STAY SAFE MN

Recommendations for Long-term Care Visitation and Activities: How and When to Safely Transition to the Next Level Throughout the COVID-19 Pandemic

This document was posted on Aug. 10, 2020, and is effective Aug. 29, 2020

Contents

This document is a guide for the strategic and careful re-introduction of visitation and activities at nursing facilities and housing with services with an arranged home care provider, also known as assisted living-type facilities, which will be referred to as ALF's for the remainder of this document.

Rationale

Balancing COVID-19 safety and visitation restrictions with the well-being of residents in long-term care and other residential settings is an urgent priority for Minnesota. Social isolation as a result of COVID-19 visitor restrictions is a significant concern and an issue that requires close cooperation between facilities, visitors, and local and state public health to address it safely and successfully.

The Minnesota Department of Health (MDH) has outlined levels for visitation and activities (see Appendix B) to guide long-term care (LTC) facilities in Minnesota in adjusting restrictions while maintaining high standards for COVID-19 safety for residents, staff, and visitors. This document combines current guidance from the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), and MDH. This document should be reviewed and implemented in conjunction with all other federal and state guidance documents from the CDC, CMS, and MDH.

Given the critical importance of limiting COVID-19 exposure in long-term care facilities, decisions about modifying visitor restrictions should be made with careful review of a number of facility-level, community, and state factors (see Appendix A). Because the pandemic affects facilities and communities in different ways, facilities should regularly monitor factors that increase risk of COVID-19. These factors include staff and visitor entry into the facility, resident movement within the facility, and resident excursions outside of the facility.

Key considerations

1. Relaxation of restrictions will increase the risk of COVID-19 infection spread.

2. Some factors will increase the risk of a COVID-19 outbreak. See Appendix A for further guidance.

3. Testing of symptomatic and high-risk residents and staff after relaxation of restrictions is as important as initial testing to continue to manage the risk. Long-term Care Testing: COVID-19 (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html)

4. Experience from long-term care facilities with COVID-19 cases in Minnesota and other states suggests that when symptomatic residents with confirmed COVID-19 are identified, asymptomatic residents often test positive as well. Asymptomatic transmission can play a role in transmission among both residents and staff.

5. Long-term care plans must include a written plan that addresses ongoing testing for residents and staff. Long-term Care Testing: COVID-19 (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html)

6. Facilities CANNOT move on to the next level if they have any facility-onset COVID-19 cases among residents or COVID-19 positive staff that worked while infectious in the last 28 days.

7. COVID-19 is expected to circulate for some time, and it may be appropriate to conduct facility-wide testing in response to additional cases detected throughout the pandemic, consistent with existing MDH guidance for long-term care testing.
    Long-term Care Testing: COVID-19 (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html).

MDH long-term care visitation and activities levels

Level 1 – See Appendix B. These visitation and activity recommendations should be used when there are active cases or there has been an exposure from a case in the past 28 days.

Level 2 – See Appendix B. These visitation and activity recommendations can be carefully implemented when there have been NO exposures from a case in the past 28 days and other requirements described in this guidance are met.

While the measures outlined in this plan are intended to help guide facilities moving into MDH LTC visitation and activities Level 2, facilities must return to MDH LTC visitation and activities Level 1 when new cases are identified. Facilities may also consider moving back to MDH LTC visitation and activities Level 1 based on their assessment of relevant risk factors in their community or facility.

When to transition to MDH LTC visitation and activities Level 2

Facilities that CANNOT transition to Level 2: facilities with COVID-19 exposure of staff or resident(s) within the past 28 days.

Facilities that MAY consider transitioning to Level 2: facilities with no exposure due to a COVID-19 positive resident, staff, or visiting health care provider within the past 28 days.

Additional considerations:

- If a resident tests positive for COVID-19, or if a staff member tests positive for COVID-19 and worked in the facility while infectious, the facility must move back to MDH LTC visitation and activities Level 1 immediately.
- Even if a facility meets the criteria to move to MDH LTC visitation and activities Level 2, there may be circumstances - for example, a high level of community transmission - that would support the facility choosing to stay in MDH LTC visitation and activities Level 1 or to move back to MDH LTC visitation and activities Level 1.
- If the facility learns that residents and/or staff were exposed to a person who visited while infectious with COVID-19, the facility must report the exposure to MDH and take appropriate action with exposed residents and staff to prevent transmission to other residents and staff. See Appendix C for further guidance.

Special considerations for facilities accepting known COVID-19 positive residents. If a facility is admitting residents with a known COVID-19 positive status, or the resident becomes COVID-19 positive within 14 days after admittance, and the facility is practicing effective transmission-based precautions to prevent transmission of COVID-19 to other residents, this alone does not prevent a facility from proceeding to, or remaining in MDH LTC visitation and activities Level 2. However, to proceed to or to remain in MDH LTC visitation and activities Level 2 under such circumstances, the facility must ensure COVID-19 positive residents are separated from other residents by, for example, having a designated COVID-19 wing and designated staff. If a resident contracts COVID-19 within the facility without a prior hospitalization within the last 14 days, the facility must go back to MDH LTC visitation and activities Level 1.

Testing for COVID-19 when transitioning to MDH LTC visitation and activities Level 2

Nursing facilities:

Data collected by MDH from March 15, 2020, to July 30, 2020, indicates that Minnesota long-term care facilities have been significantly impacted by COVID-19. To date, roughly half (53%) of nursing facilities in Minnesota have experienced outbreaks, with a total of 2,641 resident cases and 816 resident deaths associated with COVID-19. The average number of cases per outbreak in nursing facilities is 22 cases per facility. The rate of COVID-19 infections in residents in nursing facilities in Minnesota is 107 cases per 1,000 people. The average number of cases per outbreak in ALF settings is six cases per facility. The rate of COVID-19 infections in residents in ALF settings is 26 cases per 1,000 people.

While both populations are at high risk for COVID-19 infection, the data indicates residents of nursing facilities were four times more likely to be infected than residents in ALF's. Because of the increased vulnerability of residents in nursing facilities and the potential for larger, sustained outbreaks, MDH has developed the following testing guidance for nursing facilities:

As a health standard of care, all nursing facilities must complete or have completed at least one round of facility-wide testing (i.e., testing of all* staff and residents at a point in time) on or after May 1, 2020, but no later than two months after moving to MDH LTC visitation and activities Level 2.

*While we encourage 100% participation, residents and staff may refuse testing.

- Facility-wide testing conducted prior to the release of this guidance but within the required time period (i.e., within two months of moving to Level 2) is acceptable.

- Facilities may move to MDH LTC visitation and activities Level 2 before completing facility-wide testing if they continue to screen and test any symptomatic staff and residents AND have a documented plan for completing facility-wide testing within two months of moving to MDH LTC visitation and activities Level 2. The facility must have a written testing plan in place based on contingencies informed by the CDC as well as protocols for ongoing testing.

It is acceptable for facilities to complete facility-wide testing up to two months after moving to Level 2 to accommodate the time needed for coordination and scheduling. It is important that facilities demonstrate the ability to plan for and carry out facility-wide testing and establish relationships with laboratories performing COVID-19 testing.

ALF facilities:

ALF residents are also at increased risk of COVID-19. From March 15, 2020, through July 30, 2020, one-fourth (25%) of ALF settings in Minnesota experienced outbreaks, with 1,316 resident cases and 403 deaths associated with COVID-19. Before an ALF setting moves to MDH LTC visitation and activities Level 2, **as a health standard of care**, ALFs are encouraged to use one of the following testing strategies, listed in order of preference:

- At least one round of facility-wide testing of staff and residents.

- Test all staff in the facility along with all residents who leave the facility regularly, such as for dialysis or other essential medical services, or residents who have been admitted from a hospital or other facility (whether or not the referring facility has known COVID-19 cases).

- Test all staff who work at more than one LTC facility as well as residents who leave the facility regularly for dialysis or other essential medical services, or residents who have been admitted from a hospital or other facility (whether or not the referring facility has known COVID-19 cases).

At a minimum, all facilities must continue to test all residents or staff with symptoms consistent with COVID-19 and follow MDH guidance for LTC testing.
Long-term Care Testing: COVID-19
(https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html)

Testing Grid for Transitioning to MDH LTC Visitation and Activities Level 2

	Facility-wide testing (on or after May 1, 2020, but no later than two months after moving to Level 2)	Written testing plan that addresses ongoing testing	Continued testing of symptomatic staff and residents
Nursing facilities	✔	✔	✔
Assisted living type facilities	Recommended	✔	✔

Other settings and considerations

Infection prevention and control

Testing is one component of a broad-based response strategy that includes triage and clinical consultation, infection prevention and control (IPC) measures, and resident and staff health screening.

Facilities should reassess infection prevention and control practices prior to transitioning to MDH LTC visitation and activities Level 2. The MDH COVID-19 Action Plan for Congregate Settings provides a sample IPC facility action plan for congregate settings.
COVID-19 Action Plan for Congregate Settings
(https://www.health.state.mn.us/diseases/coronavirus/hcp/icpaction.pdf)

Independent living settings

MDH is aware that many LTC settings also have independent living or separate resident apartments. Independent living tenants who receive no services are not required to be screened and tested, but they are required to follow the same restrictions for visitors, source control, activities, and dining.

Residents with dementia

The COVID-19 pandemic continues to create additional challenges for people living with dementia, their families, and caregivers. This can be especially challenging in LTC settings. Facilities need to remember and consider the following for these residents:

- Preventing illness: persons living with dementia may have an impaired ability to follow or remember instructions and may need reminders regarding:
  - Hand-washing and moisturizing; consider a supervised hand-washing schedule.
  - Covering nose and mouth during a sneeze or cough.
  - Refraining from placing things in the mouth.
  - Staying in a particular area.
  - Taking medications appropriately.
  - Adopting social distancing practices and refraining from sharing items.
  - Following any other procedures that would require memory and judgment.
- Provide person-centered care.
- Help families and friends stay connected.
  Coronavirus (COVID-19): Tips for Dementia Caregivers in Long-Term or Community-Based Settings (https://www.alz.org/professionals/professional-providers/coronavirus-covid-19-tips-for-dementia-caregivers)
- Assist with eating and drinking.
- Monitor walking/unsafe wandering.
- Observe and respond to dementia-related behaviors.

A resource for direct caregivers in LTC settings is the Alzheimer's Association COVID-19 emergency preparedness webinar, Caring for Persons Living With Dementia in a Long-term or Community-Based Care Setting (https://www.youtube.com/watch?v=zVhuZteWp1Q). In the event of a major disease outbreak like COVID-19, there may be temporary staff members and non-clinical staff involved in resident care and services, and regular staff may find themselves under additional stress that makes care delivery more difficult. Also, people living with dementia may become more confused or frustrated, or even display an increase in dementia-related behaviors during a crisis. To help staff caring for people living with dementia better manage social distancing and transitions of care during this pandemic, this webinar's objectives include giving the viewer an understanding of the most recent dementia care practice recommendations and emergency preparedness guidelines developed by the Alzheimer's Association for caring for people with dementia in long-term or community-based care settings.

The Office of Ombudsman for Long-term Care

While CMS banned non-essential visits to nursing homes early in the coronavirus crisis in an attempt to stop the spread of COVID-19, exceptions have always been in place for inquiries by long-term care ombudsman programs.

The Older Americans Act (OAA), Title VII, chapter 2, sections 711 and 712, authorizes the Long-term Care Ombudsman Program. The OAA and federal regulations require the ombudsman for long-term care to provide residents of LTC facilities with access to effective advocacy in order to ensure quality of care and quality of life. Regardless of the level, LTC facilities are required to allow in-person visits from the Office of the Ombudsman for Long-term Care (OOLTC) to assist residents in protecting their health and safety, welfare, and rights when requested by a resident or when requested by a resident representative when substitute decision-making authority is activated. The LTC facility must allow OOLTC representatives access to the parts of the facility representatives can normally access and that OOLTC requests to access for its investigation or purpose in the facility. Ombudsman staff will comply with MDH-recommended symptom screening, personal protective equipment and masking requirements during any in-person visits.

Under CMS guidance and state law, LTC facilities are required to provide the state ombudsman immediate access to licensed long-term care facilities. The Ombudsman program has authority to access resident records, under 45 CFR, Section 1324.11(e)(2)(iv, v, vi), and to access the name and contact information of the resident and the resident representative (if any) where needed to perform the ombudsman's functions and duties, under 45 CFR, Section 1324.11(e)(2)(iii)), and Minnesota Statutes, section 256.9742, subdivision 4. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule, 45 CFR, part 160; and 45 CFR, part 164, subparts A and E, does not prevent a covered entity from releasing resident private health information or other resident identifying information to the ombudsman program, including but not limited to resident medical records, social or other records, a list of resident names and room numbers, or information collected in the course of a state or federal survey inspection process, 45 CFR, Section 1324.11(e)(2)(vii).

Facilities must comply with all state and federal discharge Ombudsman notification requirements.

Nursing facility staff testing payment information

The Minnesota Department of Human Services (DHS) will partner with MDH to support nursing facilities with implementing MDH guidance for conducting testing, and provide a mechanism for payment of staff tests. In order to qualify for DHS financial reimbursement of staff testing, nursing facilities must implement testing consistent with MDH guidance and other DHS reimbursement policies. A DHS memo called Employee COVID Testing addresses reimbursement for staff testing costs. It may be found on the: Nursing Facility Provider Portal (https://nfportal.dhs.state.mn.us) webpage.

Facilities will need to submit resident testing costs to Medicare/insurance carriers.

Support

Long-term Care Testing: COVID-19 (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html)
MDH guidance on LTC testing.

COVID-19 Toolkit: Information For Long-term Care Facilities
(https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
MDH LTC toolkit with guidance on personal protective equipment and emergency staffing.

Defining Crisis Staffing Shortage in Congregate Care Facilities
(https://www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html)
MDH guidance on defining crisis staffing shortage in congregate care facilities during COVID-19.

Tips for Dementia Caregivers in Long-Term or Community-Based Settings
(https://www.alz.org/professionals/professional-providers/coronavirus-covid-19-tips-for-dementia-
caregivers)
Alzheimer's Association information for professional caregivers in long-term or community-based
settings.

Resources used to develop this guidance:

CMS Memo: Nursing Home Reopening Recommendations for State and Local Officials
(https://www.cms.gov/files/document/qso-20-30-nh.pdf-0)

Preparing for COVID-19 in Nursing Homes (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-
care.html)

Minnesota-North Dakota Alzheimer's Association (https://www.alz.org/mnnd)

COVID-19 Toolkit Information For Long-term Care Facilities
(https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)

Long-term Care Testing: COVID-19
(https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html)

Appendix A: Factors that LTC facilities should consider

The risk of a COVID-19 outbreak may be higher for some facilities based on the factors described below.
Facilities should routinely assess the risk for COVID-19 transmission to ensure proper policies,
procedures, and infection control practices are in place. MDH has used Centers for Medicare and
Medicaid Services (CMS) Nursing Home Re-Opening Recommendations
(https://www.cms.gov/files/document/qso-20-30-nh.pdf-0) to develop the following Minnesota-specific
factors that LTC facilities should consider when making a decision to move to MDH LTC visitation and
activities Level 2, or back to MDH LTC visitation and activities Level 1:

- **Case activity level in community:** be informed of the level of community transmission in your
  county. Facilities should monitor the 14-day case rate in their county. Facilities can determine the
  14-day case rate on the MDH webpage Weekly Case Rate by County of Residence
  (https://www.health.state.mn.us/diseases/coronavirus/stats/index.html#wcrmap1). Select the

Weekly Case Rate by the County of Residence link and download the Weekly Case Rate by County of Residence (CSV) file. Add the numbers of the two most recent weeks in your county to determine the 14-day case rate. If that number is greater than 10, you may consider the county at elevated risk of disease transmission. If a facility is close to a county border, also assess the adjacent county's case incidence. CMS has released information regarding positivity rates: Trump Administration Announces New Resources to Protect Nursing Home Residents Against COVID-19 (https://www.cms.gov/newsroom/press-releases/trump-administration-announces-new-resources-protect-nursing-home-residents-against-covid-19).

- **Case status in the LTC facility:** facilities should have a written process in place to track the status of possible and known COVID-19 cases (resident or staff) in the facility. Facilities that have previously had an outbreak of COVID-19 may be at higher risk.

- **Adequate staffing:** ensure the facility is not in a staffing crisis, which could include using alternate staffing models; closing certain areas and reallocating staff; canceling events or activities to balance workloads, etc. Facilities that share staff with other LTC facilities are at higher risk of a COVID-19 outbreak. Before allowing modifications of visitation and activities, a facility should be in conventional or contingency capacity for staffing, and not in a crisis.
  Defining Crisis Staffing Shortage in Congregate Care Facilities: COVID-19 (https://www.health.state.mn.us/diseases/coronavirus/hcp/crisis.html).

- **Access to adequate testing:** the facility must have a written testing plan in place based on contingencies informed by the CDC as well as protocols for ongoing testing. Facilities should consider ongoing changes in risk and refer to Long-term Care Testing: COVID-19 (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctesting.html) when developing a testing plan, and should include options for managing specimen collection, test processing, and financing. The plan should **consider** the following components (note, these may not all be possible for each facility):

  - At a minimum, facilities must have the capacity to test residents and staff who develop symptoms of illness consistent with COVID-19 and have a plan in place for management of positive cases.

  - Is there capacity for all LTC residents to receive facility-wide baseline COVID-19 testing (i.e., point prevalence survey)?

  - Is there capacity for all residents to be tested upon identification of an individual with symptoms consistent with COVID-19, or if a staff member tests positive for COVID-19? If not, the facility must have a plan to isolate residents and minimize risk of further transmission.

  - Is there capacity for ongoing weekly re-testing of all negative LTC residents until no new residents test positive (e.g., serial point prevalence surveys)?

  - Is there capacity for all LTC staff (including volunteers and vendors who are in the facility on a weekly basis) to receive a single baseline COVID-19 test? If positive cases are found in staff, is there capacity to continue retesting all staff every week until no more new positive test results for COVID-19 are found?

  - Is there capacity for active screening for all staff (each shift), each resident (at least daily), and all persons entering the facility, such as vendors, volunteers, and visitors?

  - Does the facility have, or have a plan to obtain, staff to manage specimen collection?

▪ Is there an arrangement with laboratories to process tests? The test used should be able to detect SARS-CoV-2 virus (e.g., polymerase chain reaction (PCR) with greater than 95% sensitivity and greater than 90% specificity, with results obtained rapidly (e.g., within 48 hours). Antibody test results should not be used to diagnose someone with a new SARS-CoV-2 infection.

▪ Is there a plan to cover costs of testing facility residents and staff? The facility should consider a range of options to cover these costs, if direct state support is not available, including ensuring resident or staff insurance coverage is used to the greatest extent possible; using other state or federal COVID-19 funding streams; or making use of other facility resources.

▪ Nursing home facilities should be prepared to receive and implement testing strategies required by CMS to test all nursing home staff each week if the state has a 5% positivity rate. The U.S. Department of Health and Human Services is deploying testing devices over the next few months to help support this mandate.

▪ Is there a procedure for addressing residents or staff who decline or are unable to be tested? For example, isolating a symptomatic resident who refuses testing in a facility with positive COVID-19 cases.

▪ **Universal source control:** residents should wear cloth face coverings as tolerated. Visitors must wear a cloth face covering or facemask at all times. If a visitor is unable or unwilling to maintain these precautions, providers may restrict their ability to enter the facility. All visitors should maintain social distancing of at least 6 feet when possible and perform hand-washing or sanitizing upon entry to the facility.
Contingency Standards of Care for COVID-19 (https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf)

▪ **Access to adequate personal protective equipment (PPE) for staff:** contingency capacity strategy is allowable, such as CDC's guidance, Strategies to Optimize the Supply of PPE and Equipment. Before allowing modification of visitation and activity policies, a facility should be in conventional or contingency capacity for PPE, and not in crisis. All staff must wear all appropriate PPE when indicated. Facilities should ensure adequate PPE supplies that do not rely solely on accessing publicly available reserves from state inventories. See guidance:

Contingency Standards of Care for COVID-19 (https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf)

CDC: Optimizing Supply of PPE and Other Equipment during Shortages (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html)

CDC: Personal Protective Equipment (PPE) Burn Rate Calculator (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html)

▪ **Local hospital capacity:** take into account the ability of the local hospital to accept transfers from LTC facilities on general and intensive care units. Facilities should work with local county partners and regional health care coalitions to assist with determining this ability.

▪ **Staff and visitor screening:** all staff and visitors need to be actively screened for symptoms and exposure to a person with confirmed COVID-19 prior to entering the building.

Appendix B: Description of MDH LTC visitation and activities levels

Resources referred to in the tables below:

Frequently Asked Questions (FAQs) on Nursing Home Visitation (https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf)

Essential Caregiver Guidance for Long-term Care Facilities (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltccaregiver.html)

Outdoor Visitation Guidance for Long-term Care Facilities (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcoutdoor.pdf)

Guidance for Window Visits at Long-Term Care Facilities (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltcwindows.pdf)

Preparing for COVID-19 in Nursing Homes (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html)

Contingency Standards of Care for COVID-19 (https://www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf)

COVID-19 Testing Recommendations for Long-term Care Facilities (https://www.health.state.mn.us/diseases/coronavirus/hcp/ltctestrec.pdf)

MDH LTC Visitation and activities Level 1

Category:	Guidance:
General visitor restrictions	• Restrict visitation of all visitor and non-essential health care personnel. • Compassionate care visits are allowed. • Essential Caregivers are allowed. • Outdoor Visitation is allowed. • Window Visits are allowed. • Beauty Shop is unable to be open if there has been an exposure within the last 14 days.
Dining and activities	• No residents with signs or symptoms of a respiratory infection, or with confirmed diagnosis of COVID-19 (regardless of symptoms) may eat in dining rooms. For dining, LTC facilities should apply social distancing methods, such as ensuring residents sit in limited numbers at least 6 feet apart.

Category:	Guidance:
	• Group activities may be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a cloth face covering or facemask. Facilities should use creative methods to provide socialization, such as virtual activities. Facilities should also continue individualized activities. • Continue to follow guidance in LTC Toolkit.
Non-medical trips outside of LTC facility	• Cancel, or limit if possible. If a trips are necessary, residents should wear an alternative (cloth) mask when they leave their rooms and when traveling via resident transport services. • Cancel all trips outside of the LTC facility. • Continue to follow guidance in LTC Toolkit.
Screening of persons authorized to enter the LTC facility	• Actively screen all staff/authorized visitors for fever and symptoms of illness before starting each shift, per guidance in LTC Toolkit. • Actively screen all staff/visitors for exposure to persons with confirmed COVID-19. • All visitors should sign in and out and leave contact information. • In addition to facility staff, conduct health screening for other essential health care personnel, including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyor, chaplain/spiritual advisor, mortician, etc., per guidance in LTC Toolkit. • Staff should not work while sick. • All staff should wear a face mask at all times. • All visitors must wear a mask or other face covering at all times. • All staff and persons authorized to enter should conduct hand hygiene upon entering and exiting the facility. • All staff and persons authorized to enter the LTC facility should practice social distancing when possible (6 feet or greater from others).
Screening of residents in LTC facility	• Actively screen all residents for fever and symptoms of illness at least daily. Twice daily is best practice. Use pulse oximetry if possible (and disinfect between residents). Screen each shift for ill residents. Symptoms of COVID-19

Category:	Guidance:
	- may be subtle, such as new confusion or excessive fatigue. - Continue to follow guidance in LTC Toolkit and Preparing for COVID-19 in Nursing Homes.
Personal protective equipment (PPE)	- Staff should wear the appropriate PPE based on COVID-19 status, CDC guidelines, and the procedures being performed. - Follow guidance in LTC Toolkit and Contingency Standards of Care for COVID-19.
Universal source control	- When a resident leaves their room, they should wear an alternative mask, if tolerated, and should maintain social distancing of at least 6 feet from other residents at all times. - Compassionate care visitors and essential caregivers should wear the same PPE as staff. - All visitors should wear a mask (e.g. a cloth mask) at all times and practice strict hand hygiene. - Continue to follow LTC Toolkit guidance.
End-of-shift staff assessments	- LTC facilities should conduct end of shift assessments to identify PPE breaches and potential concerning exposures of staff to residents with COVID-19. - Reference LTC Toolkit, Appendix G, for PPE breach log.
Cohort units	- Plans to cohort, or group residents should be established in advance if possible, before testing results are received, and should be centered on implementation of robust infection control practices. - Continue to follow LTC Toolkit guidance.
Staff testing	- Facilities should make a plan for testing with a local health care organization or MDH if they have not done so already. - Facilities should follow MDH's COVID-19 Testing Recommendations for Long-term Care Facilities.
Resident testing	- Facilities should make a plan for testing with a local health care organization or MDH. - Facilities should follow MDH's COVID-19 Testing recommendations for Long-term Care Facilities.

MDH LTC Visitation and activities Level 2

Category:	Guidance:
General visitor restrictions	• Compassionate care visits are allowed. • Essential Caregivers are allowed. • Outdoor Visitation is allowed. • Window Visits are allowed. • Beauty Shop services are allowed. • Modifications to visitor restrictions are allowed (see below).
Dining and activities	• For dining, LTC facilities should apply social distancing methods, such as ensuring residents sit in limited numbers at least 6 feet apart. • Group activities may be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, suspected, or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a cloth face covering or facemask. Facilities should continue to use creative methods to provide socialization, such as virtual activities. Facilities should also continue individualized activities. • Continue to follow LTC Toolkit.
Non-medical trips outside of LTC facility	• Limit if possible. Residents should wear an alternative (cloth) mask when they leave their room and when traveling via resident transport services. • Allow limited number of trips outside of the LTC facility. • Continue to follow guidance in LTC Toolkit.
Screening of persons authorized to enter the LTC facility	• Actively screen all staff/visitors for fever and symptoms of illness before starting each shift, per guidance in LTC Toolkit. • Actively screen all staff/visitors for exposure to persons with confirmed COVID-19. • All visitors should sign in and out and leave contact information. • In addition to facility staff, conduct health screening for other essential health care personnel, including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyor, chaplain/spiritual advisor, mortician, etc. per guidance in LTC Toolkit. • Staff should not work while sick. • All staff should wear a face mask at all times. • All visitors must wear a mask or other face covering at all times.

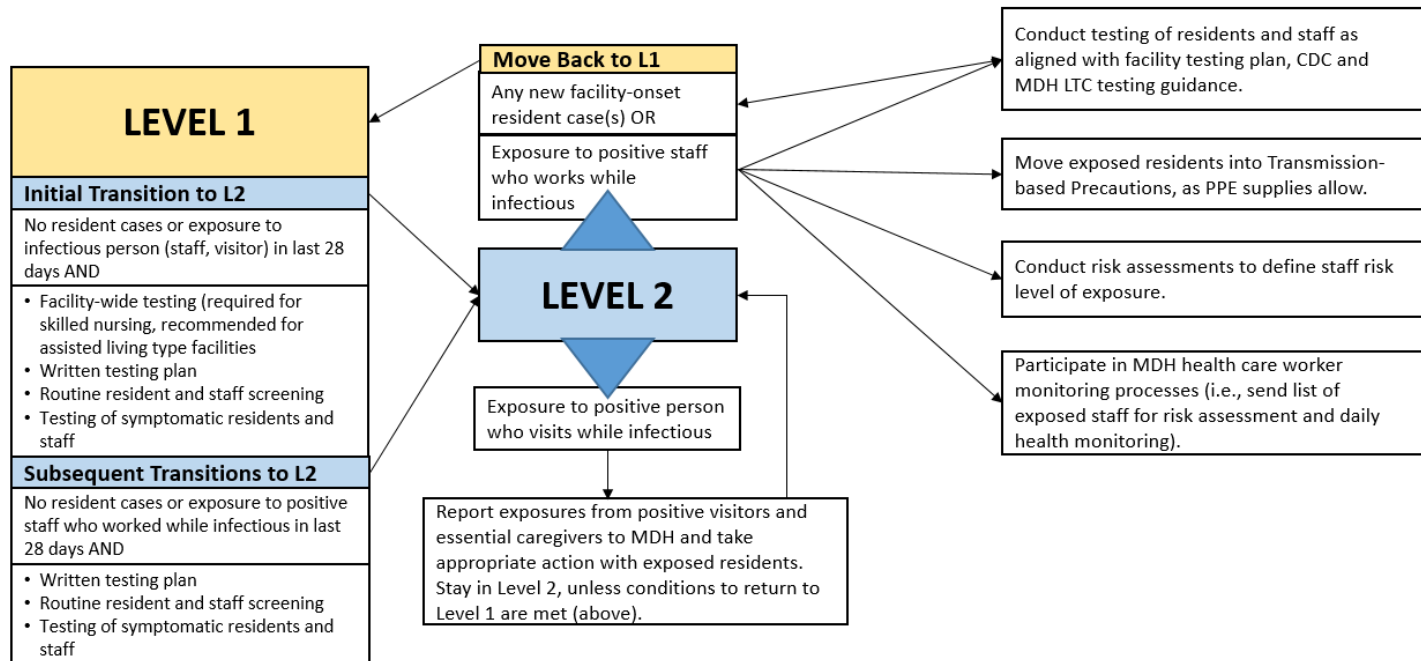| Category:	Guidance:
	- All staff and persons authorized to enter should conduct hand hygiene upon entering and exiting the facility. - All staff and persons authorized to enter the LTC facility should practice social distancing when possible (6 feet or greater from others).
Modifications of visitor restrictions/non-essential healthcare personnel/contractors	- Must have an active screening system to screen all visitors entering the facility for signs and symptoms of COVID-19, at a screening location prior to the visitor walking through the facility. - All visitors should sign in and out and leave contact information. - Must have alcohol-based hand rub available for the persons visiting residents and provide signage or verbal reminders of correct use. - Must have a system to ensure residents wear a mask, as tolerated, and visitors wear a mask or other face covering at all times. - Facilities must establish additional guidelines as needed to ensure the safety of visitations and their facility operations. These guidelines must be reasonable and must take into account the individual needs of the residents. - The visitor must proceed directly to the resident room or designated visiting area. - Facilities should consider establishing a visitation schedule for non-essential visitors that takes into account the size of the facility, the number of residents, and resident activities to better monitor the number of visitors at any given time. - Facilities may elect to limit the number of visitors per resident at a given time, but should take into consideration the resident preference, or if the resident lacks capacity to make the decision, the resident's representative preference. Visitors should follow infection prevention and control practices consistent with CDC, CMS, and MDH recommendations during the length of the visit. - A wave is the safest way to greet the resident. Due to the risk of exposure, holding hands and kissing is not allowed during visits. A quick hug from behind, to the side, or with faces turned away while wearing face coverings is lower-risk.

Category:	Guidance:
	- Visitors under age 12 must be supervised by adults who accompany them and must also comply with social distancing and face covering requirements. - If pets are allowed in the facility, they must be under control of the visitor bringing them in. Petting or holding the pet is permitted. - All visitors must maintain 6 feet social distance when possible. - Visitors must limit movement in the facility. The visitor may take the resident outside for a walk, but must maintain 6 feet of social distance after transporting the resident outside. Pushing a wheelchair is an acceptable activity while wearing PPE. - Visitors should make an effort to minimize restroom use in the facility. - Visitors are permitted for a final controlled walkthrough tour of the facility for prospective residents.
Screening of residents in LTC facility	- Actively screen all residents for fever and symptoms of illness at least daily. Twice daily is best practice. Use pulse oximetry if possible (and disinfect between residents). Screen each shift for ill residents. Symptoms of COVID-19 may be subtle, such as new confusion or excessive fatigue. - Continue to follow guidance in LTC Toolkit and Preparing for COVID-19 in Nursing Homes.
Personal protective equipment (PPE)	- Staff should wear the appropriate PPE based on COVID-19 status, CDC guidelines, and the procedures being performed. - Guidance in LTC Toolkit should be followed and Contingency Standards of Care for COVID-19 should be followed.
Universal source control	- When a resident leaves their room, they should wear an alternative mask if tolerated and should maintain social distancing of at least 6 feet from other residents at all times. - Compassionate care visitors and essential caregivers should wear the same PPE as staff. - All visitors should wear a mask (e.g. a cloth mask) at all times and practice strict hand hygiene. - Continue to follow LTC Toolkit guidance.
End of shift staff assessments	LTC facilities should conduct end-of-shift assessments to identify PPE breaches and potential concerning exposures of staff to residents with COVID-19.

Category:	Guidance:
	• Reference LTC Toolkit, Appendix G, for PPE breach log.
Cohort units	• Plans to cohort or group residents should be established in advance if possible, before testing results are received, and should be centered on implementation of robust infection control practices. • Continue to follow LTC Toolkit guidance.
Staff testing	• Facilities should be implementing and maintaining an ongoing testing plan. • Facilities should follow MDH's COVID-19 Testing Recommendations for Long-term Care Facilities.
Resident testing	• Facilities should follow MDH's COVID-19 Testing recommendations for Long-term Care Facilities.

Appendix C: Use of COVID-19 testing to guide transitions between MDH LTC visitation and activities levels

The Appendix C image above illustrates information contained in this document that facilities can use to help guide them when determining transitions between MDH LTC visitation and activities levels. The

diagram provides guidance for MDH LTC visitation and activities Level 2 transition, which includes information about when the facility can be in Level 2, as outlined throughout this document.

The diagram also depicts when the facility should move from Level 2 back to Level 1, such as a new facility onset case or exposure to positive staff while working. If the facility is exposed to a person who visits while infectious, the facility should report the exposure and take appropriate action with exposed residents. The facility can stay in Level 2 unless conditions warrant a return to Level 1.

The diagram also illustrates steps the facility should take when a staff member works while infectious: conduct testing in coordination with the facility's testing plan, the CDC, and MDH LTC testing guidance; and ensure the facility follows transmission-based precautions, conducts risk assessments, and participates in the MDH health care worker monitoring process.

Appendix D: LTC facility door signs

Facilities may modify the following signs to meet their own communication needs.

The Minnesota Department of Health (MDH) has issued recommendations for long-term care visitation and activites during the COVID-19 pandemic.

[*Facility name*] is in: **LEVEL 1**

LEVEL 1 visitation guidance

- Non-essential visitors are <u>not allowed</u> in the facility.
    - Exceptions will be made for essential caregivers, or for compassionate care visits.
- Outdoor visits are allowed (please call ***xxx-xxx-xxxx*** to arrange).
- Window visits are allowed (please call ***xxx-xxx-xxxx*** to arrange).

The most vulnerable populations live here. It is important that anyone entering this facility follow strict and current infection prevention and control practices, consistent with Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, and Minnesota Department of Health recommendations. The health and well-being of vulnerable adults and the staff who work in these facilities depends on you consistently following these practices.

The Minnesota Department of Health (MDH) has issued recommendations for long-term care visitation and activites during the COVID-19 pandemic.

[*Facility name*] is in: **LEVEL 2**

LEVEL 2 visitation guidance

- Visitors must wear a mask or other face covering at all times.

- Limit of [x] visitors per resident at a time. [this is up to the facility]

- Pets must be under the control of the visitor bringing them in. Petting or holding the pet is permitted. [remove if no pets allowed]

- Visitors under age 12 must be supervised by the adults who bring them. They must also follow social distancing and face covering requirements.

- All visitors must maintain 6 feet social distance when possible.

- Visitors must go directly to the resident room or designated visiting area.

- Visitors must limit movement in the facility. Outdoor walks are acceptable if keeping a 6 feet distance. Pushing a wheelchair is acceptable if wearing facemasks and other appropriate personal protective equipment.

- Visitors should try to use the facility restroom as little as possible.

- A wave is the safest way to greet a resident. Holding hands and kissing are not allowed during visits. A quick hug from behind, to the side, or with faces turned away while wearing face coverings is lower-risk.

- Compassionate care visits, essential caregiver visits, outdoor visits, window visits, and beauty services are also allowed.

The most vulnerable populations live here. It is important that anyone entering this facility follow strict and current infection prevention and control practices, consistent with Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, and Minnesota Department of Health recommendations. The health and well-being of vulnerable adults and the staff who work in these facilities depends on you consistently following these practices.

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08/10/2020