed to get physical therapy. And now he's getting limited exercises and he is regressing. (physical support) My son goes to chapel just for the sake of socializing, but he's not Christian. He's Asatru. So his spiritual needs are not being met because his Gothi can't visit him.

My son is not the only family member that is in a facility. My great-aunt is living in the same facility as my son. Her 93rd birthday was in November. And we didn't get to celebrate with her. In fact, the last time we got to see her was at my father's funeral the end of August. She is hard of hearing, so having to wear masks has been very hard on her. Video chatting doesn't work, because she can't hear. She needs to be close to you to see, and she can read lips. But the staff doesn't know that. And they don't ask.

I used to "pop" in to check on how my son was doing, visit with him, help with some exercises then go visit with my great-aunt. Until my father's funeral, I haven't seen my great-aunt since March. And I haven't been able to visit with her since.

This is only a small step to curb a much bigger issue. A step I am willing to take if it means I can see my son and my great-aunt again and be an active part of their daily lives.

Again, thank you for giving me this opportunity to tell a little bit of our story and to give testimony in support of this bill.

Dear Judy,

I am sending this email in regards to visitation in our long term care facilities. I have a family member in St Benedict's in Dickinson.

She will be 97 in April. She is living her last days unable to see family. She contracted COVID 19 in October and made it through. Even though she has had it we are still unable to visit except through her window. Fortunately we have had some nice days to stand outside but it is still chilly.

Our elderly should be able to make their own decisions as to whether they want to see family or not. She has told us she is living her last days in a small room. She is depressed and continually tells us she just wants to die rather than to live like this. It will be depression that takes her life before an illness does. Not only is she depressed but anxiety gets the best of her when she can't hear on the phone and we do our best to repeat what we are saying. Being face to face she can read your lips and we can see by the look on her face that she knows what we said.

The fact that she had COVID-19 in October and was able to recover is another reason that we should be allowed to visit her inside.

I work at Dickinson State University and have students in my office that work at the nursing home. There is no difference between them going in her room to assist her than there would be for me to take the same necessary precautions and see her.

Over the summer our kids and grandsons were here from Fargo. Our adult children were able to schedule an outdoor visit but our grandsons were not allowed because they weren't over 18. That broke her heart. That would have been therapy for her to see them. What difference does it make if they keep social distance and wear a mask just like adults.

Since there are no longer outdoor visits we have taken them to her window so she can see them. Our grandchildren's last memories of their great-grandma will be her crying as they tried to visit her through the window. I would rather them remember her soft hands and hugs. And being able to spend time playing cards with her. (Which playing cards is therapy to keep her mind active.)

All we worry about is how much money the facility gets from the government by putting these inconsistent rules in place.

I thank you for your time and hope to see support for our elderly.

Laurie Heick
701-290-7931
Ldheick@ndsupernet com
Dickinson ND

Testimony for: SB 2145
Date: 1/18/2021
From:
Evonne Hickok
6400 1st Ave E
Williston ND 58801
701 580 5818
eahickok@yahoo.com

I am writing in support of SB2145 as a daughter of an 85 year old long term ND resident who is now living in a LTC facility and a Family Nurse Practitioner. My mom has been a resident of a small long-term care facility for 3 years. Since the CMS and the ND VP committee have instituted restrictions, my mother and many others have suffered under isolation.

The isolation and lack of the ability to touch and assist caring for my mother has caused extreme hardship to her and our family. My mother has been denied the very reasons that she lives for which include hugs and visitation from her children, grandchildren, and great grandchildren. This has led to decline in her physical and mental capacity.

The LTC where she lives is small, has limited resources but have tried their best to care for the residents, but their hands are tied. No money, no mission. When all the residents in the facility became infected with COVID-19 the staff pulled together and worked extra shifts. Many residents died with very limited family contact.

As a Family Nurse Practitioner, I have first handedly observed the devastation of COVID 19 on residents and how it is magnified by the loss of meaningful contact with family. To many residents there is no reason to live if they cannot have contact with loved ones.

I am in favor of SB 2145 which would allow a designated caregiver to visit for support

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2145
1/27/2021

Relating to access to long-term care facilities in case of a declaration of disaster or emergency; and to declare an emergency

2:52 **Senator Lee** reopened the hearing on SB 2145. Members present: **Senator Roers, Senator Anderson, Senator Clemens, Senator Hogan, Senator Larsen**

Discussion Topics:

- Double counting nursing homes vs hospitals in reference to data in Covid deaths
- Rapid testing in basic care, nursing facilities and assisted living
- Testing requirements regarding false and positive Covid tests
- Family visitation regulations in nursing facilities

Shelly Peterson, ND Long Term Care answered committee questions.

Reier Thompson, President, Missouri Slope Care Center - Bismarck, answered questions on Covid testing, visitation of non-essential healthcare givers and following strict CDC regulations. (Testimony #3875)

Char Schmidt, Regional VP, Edgewood Healthcare Operations answered questions on family visitations and resident safety. (#3878)

Josh Askvig, State Director, AARP ND referenced difficulty for public to understand all data.

Bridget Weidner, State Dept. Health clarified how CMS designates visitors.

Additional written testimony: N/A

4:04 **Senator Lee** adjourned the hearing.

Justin Velez, Committee Clerk

#3875

Reier Thompson Testimony In Support of SB 2145
January 27, 2021
Senate Human Services Committee
Sakakawea Room
Chairman Judy Lee

Chairperson Lee and members of the Committee, my name is Reier Thompson and I am the President/CEO of Missouri Slope in Bismarck. I am here to provide facts and information relative to SB2145.

My career in long term care started as a 14 year old dietary employee at Missouri Slope. It was a great experience and my goal each day was to bring a 5 star dining experience to our residents who would sometimes give me back rubs as I delivered their food. Now, as an administrator, the goal remains for all of us in long term care to enhance and enrich the lives of those we serve. Resident rights are a basic component of assuring we are doing all we can and in treating all with dignity and respect.

Having a robust and diverse activity and social calendar is the norm for long term care centers across the country. Meeting all the emotional, spiritual, and physical needs of our residents is not only expected, it is required by the Centers for Medicare and Medicaid Services (CMS). Then, the pandemic began and resident rights went out the window in many unfortunate ways. Primarily, our once open-to-the-public care center had to lock down and stop all visitation.

Fast forward to today and you will see it is much more than just no visitation. Following the CMS guidelines has created an environment of isolation for all who live and work in long term care. Every day, we have families pleading and begging with us to open our doors. Many offer to get COVID tested or vaccinated to demonstrate they are not a risk. While this all sounds like a reasonable plan, we have absolutely no authority in making decisions that fall outside the CMS guidance.

In November, we experienced painful repercussions of failing to meet all CMS guidelines. We had a federal infection control focused survey and were cited at the highest level, known as immediate jeopardy, for readmitting residents back to their shared room. The citation explained we had failed to implement suggested protocols listed in a frequently asked questions section of a memo from CMS. Specifically, the memo used suggestive language stating it was **preferable** and that a plan **could include** readmission into single, observation rooms.

Getting an immediate jeopardy rating for failing to meet guidance that is not even in the regulations but listed in a FAQ of a memo has caused us to receive a $36,000 civil money penalty, have a ban on admissions for 16 days, and lose our nurse aide training program for two years.

My reason for bringing this to your attention is to provide a general background of some of the issues we struggle with during this pandemic and the dire consequences that we have suffered. SB2145 has a goal to designate a caregiver to provide in-person support to our residents while observing all safety protocols. Current visitation guidance from CMS specifies when inside visitation may occur and is based on county positivity rates as well as facility level outbreak status.

CMS defines an outbreak as a new COVID-19 infection in any healthcare personnel or any infection in a resident. As the largest nursing facility in the state, we have not gone two consecutive weeks without a positive resident or employee case since July, 2020. We have been thankful to see rates drop in Burleigh County the past few weeks to the lowest risk level defined by CMS of less than 5%. In order to allow inside visitation to resume in our building, we also cannot be in an outbreak status as defined by CMS for 14 days.

Eventually, we are confident we will achieve 14 days of no new COVID+ employees or residents. And as long as the county stays at a low risk level, this will be a celebrated day for all who live and work at Missouri Slope. Going forward, if we were to have a new COVID+ resident or employee, we would have to shut down inside visitation and restart the 14 day window.

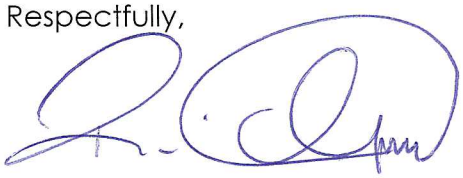
In providing even more of a window into the stringent thinking of CMS, I share with you another situation which is even more sad and unfortunate for our residents. In December, a second federal infection control focused survey took place and we were cited for allowing resident's room doors to remain open while they were on isolation protocols. We had specifically been told by the previous survey team to indicate in each resident care plan whether they desired to keep their room door open while on isolation. Moreover, the regulations stipulate we are to take measures to reduce or minimize any potential psychosocial negative effects of isolation. We have had residents beg and plead to keep their doors open, yet CMS has mandated we are to re-educate the resident and keep their door closed. These examples are not the only contradiction of regulations we have experienced throughout this pandemic and has put our organization in an impossible situation.

In order to meet the stringent CMS guidance of screening all who enter our building, we have created robust policies and procedures. When arriving at Missouri Slope, you use a doorbell system to request access. Once inside, we have designated screening personnel to assure you do not have a fever and do not fail any of the exposure or symptom related screening questions. By this time, all will have already donned PPE and are directed to limit travel inside the building to necessary areas only. Throughout this pandemic, we have turned away many people including employees and family members for either symptomatic reasons or failing to adhere to proper PPE/Infection Control protocols.

Chairperson Lee and members of this committee, my testimony here today is meant to provide you with information. My concern is this bill may set an unreal expectation of designated caregivers being granted access at a time that would not meet CMS guidelines. We are regulated by CMS and it is clearly very painful when we fail to meet all CMS guidelines and expectations.

Thank you for the opportunity to testify on behalf of my organization and the North Dakota Long Term Care Association. I am open to any questions you may have.

Respectfully,



Reier Thompson, President/CEO

#3878

Madame Chairperson and Committee Members –My name is Char Schmidt and I am the Regional Vice President for Edgewood Healthcare and oversee the operations of all the Edgewood locations in ND

From the beginning we have been trying to follow all the rules and recommendations that have come from the CDS, CMS, Dept of Health, VP3 and our own Edgewood Incident Command. We continue to follow all the guidelines for screening, masking, distancing and hand sanitization.

When it was allowed, we did open up outside visitation despite some difficulties in monitoring this. When it was allowed, we also started supervised indoor visitation, which was much better for residents, families and our ability to monitor. This past fall, when CMS enforced visitation restrictions for skilled nursing, the Assisted living and basic care communities advocated for our residents by asking for and receiving less restrictive visitation guidelines - these were implemented in early November. Unfortunately, that was right when some of the highest covid cases were occurring in long term care so some locations had to wait. Even if the guidelines had permitted visitation, we were busy trying to care for residents with whatever available staff we had and we simply would not have been able to accommodate any kind of safe visitation – even outdoor.

But throughout all of this, I think AL/BC have done a great job. We have always allowed for hospice and end of life care, compassionate care visits and accommodated unusual situations and requests. We have accommodated dedicated family caregivers by including them in our employee testing events and restricting their movement throughout the building. We have done tons of facetime, zoom calls, and live streaming events like funerals and graduations. When we were told that any resident post covid had a 90 window of some immunity, we promoted and encouraged them to get out and visit family since they would not be subject to a 14 day quarantine when they returned.

As of today, all of our Edgewood communities continue with in house visitation but we have not done in room yet except in some of our memory care neighborhoods that are much smaller. Because these communities are large, we have found that is much easier to accommodate safe visitation in dedicated areas so that we can provide the required monitoring. The other reason is that the guidelines require us to stop in room visitation if we at any time have an outbreak – which is considered to be one positive resident or employee. Even though the current positivity rate is really low right now, it's not unusual to have one positive case. As we finish up second round vaccinations, we are eagerly waiting for more guidance on our next steps.

I know that you have heard concerns about visitation from families and residents, we have heard them too. But mostly we hear the appreciation for all we are doing to keep our residents safe. We have received countless notes of thanks, gifts, food etc. from families to thank and support our staff especially when we have had outbreaks and we couldn't safely support visitation. We are grateful for their support.

Through all the regulations, recommendations and rules, we have appreciated the flexibility to make things more stringent if necessary. This was important based on the outbreak situation in a county, in a building or just available staff at any given time. This also helps when you have AL/BC communities that range in size – from very small, to very large across the state.

Thank you for the opportunity to share some information about how visitation is going from an Assisted Living and Basic Care perspective.

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2145
2/10/2021

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities in case of a declaration of disaster or emergency; and to declare an emergency.

Madam Chair Lee opened the discussion on SB 2145 at 10:40 a.m. Members present: Lee, K. Roers, Hogan, Anderson, Clemens, O. Larsen.

Discussion Topics:

- Amendment 21.0439.03002 proposal

[10:40] Senator K. Roers, District 27. Provided the committee with proposed amendment 21.0439.03002 with additional changes (testimony #6224).

Senator K. Roers moves to **ADOPT AMENDMENT** 21.0439.03003
Senator Hogan seconded

Voice Vote – motion passed

Senator K. Roers moves **DO PASS, AS AMENDED.**
Senator Hogan seconded.

Senators	Vote
Senator Judy Lee	Y
Senator Kristin Roers	Y
Senator Howard C. Anderson, Jr.	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Oley Larsen	Y

The motion passed 6-0-0
Senator K. Roers will carry SB 2145.

Additional written testimony: N/A

Madam Chair Lee closed the discussion on SB at 10:49 a.m.

Justin Velez, Committee Clerk

21.0439.03003
Title.04000

Adopted by the Human Services Committee

February 10, 2021

PROPOSED AMENDMENTS TO SENATE BILL NO. 2145

Page 1, line 2, remove "in case of a declaration of disaster or emergency"

Page 1, line 12, replace "Designated" with "Essential"

Page 1, line 12, replace ", whether a family member or friend of" with "identified by"

Page 1, line 13, remove ", who is designated by the resident or appointed by"

Page 1, line 14, replace "an individual with decisionmaking authority for the resident" with "or by the resident's designated decisionmaker"

Page 1, line 15, remove "during a declaration of disaster"

Page 1, line 16, remove "or emergency"

Page 1, after line 18, insert:

"**50-10.3-02. Scope.**

This chapter does not supersede federal authority regarding long-term care facilities or prevent the department or state department of health from taking necessary actions to render the state eligible for federal funds or reimbursement services provided in long-term care facilities."

Page 1, line 19, replace "**50-10.3-02**" with "**50-10.3-03**"

Page 1, line 19, replace "**designated**" with "**essential**"

Page 1, line 20, replace "in consultation" with "working jointly"

Page 1, line 20, replace "and" with ", the"

Page 1, line 21, after the underscored comma insert "residents and tenants, families of residents and tenants, and long-term care facility representatives,"

Page 1, line 22, replace "an individual with decisionmaking authority for the resident to" with "the resident's designated decisionmaker"

Page 1, line 23, replace "designated" with "essential"

Page 1, line 23, after "caregivers" insert ", including"

Page 1, line 24, replace "A designated" with "An essential"

Page 2, line 5, replace "a designated" with "an essential"

Page 2, line 9, replace "a designated" with "an essential"

Page 2, line 10, replace "designated" with "essential"

Page 2, line 13, replace "designated" with "essential"

Page 2, line 14, replace "**50-10.3-03**" with "**50-10.3-04**"

Page 2, line 16, remove "meet the following criteria:"

CJ 2/16 2 of 2

Page 2, remove line 17

Page 2, line 18, replace "2. The requirements" with "and cost"

Page 2, line 18, replace "and" with "or"

Page 2, line 18, remove "a"

Page 2, line 19, replace "designated" with "an essential"

Page 2, line 21, replace "**50-10.3-04**" with "**50-10.3-05**"

Page 2, line 21, replace "**designated**" with "**essential**"

Page 2, line 22, replace "a designated" with "an essential"

Page 2, line 23, replace "50-10.3-02" with "50-10.3-03"

Page 2, line 24, replace "an individual with decisionmaking authority for the resident" with "the resident's designated decisionmaker"

Page 2, line 25, replace "designated" with "essential"

Page 2, remove lines 26 through 30

Page 3, remove lines 1 through 9

Renumber accordingly

REPORT OF STANDING COMMITTEE

SB 2145: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2145 was placed on the Sixth order on the calendar.

Page 1, line 2, remove "in case of a declaration of disaster or emergency"

Page 1, line 12, replace "Designated" with "Essential"

Page 1, line 12, replace ", whether a family member or friend of" with "identified by"

Page 1, line 13, remove ", who is designated by the resident or appointed by"

Page 1, line 14, replace "an individual with decisionmaking authority for the resident" with "or by the resident's designated decisionmaker"

Page 1, line 15, remove "during a declaration of disaster"

Page 1, line 16, remove "or emergency"

Page 1, after line 18, insert:

"**50-10.3-02. Scope.**

This chapter does not supersede federal authority regarding long-term care facilities or prevent the department or state department of health from taking necessary actions to render the state eligible for federal funds or reimbursement services provided in long-term care facilities."

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Page 2, line 24, replace "an individual with decisionmaking authority for the resident" with "the resident's designated decisionmaker"

Page 2, line 25, replace "designated" with "essential"

Page 2, remove lines 26 through 30

Page 3, remove lines 1 through 9

Renumber accordingly

21.0439.03002

Sixty-seventh
Legislative Assembly
of North Dakota

SENATE BILL NO. 2145

Introduced by

Senators K. Roers, Mathern, Patten

Representatives Keiser, Rohr, Westlind

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities ~~in case of a declaration of disaster or emergency~~; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 50-10.3 of the North Dakota Century Code is created and enacted as follows:

50-10.3-01. Definitions.

As used in this chapter, unless the context clearly indicates otherwise:

1. "Declaration of disaster or emergency" means a disaster or emergency declared by the governor under chapter 37-17.1.
2. "Department" means the department of human services.
3. "Designated caregiver" means an individual, ~~whether a family member or friend of a~~ resident of a long-term care facility, ~~who is designated by the resident or appointed by an individual with decisionmaking authority for the resident~~ to provide in-person physical, spiritual, or emotional support to the resident ~~during a declaration of disaster or emergency.~~
4. "Long-term care facility" means a skilled nursing facility, basic care facility, assisted living facility, or swing-bed hospital approved to furnish long-term services.

50-10.3-02. Scope.

This chapter does not supersede federal authority regarding long-term care facilities or prevent the department or state department of health from taking necessary actions to render the state eligible for federal funds or reimbursement services provided in long-term care facilities.

~~50-10.3-02~~50-10.3-03. Access to long-term care facilities for designated caregivers.

1. The department, ~~in consultation~~working jointly with the state department of health ~~and~~, the state long-term care ombudsman, residents and tenants, families of residents and tenants, and long-term care facility representatives, shall establish protocols to allow a resident of a long-term care facility or an ~~individual with decisionmaking authority for the resident~~ to designate one or more individuals as the resident's designated caregivers, including during a declaration of disaster or emergency. A designated caregiver shall meet the necessary qualifications to enter the long-term care facility to provide in-person physical, spiritual, or emotional support to a resident of a long-term care facility in accordance with the protocols established under this section.

2. The protocols must include:

   a. Safety measures for a designated caregiver, which may include restrictions on travel, enhanced testing for communicable diseases, and the necessary safety equipment required to protect the health and safety of the residents of the long-term care facility;

   b. Procedures to replace a designated caregiver due to necessary circumstances, including illness or death of the designated caregiver; and

   c. A duration, not to exceed thirty days, during which a long-term care facility may enter a lockdown phase for the purpose of establishing safety measures for residents of the long-term care facility and designated caregivers.

~~50-10.3-03~~50-10.3-04. Additional safety requirements for residents of long-term care facilities.

A long-term care facility may establish additional safety requirements to protect the residents of the long-term care facility if the requirements ~~meet the following criteria:~~

~~1. The requirements are linked directly to a declaration of disaster or emergency; and~~

~~2. The requirements~~ and cost are not so burdensome and onerous as to substantially prevent a designated caregiver from being able to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility.

~~50-10.3-04~~50-10.3-05. Suspension of access for designated caregivers.

If a long-term care facility suspends access to the long-term care facility for a designated caregiver who violates the protocols established under section ~~50-10.3-02~~50-10.3-03, the long-

term care facility shall allow the resident, or ~~an individual with decisionmaking authority for the resident~~ the resident's designated decisionmaker, to immediately designate a replacement ~~designated~~ essential caregiver.

~~**50-10.3-05. Personal protective equipment for designated caregivers.**~~

~~A long-term care facility may require a designated caregiver to provide personal protective equipment for the designated caregiver or assume the cost of the personal protective equipment provided by the facility to allow the designated caregiver to provide in-person physical, spiritual, or emotional support.~~

~~**50-10.3-06. Applicability.**~~

~~This chapter applies for the period commencing fifteen days after a declaration of disaster or emergency and sixty days after the termination or expiration of the declaration of disaster or emergency.~~

~~**50-10.3-07. Construction.**~~

~~This chapter may not be construed to supersede federal authority regarding long-term care facilities or to prevent the department or department of human services from taking necessary actions to render the state eligible for federal funds or reimbursement services provided in long-term care facilities.~~

SECTION 2. EMERGENCY. This Act is declared to be an emergency measure.

2021 HOUSE HUMAN SERVICES

SB 2145

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

SB 2145
3/16/2021

Relating to access to long-term care facilities; and to declare an emergency

Chairman Weisz opened the committee hearing at 2:45 p.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Essential caregiver
- Personal protective equipment
- Protocol
- VP3 team

Sen. Kristin Roers, District 27 (2:45) introduced the bill and submitted testimony #9354.

Beth Sanford, Master's Prepared Registered Nurse, Fargo (2:54) testified in favor and submitted testimony #9475.

Karla Backman, State Long-Term Care Ombudsman (3:07) testified in favor and submitted testimony #9456.

Shelly Peterson, President North Dakota Long Term Care Association (3:34) testified in favor and submitted testimony #9643.

Mary Kaye Hjelle, Bismarck (4:22) testified in favor.

Charlotte Hagel, Bismarck (4:25) testified in favor.

Bonnie Leingang, Mandan (4:29) testified in favor.

Additional written testimony: #9252, #9295, #9366, #9507, #9528

Chairman Weisz adjourned at 4:36 p.m.

Tamara Krause, Committee Clerk

North Dakota Senate

State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505-0360

Senator Kristin Roers
District 27
4240 31st Avenue South
Fargo, ND 58104-8725

C: 701-566-0340
kroers@nd.gov

Committees:
Government and Veterans Affairs
Human Services

Mr Chair –

Today, I am here to introduce Senate Bill 2145, relating to establishing an Essential Caregiver for residents in Long Term Care. We are aware of the brutal toll that COVID-19 has taken on our elderly population – but I would posit that the isolation that they have endured is equally brutal.

I want to start by thanking the Department of Health, the Department of Human Services, the Vulnerable Population Protection Plan taskforce, the Reuniting Families Taskforce, the Long Term Care Ombudsman, and the Long Term Care Association for working so diligently to protect those among us that are most vulnerable. They were assigned a nearly impossible task of trying to keep an aggressive virus out of the population it most devastated. As they started their work, we knew that we needed to protect this population, and we knew how we didn't want to do it, as we had seen some states fail in ways we could not allow to happen in North Dakota. With the benefit of hindsight, we know that the information they had was minimal, and yet they created a plan that has helped to save hundreds, if not thousands of lives. So again, I say thank you.

We have now surpassed the 1-year mark when we learned that this virus was in the US, and in North Dakota. Many things have been learned in that year – we know better how the virus is spread, we have better therapeutics, and we also know that we have adequate PPE to care for all of the residents in our healthcare facilities – and we also, thankfully, have vaccines!

The time has come to acknowledge the effects of isolation in Long Term Care that were created by the policies and tactics employed at both the state and national level. We want to look forward to identify what we can do to ensure that all residents are afforded their rights – the right to see their loved ones being at the forefront – to give and receive hugs, to talk, and to make that human connection.

North Dakota Senate

State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505-0360

Senator Kristin Roers
District 27
4240 31st Avenue South
Fargo, ND 58104-8725

C: 701-566-0340
kroers@nd.gov

Committees:
Government and Veterans Affairs
Human Services

My goal with this bill is to make sure that we have standards in place for the future – to ensure that we never resort to this sort of isolation again. Isolation in other situations is used as a punishment – timeout for a child, solitary confinement for a prisoner – but these residents did nothing deserving of punishment, and yet, they are the ones that suffered for the past year.

This bill is relatively simple at its heart – it basically says, as long as the Feds haven't specifically limited visitation, no facility may deny visitation for a Long Term Care resident by their essential caregiver or caregivers. The facilities may create protocols for that visitation, but they need to allow it – these protocols may include PPE requirements, screening, or other steps – but I would believe that the loved ones of the resident would jump through all of those hoops, and then some, just for the chance to make that connection.

The numbers of letters, emails, and calls that I have received lead me to believe that this bill is necessary. And the content of those messages are beyond heartbreaking.

This past fall, I had the honor of working with COVID and non-COVID patients in the hospital and saw this isolation in person. It made me sad that people had to be hospitalized to be able to get a visitor. My coworkers have been experiencing moral distress from having to be the one standing between their patient or resident and their loved ones. I had friends relay stories to me about residents begging them to end their lives – not to let them die, but to kill them. The lasting effects on our families, our residents, and our healthcare workers will not be seen fully for years, but I fear that much of this damage cannot be undone.

I urge you to support this legislation to prevent this isolation from happening again in the future.

Thank you for your consideration.

Chairman Weisz, Vice-Chair Representative Rohr, and members of the House Human Services Committee, thank you for allowing me to speak on behalf of SB2145 regarding access to LTC facilities by Essential Caregivers.

My name is Beth Sanford. I am a Master's-Prepared Registered Nurse, born and raised in North Dakota. I got my start in nursing working in my local LTC facility at age 15. I was a nurse's aide for seven years before obtaining my BSN and then MSN from UND. My specialty is working with vulnerable populations, which includes a two-year stint in LTC and a memory care unit as a staff nurse and then nurse manager. For the last five and half years I have been employed as an assistant professor at a local university. Among the courses and content that I teach are public health, leadership, disaster-preparedness, and ethics. I am also a Doctor of Nursing Practice student specializing in Public Health and Policy. In addition, specifically related to this bill, I am former member of the Reuniting Residents and Families taskforce set up by DHS and a co-founder of the family-led organization, North Dakota Advocacy for Residents in Long Term Care.

Over the last year, I spent considerable hours reviewing and investigating the policies handed down from CMS, scrutinizing the recently rescinded Executive Order 2020.22-1 and the VP3 team guidance. The EO and VP3 team guidance impacted approximately 8,000 residents in Assisted Living Rental Properties, Basic Care and Skilled Nursing facilities, countless family members and staff—upward estimate of 100,000 North Dakotans.

I believe the visitation restrictions that violated the rights of the resident stem not solely from the federal CMS guidelines, which is what families are told, but primarily from the EO and the interpretations of the CMS guidelines by the DHS VP3 taskforce and individual facilities. **The fine print in the VP3 taskforce interpretations authorized facilities to enforce further restrictions above and beyond the executive order and federal guidelines at their own discretion.** Three additional areas confounded visitation attempts:

- Reported data collection inconsistencies.
- Quality control issues within the NDDOH and ND State lab leading to high false positivity rates; and
- An important retesting protocol aiding in eliminating false positives that restricted visitation was discontinued.

The unintended consequences of these policies have caused a lot of unnecessary suffering.

I testify before you today not only as a 25Y seasoned healthcare professional, but as a daughter of North Dakota whose family has been deeply impacted by EO and its interpretation and application.

In December of 2019, our 93Y Grandmother moved from an assisted living rental property to the skilled nursing side of her facility. Recent renovation of the facility had cut off her independent access to activities, chapel and her life-long friends on the skilled nursing side. Other than the fact that she is legally blind and walks with a walker, she is very healthy. Like every family, the visitor restrictions while residing in LTC began to take its toll on her wellbeing and quality of life including her cognition, physical & emotional health. She became unable to operate her phone isolating her further from her only living child and daily visitor, our mother. At one point she asked me if my mother was in jail. Her

conversational ability strikingly declined, and she was unable to talk about anything but the weather. She also began to complain about increased pain; likely from the hours and hours of sitting isolated alone in her room. Our mother visited her daily at the window, but it was thick-paned glass that was difficult for my grandmother to hear through in addition to her visual impairment.

In July 2020, after an incident where our family was refused a valid compassionate care visit, we removed my grandmother from the LTC facility. She is now being cared for by my mother and a local woman we have hired as there is no homecare in our county. Our family has a beautiful end to our story, our grandmother came back to life. At the age of 93, she regained her cognitive function, her emotional health, mobility and then some. She now sings, dances, laughs, tells jokes, lifts weights, exercises, walks three times per day, attends church and bible study and participates in all family events. She is truly living her best life.

However, there was only one problem. We couldn't sleep at night knowing that 8,000 other North Dakotans and their families and overworked staff were still suffering excessive visitation restrictions. Not everyone has the means or ability to bring their loved one home. Families kept contacting us from all over the state.

In September of 2020, tired of the months of run around and passing the buck from agency to agency unreturned emails and calls from state media, it was clear there was no help for residents and families in ND. The legislature was our last resort. Four resident family members and I looked to our hometown Senator, Dale Patten for help. We shared our story and informed him of the devastating unintended consequences of EO and the VP3 and facility interpretations of the CMS guidelines. Thank you to Senator Patten and Senator Roers and the other members of the Senate Human Services committee for speaking out about the excessive restrictions on LTC thus ending the media freeze on the issue. The family led organization, North Dakota Advocacy for Residents in Long Term Care was created at this time as an effort to bring families together for emotional support, inform residents and families of their rights under the 1987 Nursing Home Reform Act, and as a venue to discuss state and facility overreach. To date, over 16,000 North Dakotans have accessed information from our group and page, a confirmation that we are not the only family with a resident that required advocacy during COVID overreach. At that time, we began to discuss with Senator Roers the need to follow other states who had enacted Designated Caregiver Laws such as Colorado and Arizona. That brings us to today.

However, Lingering questions remain unanswered. We have the following requests:

- Follow up with the dozens, if not hundreds, of complaints of abuse and neglect, use of chemical and physical restraints that were referred to the Reuniting Residents and Families Taskforce Chairman, state ombudsman's office and to the department of health and human services.
- Revaluate the policy of not retesting residents in LTC facilities after an asymptomatic positive.

Further comments:

- Regarding county positivity rates: The map with the color coding of counties is not accessible to residents and families. It should be easily accessible for families on the front page of the NDDOH website and the NDLTCA website and facility website to communicate with families.
- The state lab publicly reported issues with software malfunctions and quality control problems leading to high false positivity rates in November and December of 2020. These quality control

issues led to unnecessary restrictions in visitation in LTC not allowing many residents to see family over the holidays.

In Summary, CMS Visitation Guidelines:

> 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.

SB2145 is urgently needed. Managing LTC in is a delicate balance that needs to include the holistic care for the resident including visitation of essential caregivers. Every year, there are facilities that are in violation of CMS codes that protect the rights of the resident. In fact, we have counties that are in green without one positive case in the facility that were still not allowing visitation as of last week. There are people who had not seen or touched their loved one since March 2020 before the EO was rescinded. This is an unacceptable violation of human rights and is in direct violation of the 1987 Nursing Home Reform Act Resident Bill of Rights.

The hearts of thousands of North Dakotans: residents, family, friends and staff are broken. This law is imperative not just for the days of COVID, but for all time to protect visitation freedoms of our loved ones in LTC.

Please vote in favor of SB2145.

Thank you for your time and consideration.

Testimony
SB 2145
House Human Services Committee
Representative Weisz, Chairman

March 16, 2021

Chairman Weisz and members of the House Human Services Committee, I am Karla Backman, State Long-Term Care Ombudsman – essentially the program administrator for the North Dakota Long-Term Care Ombudsman Program. I am testifying today in support of Engrossed Senate Bill 2145.

As the State Long-Term Care Ombudsman, I have the honor and responsibility of advocating to protect the health, safety, welfare, and rights of residents of long-term care facilities. As you are fully aware, in response to the public health crisis of the COVID 19 pandemic both federal and state authorities responded by waiving many rights of the residents of long-term care facilities. One of the rights waived was the right to visitation from individuals of the resident's choosing. This crisis response over the long term has been shown to have negative effects on many residents – depression, increased confusion, physical decline etc. We have just marked the one-year anniversary of federal officials banning visits in nursing homes and April 6th, 2020 is when Governor Burgum signed an executive order suspending visits in nursing homes and basic care long-term care facilities. With those actions many rights of residents of long-term care were waived. Fortunately, there has been steps forward in reopening our long-term care facilities. The Governor rescinded the executive orders for long-term care facilities last week and CMS also revised their guidance.

I support Engrossed Senate Bill 2145 as another important move towards the restoration and protection of the right of residents of long-term care facilities to have contact with individuals of their choice and their right to have visitors.

The lockdown and isolation caused by the protection from COVID-19 triggered physical, mental, and cognitive decline. The addition of an essential caregiver could have reduced this decline. The essential caregiver can also be a support to the staff of long-term care facilities. The challenge of having adequate staff to meet resident needs is ongoing. During the current public health emergency there has been an additional toll on the staff caused by infection control processes and staff shortages caused by quarantine.

I believe this bill is a step in establishing best practice for residents of long-term care facilities. It is person-centered and honors the rights of residents that should not be waived. This bill is introduced due to the handling of the COVID-19 public health emergency and I believe it will also be relevant for future events and a support of North Dakota Century Code 50-10.2 - Rights of Health Care Facility Residents.

That concludes my testimony and I welcome questions from the committee. Thank you much for your time.

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.

Shelly Peterson, President
North Dakota Long Term Care Association
1900 North 11th Street
Bismarck, ND 58501 (701) 222-0660

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
7500 Security Boulevard, Mail Stop C2-21-16
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

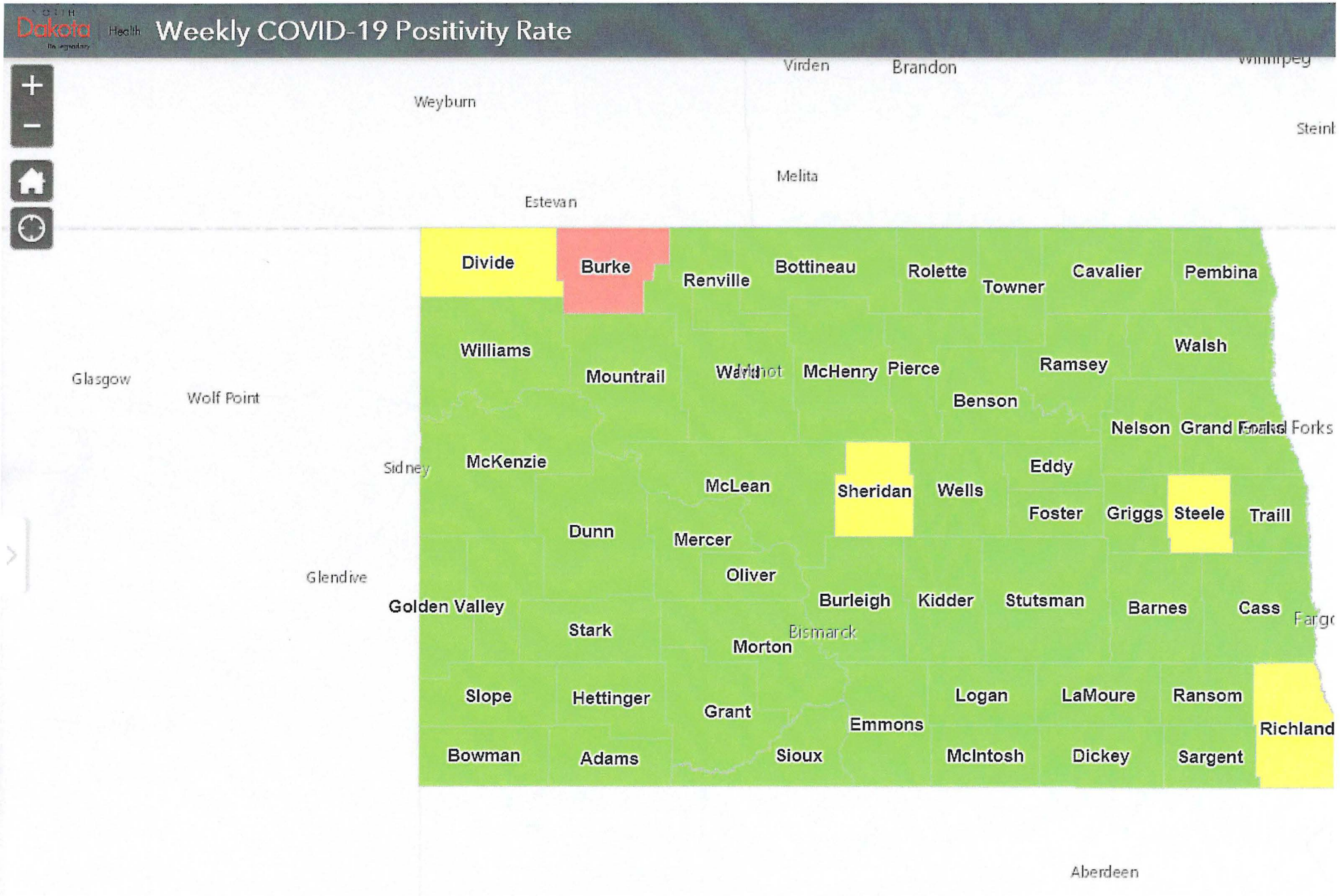
Additional CDC resources to help prevent spread of COVID-19 in shared or congregate housing settings

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

House Human Services Committee
SB 2145
Nursing Home Visitation
March 16, 2021
Janelle Moos, AARP North Dakota
jmoos@aarp.org – (701) 355-3641

Chair Weisz and members of the House Human Services Committee, my name is Janelle Moos, Advocacy Director for AARP North Dakota. I appreciate your time today and look forward to working with you on an issue that we have been working on since the start of the pandemic.

Before we get into the details of the bill I'd like to spend just a moment reminding you who we are and why we are here. AARP is a nonpartisan, nonprofit, nationwide organization with nearly 38 million members. Over 84,000 of those members live in North Dakota – a staggering number when you consider the overall population of our state.

AARP has worked with state leadership to ensure the strongest response to this pandemic possible. While the tragedy of death and illness from COVID-19 continues to plague the country's nursing homes and other long-term care (LTC) facilities, months-long visitation restrictions are also taking a serious toll[1] on the emotional and physical health of residents and their families.

While we support visitation for essential or designated caregivers, we are advocating for all visitation to resume for all residents in LTC facilities with proper testing, infection control protocols and PPE that ensures the greatest protection for residents and staff. Until that time, AARP continues to encourage the state and LTC facilities to ensure residents have access to the technology, devices and support to remain connected with their families until in person visitation can safely resume. In fact, AARP was one of the early advocates to call for increased virtual visitation to help bridge the gap when facilities are closed to in-person visitation (see attached press release from 2020).

Additionally, when the North Dakota Long Term Care Ombudsman reached out to us last year with a very similar proposal, wherein LTC residents could select an essential caregiver for in person visitation, AARP ND provided detailed comments and included suggestions to improve the proposal at that time. I have attached our August 11, 2020, letter to Karla Backman, State Long Term Care Ombudsman and in that letter you will see the principals we outlined regarding

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7205644/

visitation; including Minimizing Risk, Fairness/Universality, Individualized Plan, Responsibilities of LTC Facilities to Facilitate Visitation, Notification, and Residents without Visitors/Outdoor access. We stand by those principles today as well.

As you may know, in September 2020, the Centers for Medicare & Medicaid Services (CMS) issued new guidance for how nursing homes on protocols for safely facilitating visitation. This new guidance, that was issued on September 17, 2020, superseded previous CMS visitation guidance, and was effective immediately for all nursing homes that accept Medicare or Medicaid. The CMS guidance more closely reflects AARP's position that residents should drive how visitation is facilitated as long as it is in line with state protocols.

Additionally, the CMS guidance calls for visitation that is "person-centered," considering "the residents' physical, mental, and psychosocial well-being. Indoor visitation is allowed if there has been no new onset of COVID-19 cases in the past 14 days and the facility is not conducting outbreak testing per CMS guidelines. The guidance lays out certain core principles of infection prevention that should always be followed and gives other suggestions for how to best adapt visitation for the resident's situation and needs.

The new CMS guidance makes no distinction between essential caregivers and other visitors. Instead, nursing homes now must facilitate in-person visitation for all, consistent with the regulations, as long as there have been no new COVID-19 cases, the county positivity rate is sufficiently low, and there is no other clinical reason to restrict visitation. We are committed to and support movement toward visitation for all residents in LTC again.

Similarly, the CMS guidance clarifies "compassionate care situations" for which special visitation may occur, even when county positivity rates are high and other visitation is restricted. Previously, states and facilities struggled to apply standards for compassionate care and may have been overly restrictive on allowing such visits. Compassionate care visits may be appropriate in end-of-life situations, but also when residents are "struggling with the change in environment and lack of physical family support," "grieving after [a] friend or family member [who] recently passed away," need "help and encouragement with eating or drinking," or are "experiencing emotional distress".

While the CMS guidance makes important advances towards ensuring access to in person visitation, we believe some facilities have been slow to implement this guidance. While the ability of residents and families to communicate via virtual visitation has greatly improved and virtual visitation is not always ideal, we believe it would be prudent for the state to ensure families and residents have access to this when We encourage the state to consider amending this bill to also include facilitated virtual visitation as a guaranteed option residents and families can rely upon when numbers within a facility or a region preclude the possibility of in-person visitation from taking place.

On March 10, 2021, CMS issued updated nursing home guidance with revised visitation recommendations. In summary the updated guidance is as follows:

According to the updated guidance, facilities should allow responsible indoor visitation at all times and for all residents, regardless of vaccination status of the resident, or visitor, unless certain scenarios arise that would limit visitation for:

- Unvaccinated residents, if the COVID-19 county positivity rate is greater than 10 percent **and** less than 70 percent of residents in the facility are fully vaccinated;
- 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.

The updated guidance also emphasizes that "compassionate care" visits should be allowed at all times, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak. Compassionate care visits include visits for a resident whose health has sharply declined or is experiencing a significant change in circumstances.

In response, AARP released a statement from Nancy LeaMond, AARP Executive Vice President and Chief Advocacy & Engagement Officer, in response to the guidance from CMS that expands safe visitation in nursing homes:

> *"AARP thanks the Centers for Medicare & Medicaid Services for providing updated guidance that allows easier in-person visitation at nursing homes while continuing to emphasize infection prevention and control practices for facilities, visitors and others. This is very positive news for residents of nursing homes and their families.*
>
> *"In the year since the pandemic began, we have heard heartbreaking stories about the challenges families have had trying to see their relatives and the many important moments they missed. As we enter a new phase of this pandemic with the ongoing rollout of vaccines and growing knowledge about public health needs – including the safety, mental health, and social well-being of nursing home residents -- it is vital that these vulnerable seniors are able to safely visit with their loved ones. Residents must be able to exercise their rights to visitation, and facilities should be held accountable for ensuring such visits occur.*
>
> *"AARP will continue fighting to improve the quality of care in nursing homes and other long-term care facilities during this global health crisis and into the future."*

AARP called on CMS to review its earlier guidance in a February 23

Nursing home residents continue to bear the brunt of this pandemic, and strong visitation standards can help improve their health and quality of life. We appreciate the time to comment today.

Thank you.

#9295

Family Policy ALLIANCE of North Dakota

March 16, 2021

Dear House Human Services Committee,

Chairman Weisz and members of the House Human Services Committee, Family Policy Alliance of North Dakota would like to formally indicate its support of Senate Bill 2145.

We believe that elderly North Dakotans should never be excluded from personal interaction with their family members and friends, particularly with no end in sight, as with the COVID-19 pandemic. The endless extensions that became months of isolation is beyond the pale for any citizen of our state, let alone those who are most frail and vulnerable.

We have heard from many families how their parents or grandparents who were once vibrant and energetic elderly citizens have "withered away" because of isolation that has led to despair, depression, and other emotional trauma. Please take a firm stand to value and protect our elderly, so that we can ensure that this travesty will never happen again in our state. For these reasons, we respectfully ask for a "DO PASS" committee recommendation on SB2145.

Thank you for your consideration,

Mark Jorritsma
Executive Director
Lobbyist #147

1515 Burnt Boat Drive., Ste. C148
Bismarck, ND 58503

P 866.655.4545

UNLEASHING CITIZENSHIP
FamilyPolicyAlliance.com/NorthDakota

ND

A Public Policy Partner of Focus on the Family

#9366

House Member,

Under no circumstance should our constitutional rights be violated in a pandemic to see our loved ones in any type of senior home or otherwise!

The cure was worse than the pandemic. Many died without seeing their family and many did not get to say goodbye to a senior in a home!

These lockdown EO were unconstitutional and should never happen again.

Thank you,

Mr. Mitchell S. Sanderson

✧ 1912-2021 ✧
1515 Burnt Boat Drive
Suite C #325
Bismarck, ND 58503
701-335-6376

March 16, 2021

Chair Weisz and Members of the House Human Services Committee,

I am writing on behalf of the North Dakota Nurses Association in support of SB 2145, a bill that would assign designated caregivers to long term care residents.

For many months, long term care residents and their families dealt with the stress and strain of isolation due to efforts to keep them safe from COVID-19. Senate Bill 2145 would allow designated caregivers. It states, "a designated caregiver is an individual, whether a family member or friend of a resident of a long-term care facility, who is designated by the resident or appointed by an individual with decision-making authority for the resident to provide in-person physical, spiritual, or emotional support to the resident during a declaration of disaster or emergency".

The North Dakota Nurses Association supports SB 2145. The designated caregivers could open a well-needed support line. The caregivers would be subject to standardized safety protocols, and individual facilities would have leeway to ask for some additional precautions.

In the facilities where residents have been unable to see family, nursing staff have been the sole caregivers, providing the physical and emotional support for their patients. This could impact nurses with either burnout or compassion fatigue. With these, "commonly reported symptoms include fatigue, illness, headaches, insomnia, disillusionment, emotional instability, anger, sense of hopelessness, and excessive rigidity in interpersonal relations (Epp, 2012; Jenkins & Warren, 2012). "Compassion fatigue has a different source of stress. The stress comes from the nurse's involvement in relationships with patients and families in which the nurse witnesses the trauma or suffering of patients. The cumulative effect causes physical, mental, and spiritual symptoms in the nurse" (Wentzel & Brysiewicz, 2014).

As the mission of NDNA is to advance the nursing profession by promoting professional development of nurses, fostering high standards of nursing practice, promoting the safety and well-being of nurses in the workplace, and by advocating on health care issues affecting nurses and the public, we feel SB 2145 would not only improve the quality of life for our wonderful residents, but also our valuable resource of *nurses*.

Sincerely,

Sherri Miller, BS, BSN, RN
director@ndna.org
Executive Director
North Dakota Nurses Association

House Human Services Committee
SB 2145
03/16/2021
2:45 pm

Chairman Weisz and members of the House Human Services Committee,

North Dakota Right to Life is dedicated to protecting the lives of every human from conception to natural death. We stand at 2,500 members strong who whole-heartedly believe this mission statement. Every human at every stage of life. I feel that our organization is often associated with our dedication to fighting for the unborn, but I wanted to take this opportunity to talk about the importance of protecting individuals as they age until they experience natural death. Recently, I was reading an article by Wesley Smith in the National Review that discussed the point of view from a doctor in New Jersey. His grandfather, at the age of 103 years old, did not qualify for assisted suicide but wanted to hasten his death due to the isolation he felt during COVID-19. Here is a direct paragraph taken from this article.

> "I described another option to Grandpa: he could voluntarily stop eating and drinking. He'd never considered this possibility (which reminded me again how one's family members and clinicians contribute to inequities in end-of-life care). The option intrigued Grandpa, and during subsequent visits he reinforced his plan to pursue it. I insisted that he first move into my home. I wanted to ensure the quality of his care, knowing that I could enroll him in my health system's hospice program. But I also wished to test his resolve, reasoning that his mind might change once his isolation ended."

To further summarize this article, after the grandfather had moved into his grandson's home, he changed his opinion on starvation and was thriving in his new environment. After a few weeks, he decided to continue forward with death by starvation and to make the decision easier, his grandson sedated him to stop any urges to resist.

The most interesting part of this is the reasoning behind the decision to request physician assisted suicide. Based on a study performed in Canada in 2018 on 112 patients who requested physician assisted suicide, one of the top reasonings for this request was due to loss of purpose they felt in their life or the inability to accept their diagnosis. Given this information, what options do we have to provide hope and comfort to our loved ones who are suffering? Listen to these individuals and find ways to alleviate the physical, mental, or emotional pain that they are feeling. Offer to document preferences and values regarding the patient's end of life care. Understand the important religious or cultural practices that each individual holds in order to remain true to their wishes. And lastly, be there for them to support them in their final days which helps reduce the feelings of isolation experienced by so many.

Let us focus on raising awareness of the danger to our older generations of physician assisted suicide and euthanasia. Please check out the article below which was referenced in this section for further information.

I strongly encourage all to vote in favor of this bill in order to give long-term care patients the ability to have comfort in a designated caregiver during times of a disaster or emergency. Please vote for a DO PASS recommendation on SB 2145.

Article referenced: https://www.nationalreview.com/corner/suicide-by-starvation-and-expanded-assisted-suicide-promoted-in-new-england-journal-of-medicine/

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

SB 2145
3/24/2021

Relating to access to long-term care facilities; and to declare an emergency

Chairman Weisz opened the committee meeting at 11:02 a.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Designated caregiver
- Assisted living regulation
- Essential caregiver liability and immunity
- Personal protective equipment shortage
- Infection control training

Rep. Bill Tveit (11:23) presented proposed amendments on Page 1, Line 14 &15 remove basic care facility and assisted living facility and replace language on Page 2, Lines 17-21 with “a long-term care facility may establish additional safety requirements to protect the residents; the facility may require a designated caregiver to provide personal protective equipment for the designated caregiver or assume the cost of the personal protective equipment provided by the facility to allow the designated caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility” - #11401

Rep. Karen Rohr (11:24) second

Voice Vote – Motion Carried

Rep. Bill Tveit (11:34) moved **Do Pass As Amended**

Rep. Kathy Skroch (11:35) second

Representatives	Vote
Representative Robin Weisz	N
Representative Karen M. Rohr	Y
Representative Mike Beltz	N
Representative Chuck Damschen	N
Representative Bill Devlin	N
Representative Gretchen Dobervich	Y
Representative Clayton Fegley	N
Representative Dwight Kiefert	N
Representative Todd Porter	N
Representative Matthew Ruby	A
Representative Mary Schneider	Y
Representative Kathy Skroch	Y
Representative Bill Tveit	Y
Representative Greg Westlind	Y

Motion Failed Do Pass As Amended 6-7-1

NOTE: SB 2145 held until next week

Chairman Weisz adjourned at 11:38 a.m.

Tamara Krause, Committee Clerk

Amendment to SB 2145

Page 1. Lines 14 & 15 remove "assisted living facility"

Page 2, lines 14, 15 & 16 remove all of subsection c.

Replace line 17 thru 21 on page 2 with the following:

50 - 10.3-04. **Additional safety requirements for residents of long-term care facilities.**

A long-term care facility may establish additional safety requirements to protect the residents; the facility may require a designated caregiver to provide personal protective equipment for the designated caregiver or assume the cost of the personal protective equipment provided by the facility to allow the designated caregiver to provide in – person physical, spiritual, or emotional support to a resident of the long-term care facility.

Re-number accordingly

Amendment to SB 2145

Page 1. Lines 14 & 15 remove "assisted living facility"

Page 2, lines 14, 15 & 16 remove all of subsection c.

Replace line 17 thru 21 on page 2 with the following:

50 - 10.3-04. **Additional safety requirements for residents of long-term care facilities.**

A long-term care facility may establish additional safety requirements to protect the residents; the facility may require a designated caregiver to provide personal protective equipment for the designated caregiver or assume the cost of the personal protective equipment provided by the facility to allow the designated caregiver to provide in – person physical, spiritual, or emotional support to a resident of the long-term care facility.

Re-number accordingly

2021 HOUSE STANDING COMMITTEE MINUTES

Human Services Committee
Pioneer Room, State Capitol

SB 2145
3/31/2021

Relating to access to long-term care facilities; and to declare an emergency

Chairman Weisz opened the committee meeting at 9:05 a.m.

Representatives	Attendance
Representative Robin Weisz	P
Representative Karen M. Rohr	P
Representative Mike Beltz	P
Representative Chuck Damschen	P
Representative Bill Devlin	P
Representative Gretchen Dobervich	P
Representative Clayton Fegley	P
Representative Dwight Kiefert	P
Representative Todd Porter	P
Representative Matthew Ruby	P
Representative Mary Schneider	P
Representative Kathy Skroch	P
Representative Bill Tveit	P
Representative Greg Westlind	P

Discussion Topics:

- Basic care state regulation
- Safety measure protocols
- Personal protective equipment stockpiles
- Supply chain
- Facility liability

Rep. Kathy Skroch (9:14) moved to put “basic care facility” back into the bill (had been previously removed 3/24/2021).

Rep. Karen Rohr (9:14) second

Voice Vote – Motion Carried

Rep. Bill Tveit (9:26) presented adding Page 2, Line 14, 15, 16 following essential caregiver “any extension deemed necessary for continued safety and wellbeing concerns that could extend the lockdown beyond the original 30 days must be mutually agreed to by the local facilities manager affected and the state long-term care ombudsman, revisited and approved by the same parties every 30 days.” - #11142.

Rep. Todd Porter (9:35) presented **Amendment 21.0439.04001** - #11155.

Rep. Bill Tveit (10:06) moved to adopt **Amendment 21.0439.04001** along with proposed amendments deleting 30 days but adding "protocols need to be established in 30 days," added training requirements, and to adopt Indiana's liability clause statement.

Rep. Kathy Skroch (10:07) second

Voice Vote – Motion Carried

Rep. Bill Tveit (10:08) moved **Do Pass As Amended**

Rep. Kathy Skroch (10:08) second

Representatives	Vote
Representative Robin Weisz	Y
Representative Karen M. Rohr	Y
Representative Mike Beltz	Y
Representative Chuck Damschen	Y
Representative Bill Devlin	Y
Representative Gretchen Dobervich	Y
Representative Clayton Fegley	Y
Representative Dwight Kiefert	N
Representative Todd Porter	Y
Representative Matthew Ruby	Y
Representative Mary Schneider	Y
Representative Kathy Skroch	Y
Representative Bill Tveit	Y
Representative Greg Westlind	Y

Motion Carried Do Pass As Amended 13-1-0

Bill Carrier: Rep. Karen Rohr

Chairman Weisz adjourned at 10:10 AM.

Tamara Krause, Committee Clerk

21.0439.04001
Title.

Prepared by the Legislative Council staff for
Representative Porter
March 25, 2021

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2145

Page 1, line 14, remove ", basic care facility, assisted"

Page 1, line 15, remove "living facility,"

Page 2, line 10, after "equipment" insert "and related training"

Page 2, line 19, remove "if the requirements and cost are not so burdensome or"

Page 2, line 20, replace "onerous as to substantially prevent an essential caregiver from being able" with ". The long-term care facility may require an essential caregiver provide personal protective equipment for the essential caregiver and undergo any related training or to assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver"

Page 2, line 24, after "protocols" insert "and safety requirement"

Page 2, line 24, replace "section" with "sections"

Page 2, line 24, after "50-10.3-03" insert "and 50-10.3-04"

Page 2, after line 26, insert:

"**50-10.3-06. Liability.**

In complying with this chapter, a long-term care facility is immune from civil liability for any act or omission in response to a declaration of disaster or emergency which causes or contributes, directly or indirectly, to the death or injury of an essential caregiver."

Renumber accordingly

Amendment to SB 2145. (Representative Tveit)

Page 1. Lines 14 & 15 remove only: assisted living facility"

Page 2, lines 14, 15 & 16, following "essential caregiver." Add the following:

Any extension deemed necessary, for continued safety and well being concerns, that could extend the lock down beyond the original 30 days, must be mutually agreed to by the Local Facilities Manager affected and the State Long Term Care Ombudsman, revisited and approved by the same parties every 30 days.

Replace line 17 thru 21 on page 2 with the following:

50 - 10.3-04. **Additional safety requirements for residents of long-term care facilities.**
A long-term care facility may establish additional safety requirements to protect the residents; the facility may require a designated caregiver to provide personal protective equipment for the designated caregiver or assume the cost of the personal protective equipment provided by the facility to allow the designated caregiver to provide in – person physical, spiritual, or emotional support to a resident of the long-term care facility.

Re-number accordingly

21.0439.04002
Title.05000

Adopted by the House Human Services Committee

March 31, 2021

3/31/21

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2145

Page 1, line 14, remove "assisted"

Page 1, line 15, remove "living facility."

Page 1, line 24, after "establish" insert "basic"

Page 2, line 3, after the underscored period insert "If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall update the protocols within thirty days of the restricted access."

Page 2, line 11, after the underscored semicolon insert "and"

Page 2, line 13, remove "; and"

Page 2, remove lines 14 and 15

Page 2, line 16, remove "residents of the long-term care facility and essential caregivers"

Page 2, line 19, remove "of the long-term care facility if the requirements and cost are not so burdensome or"

Page 2, remove line 20

Page 2, line 21, remove "physical, spiritual, or emotional support to a resident of the long-term care facility"

Page 2, line 21, after the underscored period insert "The facility may require an essential caregiver to provide personal protective equipment for the essential caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility."

Page 2, after line 26, insert:

"**50-10.3-06. Liability.**

A facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for damages, including punitive damages, for any act or omission related to the implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct."

Renumber accordingly

REPORT OF STANDING COMMITTEE

SB 2145, as engrossed: Human Services Committee (Rep. Weisz, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (13 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Engrossed SB 2145 was placed on the Sixth order on the calendar.

Page 1, line 14, remove "assisted"

Page 1, line 15, remove "living facility,"

Page 1, line 24, after "establish" insert "basic"

Page 2, line 3, after the underscored period insert "If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall update the protocols within thirty days of the restricted access."

Page 2, line 11, after the underscored semicolon insert "and"

Page 2, line 13, remove "; and"

Page 2, remove lines 14 and 15

Page 2, line 16, remove "residents of the long-term care facility and essential caregivers"

Page 2, line 19, remove "of the long-term care facility if the requirements and cost are not so burdensome or"

Page 2, remove line 20

Page 2, line 21, remove "physical, spiritual, or emotional support to a resident of the long-term care facility"

Page 2, line 21, after the underscored period insert "The facility may require an essential caregiver to provide personal protective equipment for the essential caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility."

Page 2, after line 26, insert:

"**50-10.3-06. Liability.**

A facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for damages, including punitive damages, for any act or omission related to the implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct."

Renumber accordingly

Amendment to SB 2145. (Representative Tveit)

Page 1. Lines 14 & 15 remove only: assisted living facility"

Page 2, lines 14, 15 & 16, following "essential caregiver." Add the following:

Any extension deemed necessary, for continued safety and well being concerns, that could extend the lock down beyond the original 30 days, must be mutually agreed to by the Local Facilities Manager affected and the State Long Term Care Ombudsman, revisited and approved by the same parties every 30 days.

Replace line 17 thru 21 on page 2 with the following:

50 - 10.3-04. **Additional safety requirements for residents of long-term care facilities.**
A long-term care facility may establish additional safety requirements to protect the residents; the facility may require a designated caregiver to provide personal protective equipment for the designated caregiver or assume the cost of the personal protective equipment provided by the facility to allow the designated caregiver to provide in – person physical, spiritual, or emotional support to a resident of the long-term care facility.

Re-number accordingly

21.0439.04001
Title.

Prepared by the Legislative Council staff for
Representative Porter
March 25, 2021

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2145

Page 1, line 14, remove ", basic care facility, assisted"

Page 1, line 15, remove "living facility,"

Page 2, line 10, after "equipment" insert "and related training"

Page 2, line 19, remove "if the requirements and cost are not so burdensome or"

Page 2, line 20, replace "onerous as to substantially prevent an essential caregiver from being able" with ". The long-term care facility may require an essential caregiver provide personal protective equipment for the essential caregiver and undergo any related training or to assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver"

Page 2, line 24, after "protocols" insert "and safety requirement"

Page 2, line 24, replace "section" with "sections"

Page 2, line 24, after "50-10.3-03" insert "and 50-10.3-04"

Page 2, after line 26, insert:

"**50-10.3-06. Liability.**

In complying with this chapter, a long-term care facility is immune from civil liability for any act or omission in response to a declaration of disaster or emergency which causes or contributes, directly or indirectly, to the death or injury of an essential caregiver."

Renumber accordingly

2021 CONFERENCE COMMITTEE

SB 2145

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2145
4/20/2021
Conference Committee

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities; and to declare an emergency.

Madam Chair K. Roers opened the conference committee on SB 2145 at 10:30 a.m. Members present: Senator K. Roers, O. Larsen, Hogan, Representative Tveit, Skroch, Rohr.

Discussion Topics:

- House actions
- Inclusion of assisted living facilities in SB 2145
- CMS regulations
- 30-day protocol revisions

Additional written testimony: N/A

Madam Chair K. Roers closed the conference committee on SB 2145 at 10:42 a.m.

Justin Velez, Committee Clerk

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2145
4/21/2021
Conference Committee

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities; and to declare an emergency.

Madam Chair K. Roers opened the conference committee on SB 2145 at 2:29 p.m. Members present: Senator K. Roers, O. Larsen, Hogan, Representative Tviet, Skroch, Rohr.

Discussion Topics:

- Proposed amendment
- Assisted living facilities visitation restrictions
- 30-day restriction timeline

[2:30] Senator K. Roers, District 27. Provided the committee with proposed amendment 21.0439.04004 (testimony #11591).

Additional written testimony: N/A

Madam Chair K. Roers closed the conference committee on SB 2145 at 2:41 p.m.

Justin Velez, Committee Clerk

21.0439.04004

Sixty-seventh
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED SENATE BILL NO. 2145

Introduced by

Senators K. Roers, Mathern, Patten

Representatives Keiser, Rohr, Westlind

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 50-10.3 of the North Dakota Century Code is created and enacted as follows:

50-10.3-01. Definitions.

As used in this chapter, unless the context clearly indicates otherwise:

1. "Declaration of disaster or emergency" means a disaster or emergency declared by the governor under chapter 37-17.1.
2. "Department" means the department of human services.
3. "Essential caregiver" means an individual identified by a resident of a long-term care facility or by the resident's designated decisionmaker to provide in-person physical, spiritual, or emotional support to the resident.
4. "Long-term care facility" means a skilled nursing facility, basic care facility, ~~assisted living facility,~~ or swing-bed hospital approved to furnish long-term services.

50-10.3-02. Scope - Limitation.

1. This chapter does not supersede federal authority regarding long-term care facilities or prevent the department or state department of health from taking necessary actions to render the state eligible for federal funds or reimbursement services provided in long-term care facilities.
2. Notwithstanding contrary law, including chapter 37-17.1, section 23-01-05, and chapter 23-07.6, the state may not impose visitation restrictions on residents of an assisted living facility.

50-10.3-03. Access to long-term care facilities for essential caregivers.

1. The department, working jointly with the state department of health, the state long-term care ombudsman, residents and tenants, families of residents and tenants, and long-term care facility representatives, shall establish basic protocols to allow a resident of a long-term care facility or the resident's designated decisionmaker designate one or more individuals as the resident's essential caregivers, including during a declaration of disaster or emergency.

   a. If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall review and update the protocols every thirty days during the period of restriction, including an assessment of the need for continuation of the restriction.

   b. An essential caregiver shall meet the necessary qualifications to enter the long-term care facility to provide in-person physical, spiritual, or emotional support to a resident of a long-term care facility in accordance with the protocols established under this section.

2. The protocols must include:

   a. Safety measures for an essential caregiver which may include restrictions on travel, enhanced testing for communicable diseases, and the necessary safety equipment required to protect the health and safety of the residents of the long-term care facility; and

   b. Procedures to replace an essential caregiver due to necessary circumstances, including illness or death of the essential caregiver~~; and~~

   ~~c. A duration, not to exceed thirty days, during which a long-term care facility may enter a lockdown phase for the purpose of establishing safety measures for residents of the long-term care facility and essential caregivers.~~

50-10.3-04. Additional safety requirements for residents of long-term care facilities.

A long-term care facility may establish additional safety requirements to protect the residents ~~of the long-term care facility if the requirements and cost are not so burdensome or onerous as to substantially prevent an essential caregiver from being able to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility~~. The facility may require an essential caregiver to provide personal protective equipment for the essential

caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility.

50-10.3-05. Suspension of access for essential caregivers.

If a long-term care facility suspends access to the long-term care facility for an essential caregiver who violates the protocols established under section 50-10.3-03, the long-term care facility shall allow the resident, or the resident's designated decisionmaker, to immediately designate a replacement essential caregiver.

50-10.3-06. Liability.

A long-term care facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for damages, including punitive damages, for any act or omission related to the implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct.

SECTION 2. EMERGENCY. This Act is declared to be an emergency measure.

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2145
4/22/2021
Conference Committee

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities; and to declare an emergency.

Madam Chair K. Roers opened the conference committee on SB 2145 at 2:31 p.m. Members present: Senator K. Roers, O. Larsen, Hogan, Representative Tveit, Skroch, Rohr.

Discussion Topics:

- Proposed amendment

[2:32] Senator Kristen Roers, District 27. Provided the committee with proposed amendment 21.0439.04005 (testimony #11616).

Senator Hogan moves the **HOUSE RECEDE TO HOUSE AMENDMENTS AND AMEND AS FOLLOWS:** 21.0439.04005.
Senator O. Larsen seconded.

Motion passed 6-0-0.

Senator K. Roers and **Representative Tveit** will carry SB 2145.

NOTE: Conference committee report was never sent to floor due to committee holding bill. SB 2145 was voted out of committee on April 27th, 2021.

Additional written testimony: N/A

Madam Chair K. Roers closed the conference committee at 2:35 p.m.

Justin Velez, Committee Clerk

21.0439.04005
Title.06000

Prepared by the Legislative Council staff for
Senator K. Roers
April 21, 2021

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2145

That the House recede from its amendments as printed on page 1318 of the Senate Journal and page 1436 of the House Journal and that Engrossed Senate Bill No. 2145 be amended as follows:

Page 1, line 14, remove "assisted"

Page 1, line 15, remove "living facility,"

Page 1, line 24, after "establish" insert "basic"

Page 2, after the underscored period insert:

"a. If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall review and update the protocols every thirty days during the period of restriction, including an assessment of the need for continuation of the restriction.

b."

Page 2, line 11, after the underscored semicolon insert "and"

Page 2, line 13, remove "; and"

Page 2, remove lines 14 and 15

Page 2, line 16, remove "residents of the long-term care facility and essential caregivers"

Page 2, line 19, remove "of the long-term care facility if the requirements and cost are not so burdensome or"

Page 2, remove line 20

Page 2, line 21, remove "physical, spiritual, or emotional support to a resident of the long-term care facility"

Page 2, line 21, after the underscored period insert "The facility may require an essential caregiver to provide personal protective equipment for the essential caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility."

Page 2, after line 26, insert:

"**50-10.3-06. Liability.**

A long-term care facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for damages, including punitive damages, for any act or omission related to the implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct."

Renumber accordingly

Date: 4/22/2021
Roll Call Vote #: 1

2021 SENATE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2145 as (re) engrossed

Senate Human Services Committee

Action Taken
- ☐ **SENATE accede to House Amendments**
- ☐ **SENATE accede to House Amendments and further amend**
- ☐ **HOUSE recede from House amendments**
- ☒ **HOUSE recede from House amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Senator Hogan Seconded by: Senator O. Larsen

Senators				Yes	No		Representatives				Yes	No
Senator K. Roers				X			Representative Tveit				X	
Senator Hogan				X			Representative Skroch				X	
Senator O. Larsen				X			Representative Rohr				X	
Total Senate Vote				3	0		Total Rep. Vote				3	0

Vote Count Yes: 6 No: 0 Absent: 0

Senate Carrier Senator K. Roers House Carrier Representative Tveit

LC Number 21.0439 . 04005 of amendment

LC Number 21.0439 . 06000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Continuously update protocols for long-term care facilities in the event of a declaration of disaster or emergency. The facility may require essential caregivers to provide PPE equipment. Liability clause.

21.0439.04005

Sixty-seventh
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED SENATE BILL NO. 2145

Introduced by

Senators K. Roers, Mathern, Patten

Representatives Keiser, Rohr, Westlind

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 50-10.3 of the North Dakota Century Code is created and enacted as follows:

50-10.3-01. Definitions.

As used in this chapter, unless the context clearly indicates otherwise:

1. "Declaration of disaster or emergency" means a disaster or emergency declared by the governor under chapter 37-17.1.
2. "Department" means the department of human services.
3. "Essential caregiver" means an individual identified by a resident of a long-term care facility or by the resident's designated decisionmaker to provide in-person physical, spiritual, or emotional support to the resident.
4. "Long-term care facility" means a skilled nursing facility, basic care facility, ~~assisted living facility,~~ or swing-bed hospital approved to furnish long-term services.

50-10.3-02. Scope.

This chapter does not supersede federal authority regarding long-term care facilities or prevent the department or state department of health from taking necessary actions to render the state eligible for federal funds or reimbursement services provided in long-term care facilities.

50-10.3-03. Access to long-term care facilities for essential caregivers.

1. The department, working jointly with the state department of health, the state long-term care ombudsman, residents and tenants, families of residents and tenants, and long-term care facility representatives, shall establish basic protocols to allow a

resident of a long-term care facility or the resident's designated decisionmaker designate one or more individuals as the resident's essential caregivers, including during a declaration of disaster or emergency.

a. If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall review and update the protocols every thirty days during the period of restriction, including an assessment of the need for continuation of the restriction.

b. An essential caregiver shall meet the necessary qualifications to enter the long-term care facility to provide in-person physical, spiritual, or emotional support to a resident of a long-term care facility in accordance with the protocols established under this section.

2. The protocols must include:

a. Safety measures for an essential caregiver which may include restrictions on travel, enhanced testing for communicable diseases, and the necessary safety equipment required to protect the health and safety of the residents of the long-term care facility; and

b. Procedures to replace an essential caregiver due to necessary circumstances, including illness or death of the essential caregiver~~; and~~

~~c. A duration, not to exceed thirty days, during which a long-term care facility may enter a lockdown phase for the purpose of establishing safety measures for residents of the long-term care facility and essential caregivers.~~

50-10.3-04. Additional safety requirements for residents of long-term care facilities.

A long-term care facility may establish additional safety requirements to protect the residents ~~of the long-term care facility if the requirements and cost are not so burdensome or onerous as to substantially prevent an essential caregiver from being able to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility~~. The facility may require an essential caregiver to provide personal protective equipment for the essential caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility.

50-10.3-05. Suspension of access for essential caregivers.

If a long-term care facility suspends access to the long-term care facility for an essential caregiver who violates the protocols established under section 50-10.3-03, the long-term care facility shall allow the resident, or the resident's designated decisionmaker, to immediately designate a replacement essential caregiver.

50-10.3-06. Liability.

A long-term care facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for damages, including punitive damages, for any act or omission related to the implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct.

SECTION 2. EMERGENCY. This Act is declared to be an emergency measure.

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2145
4/26/2021
Conference committee

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities; and to declare an emergency.

Madam Chair K. Roers opened the conference committee on SB 2145 at 11:03 a.m. Members present: Senator K. Roers, O. Larsen, Hogan, Representative Tveit, Skroch, Rohr.

Discussion Topics:

- Proposed amendment
- Unaccompanied undocumented minors
- Foster care V.S. housing families
- Federal facilities for undocumented minors

[11:05] Representative Robin Weisz, District 14. Provided the committee with proposed amendment 21.0439.04006 (testimony #11641).

Representative Tveit moves the **HOUSE RECEDE FROM HOUSE AMENDMENTS AND AMEND AS FOLLOWS:** the addition of 21.0439.04005 and 21.0439.04006 amendments. **Senator Hogan** seconded.

Representative Tveit moves to table vote.
Senator Hogan seconded.

Voice vote – motion passed.

Additional written testimony: (1)

Senator K. Roers, District 27. Proposed amendment 21.0439.04005 (testimony #11616).

Madam Chair K. Roers closed the conference committee on SB 2145 at 11:28 a.m.

Justin Velez, Committee Clerk

21.0439.04006
Title.

Prepared by the Legislative Council staff for
Representative Weisz
April 23, 2021

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2145

That the House recede from its amendments as printed on page 1318 of the Senate Journal and page 1436 of the House Journal and that Engrossed Senate Bill No. 2145 be amended as follows:

Page 1, line 1, after "50-10.3" insert "and a new section to chapter 50-11"

Page 1, line 2, after "facilities" insert "and unaccompanied undocumented children"

Page 2, after line 26, insert:

"**SECTION 2.** A new section to chapter 50-11 of the North Dakota Century Code is created and enacted as follows:

Unaccompanied undocumented children.

A person may not arrange for or promote care provided in a facility for unaccompanied undocumented children unless the facility has a license or approval issued by the department."

Renumber accordingly

21.0439.04005

FIRST ENGROSSMENT

Sixty-seventh
Legislative Assembly
of North Dakota

ENGROSSED SENATE BILL NO. 2145

Introduced by

Senators K. Roers, Mathern, Patten

Representatives Keiser, Rohr, Westlind

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 50-10.3 of the North Dakota Century Code is created and enacted as follows:

50-10.3-01. Definitions.

As used in this chapter, unless the context clearly indicates otherwise:

1. "Declaration of disaster or emergency" means a disaster or emergency declared by the governor under chapter 37-17.1.
2. "Department" means the department of human services.
3. "Essential caregiver" means an individual identified by a resident of a long-term care facility or by the resident's designated decisionmaker to provide in-person physical, spiritual, or emotional support to the resident.
4. "Long-term care facility" means a skilled nursing facility, basic care facility, ~~assisted living facility,~~ or swing-bed hospital approved to furnish long-term services.

50-10.3-02. Scope.

This chapter does not supersede federal authority regarding long-term care facilities or prevent the department or state department of health from taking necessary actions to render the state eligible for federal funds or reimbursement services provided in long-term care facilities.

50-10.3-03. Access to long-term care facilities for essential caregivers.

1. The department, working jointly with the state department of health, the state long-term care ombudsman, residents and tenants, families of residents and tenants, and long-term care facility representatives, shall establish basic protocols to allow a

resident of a long-term care facility or the resident's designated decisionmaker designate one or more individuals as the resident's essential caregivers, including during a declaration of disaster or emergency.

a. If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall review and update the protocols every thirty days during the period of restriction, including an assessment of the need for continuation of the restriction.

b. An essential caregiver shall meet the necessary qualifications to enter the long-term care facility to provide in-person physical, spiritual, or emotional support to a resident of a long-term care facility in accordance with the protocols established under this section.

2. The protocols must include:

a. Safety measures for an essential caregiver which may include restrictions on travel, enhanced testing for communicable diseases, and the necessary safety equipment required to protect the health and safety of the residents of the long-term care facility; and

b. Procedures to replace an essential caregiver due to necessary circumstances, including illness or death of the essential caregiver~~; and~~

~~c. A duration, not to exceed thirty days, during which a long-term care facility may enter a lockdown phase for the purpose of establishing safety measures for residents of the long-term care facility and essential caregivers.~~

50-10.3-04. Additional safety requirements for residents of long-term care facilities.

A long-term care facility may establish additional safety requirements to protect the residents ~~of the long-term care facility if the requirements and cost are not so burdensome or onerous as to substantially prevent an essential caregiver from being able to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility~~. The facility may require an essential caregiver to provide personal protective equipment for the essential caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility.

50-10.3-05. Suspension of access for essential caregivers.

If a long-term care facility suspends access to the long-term care facility for an essential caregiver who violates the protocols established under section 50-10.3-03, the long-term care facility shall allow the resident, or the resident's designated decisionmaker, to immediately designate a replacement essential caregiver.

50-10.3-06. Liability.

A long-term care facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for damages, including punitive damages, for any act or omission related to the implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct.

SECTION 2. EMERGENCY. This Act is declared to be an emergency measure.

2021 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Sakakawea Room, State Capitol

SB 2145
4/27/2021
Conference Committee

A BILL for an Act to create and enact chapter 50-10.3 of the North Dakota Century Code, relating to access to long-term care facilities; and to declare an emergency.

Madam Chair K. Roers opened the conference committee on SB 2145 at 9:30 a.m. Members present: Senator K. Roers, O. Larsen, Hogan, Representative Tveit, Skroch, Rohr.

Discussion Topics:

- Proposed amendment
- Bill action

[9:31] Senator K. Roers. Provided committee with proposed amendment 21.0439.04008 (testimony #11666 and #11667).

Senator Hogan moves to **WITHDRAW RECEDE FROM HOUSE AMENDMENTS MOTION**
Representative Tveit seconded.

Voice vote – Motion passed.

Representative Tveit moves the **HOUSE RECEDE FROM HOUSE AMENDMENTS AND AMENDS AS FOLLOWS:** 21.0439.04008.
Senator O. Larsen seconded.

Motion passed 6-0-0.

Senator K. Roers and **Representative Tveit** will carry SB 2145.

Additional written testimony: N/A

Madam Chair K. Roers closed the conference committee on SB 2145 at 9:32 a.m.

Justin Velez, Committee Clerk

CS 4/2 1/2

21.0439.04008
Title.07000

Prepared by the Legislative Council staff for
Conference Committee
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2145

That the House recede from its amendments as printed on page 1318 of the Senate Journal and page 1436 of the House Journal and that Engrossed Senate Bill No. 2145 be amended as follows:

Page 1, line 1, after "50-10.3" insert "and a new section to chapter 50-11"

Page 1, line 2, after "facilities" insert "and unaccompanied undocumented children"

Page 1, line 14, remove "assisted"

Page 1, line 15, remove "living facility,"

Page 1, line 24, after "establish" insert "basic"

Page 2, line 3, after the underscored period insert:

"a. If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall review and update the protocols every thirty days during the period of restriction, including an assessment of the need for continuation of the restriction.

b."

Page 2, line 11, after the underscored semicolon insert "and"

Page 2, line 13, remove "; and"

Page 2, remove lines 14 and 15

Page 2, line 16, remove "residents of the long-term care facility and essential caregivers"

Page 2, line 19, remove "of the long-term care facility if the requirements and cost are not so burdensome or"

Page 2, remove line 20

Page 2, line 21, remove "physical, spiritual, or emotional support to a resident of the long-term care facility"

Page 2, line 21, after the underscored period insert "The facility may require an essential caregiver to provide personal protective equipment for the essential caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility."

Page 2, after line 26, insert:

"**50-10.3-06. Liability.**

A long-term care facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for damages, including punitive damages, for any act or omission related to the

implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct.

SECTION 2. A new section to chapter 50-11 of the North Dakota Century Code is created and enacted as follows:

Unaccompanied undocumented children.

A person may not arrange for or promote care provided in a facility for unaccompanied undocumented children unless the facility has a license or approval issued by the department."

Renumber accordingly

Date: 4/27/2021
Roll Call Vote #: 1

2021 SENATE CONFERENCE COMMITTEE
ROLL CALL VOTES

BILL/RESOLUTION NO. SB 2145 as (re) engrossed

Senate Human Services Committee

Action Taken
- ☐ **SENATE accede to House Amendments**
- ☐ **SENATE accede to House Amendments and further amend**
- ☐ **HOUSE recede from House amendments**
- ☒ **HOUSE recede from House amendments and amend as follows**

☐ **Unable to agree**, recommends that the committee be discharged and a new committee be appointed

Motion Made by: Representative Tveit Seconded by: Senator O, Larsen

Senators				Yes	No		Representatives				Yes	No
Senator K. Roers				X			Representative Tveit				X	
Senator O. Larsen				X			Representative Skroch				X	
Senator Hogan				X			Representative Rohr				X	
Total Senate Vote				3	0		Total Rep. Vote				3	0

Vote Count Yes: 6 No: 0 Absent: 0

Senate Carrier Senator K. Roers House Carrier Representative Tveit

LC Number 21.0439 . 04008 of amendment

LC Number 21.0439 . 07000 of engrossment

Emergency clause added or deleted

Statement of purpose of amendment

Updating protocols every thirty days of long-term care facilities during a disaster or emergency that results in restricted visitor access. Long-term facility staff and contractor's liability. Unaccompanied undocumented children care at department approved and/or licensed facility.

Insert LC: 21.0439.04008
Senate Carrier: K. Roers
House Carrier: Tveit

REPORT OF CONFERENCE COMMITTEE

SB 2145, as engrossed: Your conference committee (Sens. K. Roers, O. Larsen, Hogan and Reps. Tveit, Skroch, Rohr) recommends that the **HOUSE RECEDE** from the House amendments as printed on SJ pages 1318-1319, adopt amendments as follows, and place SB 2145 on the Seventh order:

That the House recede from its amendments as printed on page 1318 of the Senate Journal and page 1436 of the House Journal and that Engrossed Senate Bill No. 2145 be amended as follows:

Page 1, line 1, after "50-10.3" insert "and a new section to chapter 50-11"

Page 1, line 2, after "facilities" insert "and unaccompanied undocumented children"

Page 1, line 14, remove "assisted"

Page 1, line 15, remove "living facility,"

Page 1, line 24, after "establish" insert "basic"

Page 2, line 3, after the underscored period insert:

"a. If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall review and update the protocols every thirty days during the period of restriction, including an assessment of the need for continuation of the restriction.

b."

Page 2, line 11, after the underscored semicolon insert "and"

Page 2, line 13, remove "; and"

Page 2, remove lines 14 and 15

Page 2, line 16, remove "residents of the long-term care facility and essential caregivers"

Page 2, line 19, remove "of the long-term care facility if the requirements and cost are not so burdensome or"

Page 2, remove line 20

Page 2, line 21, remove "physical, spiritual, or emotional support to a resident of the long-term care facility"

Page 2, line 21, after the underscored period insert "The facility may require an essential caregiver to provide personal protective equipment for the essential caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility."

Page 2, after line 26, insert:

"**50-10.3-06. Liability.**

A long-term care facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for

damages, including punitive damages, for any act or omission related to the implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct.

SECTION 2. A new section to chapter 50-11 of the North Dakota Century Code is created and enacted as follows:

Unaccompanied undocumented children.

A person may not arrange for or promote care provided in a facility for unaccompanied undocumented children unless the facility has a license or approval issued by the department."

Renumber accordingly

Engrossed SB 2145 was placed on the Seventh order of business on the calendar.

21.0439.04008
Title.

Prepared by the Legislative Council staff for
Conference Committee
April 26, 2021

PROPOSED AMENDMENTS TO ENGROSSED SENATE BILL NO. 2145

That the House recede from its amendments as printed on page 1318 of the Senate Journal and page 1436 of the House Journal and that Engrossed Senate Bill No. 2145 be amended as follows:

Page 1, line 1, after "50-10.3" insert "and a new section to chapter 50-11"

Page 1, line 2, after "facilities" insert "and unaccompanied undocumented children"

Page 1, line 14, remove "assisted"

Page 1, line 15, remove "living facility,"

Page 1, line 24, after "establish" insert "basic"

Page 2, after the underscored period insert:

"a. If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall review and update the protocols every thirty days during the period of restriction, including an assessment of the need for continuation of the restriction.

b."

Page 2, line 11, after the underscored semicolon insert "and"

Page 2, line 13, remove "; and"

Page 2, remove lines 14 and 15

Page 2, line 16, remove "residents of the long-term care facility and essential caregivers"

Page 2, line 19, remove "of the long-term care facility if the requirements and cost are not so burdensome or"

Page 2, remove line 20

Page 2, line 21, remove "physical, spiritual, or emotional support to a resident of the long-term care facility"

Page 2, line 21, after the underscored period insert "The facility may require an essential caregiver to provide personal protective equipment for the essential caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility."

Page 2, after line 26, insert:

"**50-10.3-06. Liability.**

A long-term care facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for damages, including punitive damages, for any act or omission related to the

implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct.

SECTION 2. A new section to chapter 50-11 of the North Dakota Century Code is created and enacted as follows:

Unaccompanied undocumented children.

A person may not arrange for or promote care provided in a facility for unaccompanied undocumented children unless the facility has a license or approval issued by the department."

Renumber accordingly

21.0439.04008

Sixty-seventh
Legislative Assembly
of North Dakota

FIRST ENGROSSMENT

ENGROSSED SENATE BILL NO. 2145

Introduced by

Senators K. Roers, Mathern, Patten

Representatives Keiser, Rohr, Westlind

A BILL for an Act to create and enact chapter 50-10.3 and a new section to chapter 50-11 of the North Dakota Century Code, relating to access to long-term care facilities and unaccompanied undocumented children; and to declare an emergency.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 50-10.3 of the North Dakota Century Code is created and enacted as follows:

50-10.3-01. Definitions.

As used in this chapter, unless the context clearly indicates otherwise:

1. "Declaration of disaster or emergency" means a disaster or emergency declared by the governor under chapter 37-17.1.
2. "Department" means the department of human services.
3. "Essential caregiver" means an individual identified by a resident of a long-term care facility or by the resident's designated decisionmaker to provide in-person physical, spiritual, or emotional support to the resident.
4. "Long-term care facility" means a skilled nursing facility, basic care facility, ~~assisted living facility,~~ or swing-bed hospital approved to furnish long-term services.

50-10.3-02. Scope.

This chapter does not supersede federal authority regarding long-term care facilities or prevent the department or state department of health from taking necessary actions to render the state eligible for federal funds or reimbursement services provided in long-term care facilities.

50-10.3-03. Access to long-term care facilities for essential caregivers.

1. The department, working jointly with the state department of health, the state long-term care ombudsman, residents and tenants, families of residents and tenants, and

long-term care facility representatives, shall establish basic protocols to allow a resident of a long-term care facility or the resident's designated decisionmaker designate one or more individuals as the resident's essential caregivers, including during a declaration of disaster or emergency.

a. If a declaration of disaster or emergency results in restricted access to a long-term care facility, the department shall review and update the protocols every thirty days during the period of restriction, including an assessment of the need for continuation of the restriction.

b. An essential caregiver shall meet the necessary qualifications to enter the long-term care facility to provide in-person physical, spiritual, or emotional support to a resident of a long-term care facility in accordance with the protocols established under this section.

2. The protocols must include:

a. Safety measures for an essential caregiver which may include restrictions on travel, enhanced testing for communicable diseases, and the necessary safety equipment required to protect the health and safety of the residents of the long-term care facility; and

b. Procedures to replace an essential caregiver due to necessary circumstances, including illness or death of the essential caregiver~~; and~~

~~c. A duration, not to exceed thirty days, during which a long-term care facility may enter a lockdown phase for the purpose of establishing safety measures for residents of the long-term care facility and essential caregivers~~.

50-10.3-04. Additional safety requirements for residents of long-term care facilities.

A long-term care facility may establish additional safety requirements to protect the residents~~ of the long-term care facility if the requirements and cost are not so burdensome or onerous as to substantially prevent an essential caregiver from being able to provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility~~. The facility may require an essential caregiver to provide personal protective equipment for the essential caregiver and undergo any related training or assume the cost of the personal protective equipment and any related training provided by the facility to allow the essential caregiver to

provide in-person physical, spiritual, or emotional support to a resident of the long-term care facility.

50-10.3-05. Suspension of access for essential caregivers.

If a long-term care facility suspends access to the long-term care facility for an essential caregiver who violates the protocols established under section 50-10.3-03, the long-term care facility shall allow the resident, or the resident's designated decisionmaker, to immediately designate a replacement essential caregiver.

50-10.3-06. Liability.

A long-term care facility, facility employee, or facility contractor that, in good faith, implements or complies with this chapter may not be held civilly liable for damages, including punitive damages, for any act or omission related to the implementation of this chapter. This section does not apply to any act or omission that constitutes gross negligence or willful or wanton misconduct.

SECTION 2. A new section to chapter 50-11 of the North Dakota Century Code is created and enacted as follows:

Unaccompanied undocumented children.

A person may not arrange for or promote care provided in a facility for unaccompanied undocumented children unless the facility has a license or approval issued by the department.

SECTION 3. EMERGENCY. This Act is declared to be an emergency measure.