STAY SAFE MN

Minnesota Home Care Provider/Assisted Living Visitation and Activities Guidance Throughout the COVID-19 Pandemic

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

The Centers for Medicare and Medicaid Services (CMS) documents QSO 20-30 (www.cms.gov/files/document/qso-20-30-nh.pdf-0) and QSO 20-39 (www.cms.gov/files/document/qso-20-39-nh.pdf) for nursing homes was used as a resource to develop this guidance, in addition to documents from the Centers for Disease Control, the Minnesota Department of Health, and the Alzheimer's Association.

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Contents

Visitation guidance for nursing home facilities can be found in the Centers for Medicare and Medicaid Services (CMS) document, Nursing Home Visitation QSO-20-39 (www.cms.gov/files/document/qso-20-39-nh.pdf). The visitation guidance below pertains only to home care and assisted living providers.

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 safely and successfully.

This document combines current guidance from the Centers for Disease Control and Prevention (CDC) and the Minnesota Department of Health (MDH). This document should be reviewed and implemented in conjunction with all other federal and state guidance documents from the CDC and MDH.

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, and outdoors; and for circumstances beyond compassionate care situations. Given the critical importance of limiting COVID-19 exposure in assisted living facilities, decisions on modifications of visitor restrictions should be made with careful review of a number of facility-level, community, and state factors. See Appendix A. Facilities should also consider resident-specific factors, resident needs and desires, and person-centered care. 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 or observations about signs or symptoms), and denial of entry of those with signs or symptoms
- Hand hygiene (use of alcohol-based hand rub is preferred). See Clean Hands Count (www.cdc.gov/handhygiene/pdfs/Provider-Factsheet-508.pdf).
- Face covering or mask (covering mouth and nose).
- Social distancing at least 6 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).

These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance, Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities (www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html), for assisted living facilities, and should be adhered to at all times. Additionally, visitation should be person-centered, consider each resident's 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 dividers, curtains). See MDH Guidance for Temporary Tent Structures and Clear Dividers for Long-term Care Visitation (www.health.state.mn.us/diseases/coronavirus/hcp/ltcvisittent.pdf).

Assisted living facilities should allow 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 taking a person-centered approach and adhering to these core principles, visitation should occur safely, based on the guidance below.

Outdoor visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred and can also be conducted in a manner that reduces the risk of transmission. Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever practicable. Aside from weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual resident's health status (e.g., medical condition(s), COVID-19 status), or a facility's outbreak status, outdoor visitation should be facilitated routinely.

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. See MDH Guidance for Temporary Tent Structures and Clear Dividers for Long-term Care Visitation (www.health.state.mn.us/diseases/coronavirus/hcp/ltcvisittent.pdf). When conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring at the same time to support safe infection prevention actions (e.g., maintaining social distancing). We also recommend reasonable limits on the number of people visiting with any one resident at the same time.

If the outdoor visitation area can only be accessed by walking through the facility, visitors must limit movement in the facility. For example, visitors should not walk around different halls of the facility. Instead, direct them to proceed directly to the designated visitation area and to limit their interactions with others. See MDH Outdoor Visitation Guidance for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltcoutdoor.pdf) for more outdoor visitation information.

Indoor visitation

Facilities should accommodate and support indoor visitation, including visits for reasons beyond compassionate care situations, based on the following guidelines:

- There have been no new COVID-19 case(s) in staff or facility-onset COVID-19 resident cases in the last 14 days. See CDC's Duration of Isolation and Precautions for Adults with COVID-19 (www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html).
  - Residents admitted to the facility with known COVID-19 positive status, and residents who develop COVID-19 during the 14-day quarantine period for new admissions and readmissions, are not considered facility-onset cases as long as the residents have been in appropriate transmission-based precautions.
- Visitors should be able to adhere to the core principles COVID-19 infection prevention and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children.
- Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors.
- Facilities should limit 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. In shared apartment situations, the resident should be in a separate room from their roommate when visits occur.

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

Facilities should use the COVID-19 county positivity rate (the number of positive tests divided by the total number of tests performed), found on the MDH webpage, COVID-19 Weekly Report (www.health.state.mn.us/diseases/coronavirus/stats/index.html). Select the Weekly Test Rate by County of Residence link and download the Weekly Percent of Tests Positive by County of Residence (CSV) file. Add the numbers of the two most recent weeks in your county and divide by two to determine the 14-day county positivity rate. If the facility is part of a campus where the nursing home is using CMS data to calculate positivity rate, the facility may use CMS data for consistency across the campus.

- Low (<5%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond essential caregiver and compassionate care visits).
- Medium (5% – 10%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond essential caregiver and compassionate care visits).
- High (>10%) = Visitation should only occur for essential caregiver and compassionate care situations, according to the core principles of COVID-19 infection prevention and facility policies.

Facilities may also monitor the positivity rates of adjacent counties. See Appendix A. The county positivity rate does not need to be considered for outdoor visitation. See Appendix B for visitation guidance for low, medium, and high county positivity rates. See Appendix C for visitation guidance flowchart.

COVID-19 testing in assisted living facilities

Assisted living facility residents are at an increased risk of COVID-19. Facilities must (1) have a written testing plan based on recommendations from MDH and CDC, (2) maintain capacity to test residents and staff who develop symptoms of illness consistent with COVID-19, and (3) have a plan in place for management of positive cases. Facilities should make their testing plans available when requested by MDH or other interested persons.

Upon identification of a new COVID-19 infection in any staff or residents, as a health standard of care, all staff and residents should be tested, and all staff and residents that test negative should be retested every three days to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the last exposure date.

MDH recommends facilities strongly consider conducting ongoing testing to identify cases while COVID-19 is circulating in community. Ongoing testing could include:

- Testing of all staff once weekly or every other week.
- Testing staff who work at more than one long-term care facility.
- Testing of staff who have had close contact with a household member or social contact with confirmed COVID-19.
- Testing 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).

See more MDH information about COVID-19 Testing Recommendations for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltctestrec.pdf).

Visitor testing

Antigen tests are not validated for testing of asymptomatic individuals, particularly outside of a routine screening program. If facilities conduct testing of visitors and/or essential caregivers, MDH recommends using RT-PCR testing.

While not required, facilities may encourage visitors to get tested on their own prior to coming to the facility (e.g., within two to three days) with proof of negative test results and the test date. Return to visiting for people who test positive should be guided by CDC and MDH community recommendations for discontinuation of isolation, If You Are Sick: COVID-19 (www.health.state.mn.us/diseases/coronavirus/sick.html).

Facilities that learn of a COVID-19-positive visitor who was present while infectious should report to MDH by using the long-term care case report form, Submitting Clinical Information on Long-term Care COVID-19 Cases and Reporting Discrepant Laboratory Results (https://redcap-c19.web.health.state.mn.us/redcap/surveys/?s=H8MT9TTNCD). Indicate "visitor" or "essential caregiver" in the relevant field.

Essential caregivers

Recognizing the critical role family members and other close, outside caregivers have in the care and support of residents, and recognizing how they advocate for the resident, it is strongly recommended that assisted living facilities develop a process to designate essential caregivers, where appropriate. This is consistent with the MDH Essential Caregiver Guidance for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltccaregiver.html), issued on July 10, 2020.

An essential caregiver could be an individual who was previously actively engaged with the resident or is committed to providing companionship and/or assistance with activities of daily living. Assisted living facilities are not required to implement an essential caregiver program, but this guidance provides recommendations for those facilities that choose to do so. The goal of such a designation is to help ensure these high-risk residents continue to receive individualized, person-centered care. MDH has Essential Caregiver Guidance for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltccaregiver.html). In an effort to be consistent with CMS guidance, MDH will consider essential caregiver visits as a type of compassionate care visit.

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 until recently being admitted to assisted living, 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 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.

Lastly, at all times, 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 all appropriate infection prevention guidelines, and for a limited amount of time. 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

We believe the guidance above represents reasonable ways an assisted living facility can facilitate in-person visitation. Except for on-going use of virtual visits, facilities may still restrict visitation due to the COVID-19 positivity rate (see the Weekly Test Rate by County of Residence link on the webpage, COVID-19 Weekly Report (www.health.state.mn.us/diseases/coronavirus/stats/index.html); the facility's COVID-19 status; a resident's COVID-19 status; visitor symptoms; lack of adherence to proper infection control practices; or other relevant factors related to the COVID-19 public health emergency. See Appendix A. However, facilities may not restrict visitation without a reasonable clinical or safety cause, and doing so may constitute a potential violation of Minnesota Statutes, chapter 144A, section 144A.44 (2),(4),(13),(19) or (22) (www.revisor.mn.gov/statutes/cite/144A.44). For example, if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, an assisted living must facilitate in-person visitation consistent with the 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 Minnesota Statutes, chapter 144A, section 144A.44 (2),(4),(13),(19) or (22) (www.revisor.mn.gov/statutes/cite/144A.44), 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 for compassionate care situations that are virtual, through windows, or in-person, 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.

Independent living tenants in assisted living settings

MDH is aware that many long-term care settings also have independent living or separate resident apartments. Independent living tenants who receive no services are not required to be screened and tested for COVID-19, but they are required to follow the same restrictions for visitors, source control, activities, and dining.

Access to the long-term care Ombudsman

While CMS banned non-essential visits to facilities 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 711/712, authorizes the Long-Term Care Ombudsman Program. The OAA and federal regulations require the Ombudsman for Long-Term Care program to provide services to residents of long-term care facilities with access to effective advocacy in order to ensure the quality of care and quality of life they deserve and are entitled to by resident rights law. During all MDH long-term care levels of COVID-19 response, long-term care facilities are required to

allow in-person visits from the Office of the Ombudsman for Long-Term Care ("OOLTC") when they are deemed important by 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 due to resident inability to comprehend because of the complications of disease or advanced dementia. The long-term care facility must allow OOLTC representatives access to parts of the facility that the representatives could normally access and that OOLTC requests for its investigation or purpose in the facility. Under CMS guidance and State law, long-term care 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, 45 CFR, section 1324.11(e)(2) (iv, v, vi), and access to the name and contact information of the resident and the resident representative, if any, where needed to perform the functions and duties, 45 CFR, section 1324.11(e)(2)(iii), Minn. Statute, 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 preclude release by covered entities of 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).

For all non-cohorting, non-COVID-19 discharges, facilities must comply with all state and federal discharge Ombudsman notification requirements, as applicable. Ombudsman staff will comply with MDH-recommended symptom screening, PPE and masking requirements during any in-person visit. Visits between representatives of the Ombudsman program and residents should not be supervised by facility staff, unless requested by the Ombudsman representative.

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 long-term care 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 keep families and friends connected. See Alzheimer's Association Coronavirus (COVID-19): Tips for Dementia Caregivers in Long-Term or Community-Based Settings (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.

An Alzheimer's Association webinar, Caring for persons living with dementia in a long-term or community-based care settings (www.youtube.com/watch?v=zVhuZteWp1Q), has objectives for direct caregivers in long-term care settings. 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, 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.

Disability rights laws and protection & advocacy (P&A) programs

Resident rights, 42 CFR, section 483.10(f)(4)(i)(E) and (F), requires the assisted living facility to allow immediate access to a resident by any representative of the state's designated protection and advocacy system, as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (PAIMI Act). Protection & advocacy (P&A) programs authorized under the DD and PAIMI Acts protect the rights of individuals with developmental, mental health, and other disabilities and are authorized to "investigate incidents of abuse and neglect … if the incidents are reported or if there is probable cause to believe the incidents occurred," 42 U.S. Code, section 15043(a)(2)(B) (DD Act), and to "have access at reasonable times to any individual with a developmental disability in a location in which services, supports, and other assistance are provided to such an individual." See 42 U.S. Code, section 15043(a)(2)(H) (DD Act) and 42 CFR 51.42 (PAIMI Act). Under its federal authority, 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." See 42 CFR 51.42(c); 45 CFR 1326.27. The P&A program has similar authority under the Protection and Advocacy of Individual Rights Program of the Rehabilitation Act of 1973 (PAIR Act), 29 U.S Code, section 794e, and the Traumatic Brain Injury Act of 1996 (TBI Act) (P.L. 104-66), reauthorized as part of the Children's Health Act of 2000 (P.L. 106-310). In Minnesota, the designated protection and advocacy system for the DD Act and the PAIMI Act is the Minnesota Disability Law Center, a division of Mid-Minnesota Legal Aid, 1-800-292-4150.

Entry of health care 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 do not show 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.

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 using a face covering. 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. MDH has guidance for communal activities and dining in the COVID-19 Toolkit: Information for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf).

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 often. The MDH COVID-19 Action Plan for Congregate Settings (www.health.state.mn.us/diseases/coronavirus/hcp/icpaction.pdf) provides a sample IPC facility action plan for congregate settings.

Survey considerations

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance, Minnesota Statutes, chapter 144A, section 144A.44 (2),(4),(8),(9),(13),(19),(22) (www.revisor.mn.gov/statutes/cite/144A.44).

- For concerns related to a facility limiting visitors without a reasonable clinical and safety cause, surveyors should investigate for non-compliance, Minnesota Statutes, chapter 144A, section 144A.44 (2),(4),(8),(9), (13),(19),(22) (www.revisor.mn.gov/statutes/cite/144A.44).

- For concerns related to ombudsman access to the resident and the resident's medical record, surveyors should investigate for non-compliance at Minnesota Statutes, chapter 144A, section 144A.4794 (c)(1),(2),(3) (www.revisor.mn.gov/statutes/cite/144A.4794).
- For concerns related to lack of adherence to infection control practices, surveyors should investigate for non-compliance, Minnesota Statutes, chapter 144A, section 144A.4798 (www.revisor.mn.gov/statutes/cite/144A.4798).

Appendix A: Factors 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 their risk for COVID-19 transmission to ensure proper policies, procedures, and infection control practices are in place. MDH has used the Centers for Medicare and Medicaid Services (CMS) Nursing Home Re-Opening Recommendations (www.cms.gov/files/document/qso-20-30-nh.pdf-0) to develop the following Minnesota-specific factors that facilities should consider when determining COVID-19 risk factors:

- Case activity level in community: Be informed of the level of community transmission in your county. Facilities should monitor the 14-day positivity rate in their county. Facilities can determine the 14-day positivity rate on the MDH webpage, COVID-19 Weekly Report (www.health.state.mn.us/diseases/coronavirus/stats/index.html). Select the Weekly Test Rate by County of Residence link and download the Weekly Percent of Tests Positive by County of Residence (CSV) file. Add the numbers of the two most recent weeks in your county and divide by two to determine the 14-day positivity rate. If the facility is a part of a campus where the nursing home is using CMS data to calculate positivity rate, the facility may use CMS data for consistency across the campus. If a facility is close to a county border, also assess the adjacent county's case incidence.
- Case status in the 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 of staff, canceling events or activities to balance workloads, etc. Facilities that share staff with other long-term care facilities are at higher risk of 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. See MDH guidance on Defining Crisis Staffing Shortage in Congregate Care Facilities: COVID-19 (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, and should make its testing plans available when requested by MDH or other interested persons. Facilities should consider ongoing changes in risk and refer to MDH guidance at Long-term Care Testing: COVID-19 (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, not all of these may be possible for each facility):

- At 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 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 residents until no new residents test positive (e.g., serial point prevalence survey)?
- Is there capacity for all 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 re-test all staff every week until there are no more new positive test results for COVID-19?
- Is there capacity for screening 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.
- Is there a procedure for addressing residents or staff who decline or are unable to be tested (e.g., symptomatic resident refusing testing in a facility with positive COVID-19 cases should be isolated)?
- 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 wear a cloth face covering or facemask at all times, providers may restrict their ability to enter the facility. All visitors should maintain social distancing (stay at least 6 feet away from others when possible and perform hand washing or sanitizing upon entering the facility. See Contingency Standards of Care for COVID-19 (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 on 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 personal protective equipment, and not in crisis. See CDC information, Optimizing Personal Protective Equipment (PPE) Supplies (www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html) and the Personal Protective Equipment Burn Rate Calculator

(www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html). All staff must wear all appropriate personal protective equipment when indicated. Facilities should ensure adequate PPE supplies that do not solely rely on accessing publicly available reserves from state inventories. See MDH guidance on Contingency Standards of Care for COVID-19 (www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf).

- Local hospital capacity: Take into account the ability of the local hospital to accept transfers from long-term care 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 screened prior to entry into the building for symptoms and exposure to a person with confirmed COVID-19.

Appendix B: Tables

Visitation and Activity Guidance for Counties with High Positivity Rate (>10%)

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, long-term care 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, or who are in 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.

Category:	Guidance:
	▪ Continue to follow guidance in the COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf) for long-term care facilities.
Non-medical trips outside of long-term care facility	▪ Cancel, or limit, if possible. If trip is necessary, residents should wear a cloth mask when they leave their room and when traveling via resident transport services. ▪ Cancel all trips outside of the long-term care facility. ▪ Continue to follow guidance in the toolkit for long-term care facilities. COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
Screening of persons authorized to enter the long-term care facility	▪ Screen all staff/authorized visitors for fever and symptoms of illness before starting each shift, per guidance in the long-term care toolkit. ▪ 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 surveyors, chaplain/spiritual advisor, mortician, etc. per guidance in the long-term care toolkit. ▪ Staff should not work while sick. ▪ All staff should wear a facemask 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 facility should practice social distancing when possible, staying at least 6 feet away from others (exceptions may be granted for essential caregiver visits and compassionate care visits, for a limited amount of time, while following all appropriate infection prevention guidelines). COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)

Category:	Guidance:
Screening of residents in long-term care 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 the long-term care toolkit and CDC guidance. COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
Personal protective equipment (PPE)	▪ Staff should wear the appropriate personal protective equipment, based on COVID-19 status, CDC guidelines, and the procedures being performed. ▪ Follow guidance: Contingency Standards of Care for COVID-19 (www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf) COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
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 personal protective equipment as staff. ▪ All visitors should wear a mask (e.g., a cloth mask) at all times and practice strict hand hygiene. COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
End-of-shift staff assessments	▪ Long-term care facilities should conduct end-of-shift assessments to identify personal protection equipment breaches and potential concerning exposures of staff to residents with COVID-19. ▪ See Appendix G in the long-term care toolkit for a personal protective equipment breach log. COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
Cohort units	▪ Plans to cohort, or group, residents should be established in advance if possible, before testing results are received, and should

Category:	Guidance:
	be centered on implementation of robust infection control practices. ▪ Continue to follow long-term care toolkit guidance: COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf).
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 (www.health.state.mn.us/diseases/coronavirus/hcp/ltctestrec.pdf).
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 (www.health.state.mn.us/diseases/coronavirus/hcp/ltctestrec.pdf).

Visitation and Activity Guidance for Counties with Low or Medium Positivity Rate (<10%)

Category:	Guidance:
General visitor restrictions	▪ Compassionate care visits are allowed: CMS: Frequently Asked Questions (FAQs) on Nursing Home Visitation (www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf). ▪ Essential Caregiver visits allowed: Essential Caregiver Guidance for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltccaregiver.html) ▪ Outdoor visitation is allowed: Outdoor Visitation Guidance for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltcoutdoor.pdf) ▪ Window visits are allowed: Guidance for Window Visits at Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltcwindows.pdf) ▪ Beauty shop visits are allowed: Beauty Shop Guidance for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltcbeauty.pdf) ▪ Modifications to visitor restrictions are allowed (see below).

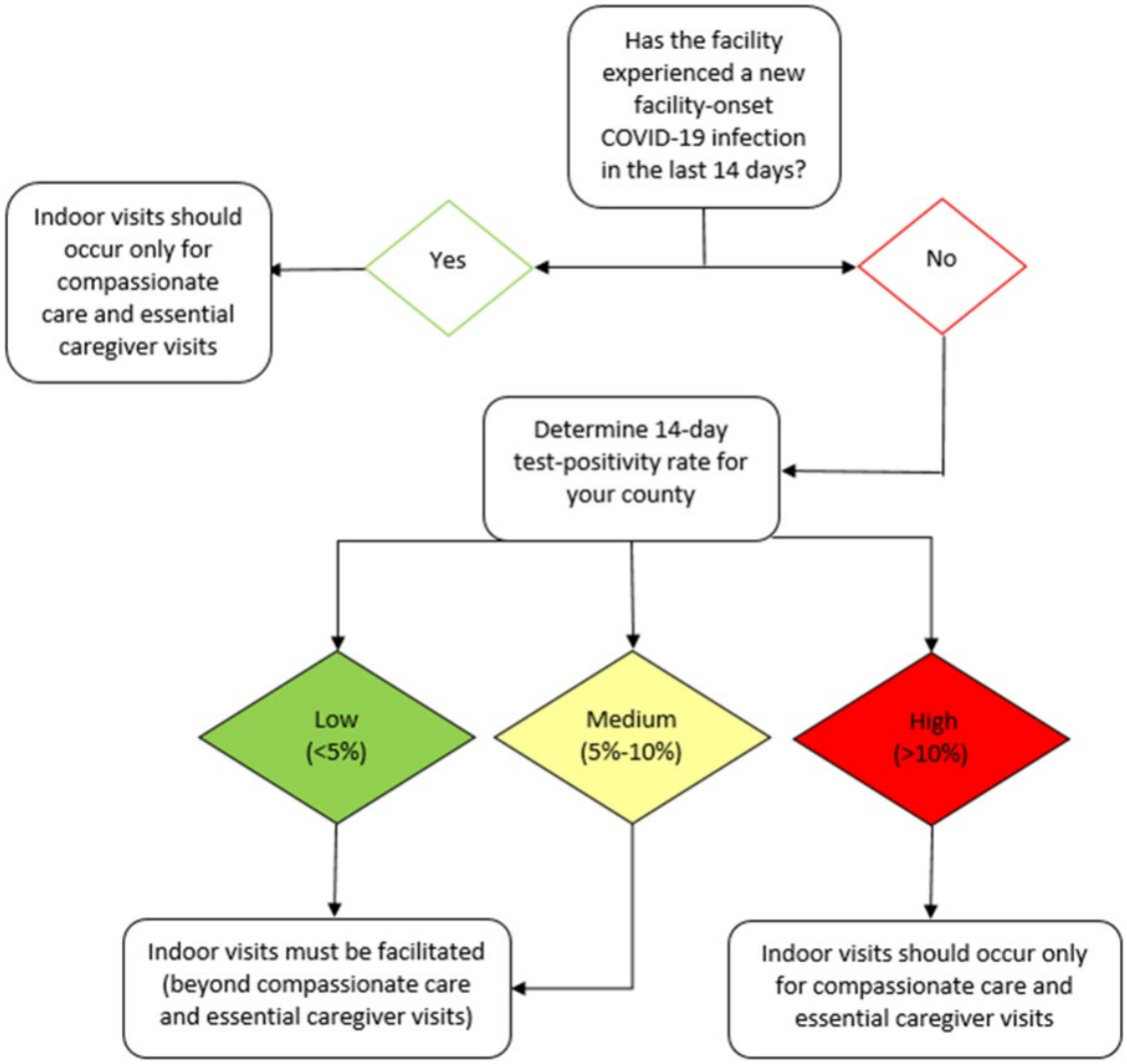
Category:	Guidance:
Dining and activities	▪ For dining, long-term care facilities should apply social distancing methods, such as ensuring residents sit in limited numbers at least 6 feet apart. ▪ Group activities may be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or in 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 long-term care toolkit guidance: COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf).
Non-medical trips outside of the long-term care facility	▪ Limit, if possible. Residents should wear a cloth mask when they leave their room and when traveling via resident transport services. ▪ Allow limited number of trips outside of the long-term care facility. ▪ Continue to follow long-term care toolkit guidance: COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf).
Screening of persons authorized to enter the long-term care facility	▪ Screen all staff/visitors for fever and symptoms of illness before starting each shift, per guidance in the long-term care toolkit. ▪ 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 surveyors, chaplain/spiritual advisor, mortician, etc., per guidance in the long-term care toolkit. ▪ Staff should not work while sick. ▪ All staff should wear a facemask 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 long-term care facility should practice social distancing when possible (stay at least 6 feet away from others).

Category:	Guidance:
	COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
Modifications of visitor restrictions/non-essential health care personnel/contractors	▪ Must have a 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, or if the resident lacks capacity to make the decision, the resident's representative preference. Residents may rotate who visits them over time, and are not required to select a limited number of visitors. 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. ▪ If pets are allowed in the facility, they must be under control of the visitor bringing them in. Petting or holding pets is permitted. ▪ Visitors must limit movement in the facility. The visitor may take the resident outside for a walk during their time of visitation, but must stay 6 feet apart after transporting the resident outside. Pushing a wheelchair is an acceptable activity while wearing personal protective equipment.

Category:	Guidance:
	▪ 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 the long-term care 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: COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf) CDC: Preparing for COVID-19 in Nursing Homes (www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html)
Personal protective equipment (PPE)	▪ Staff should wear the appropriate personal protective equipment, based on COVID-19 status, CDC guidelines, and the procedures being performed. ▪ Follow guidance: Contingency Standards of Care for COVID-19 (www.health.state.mn.us/communities/ep/surge/crisis/ppegrid.pdf) COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
Universal source control	▪ When a resident leaves their room, they should wear a cloth mask if tolerated and should stay at least 6 feet away from other residents at all times. ▪ Compassionate care visitors and essential caregivers should wear the same personal protective equipment as staff. ▪ All visitors should wear a mask (e.g., a cloth mask) at all times and practice strict hand hygiene. ▪ Continue to follow long-term care toolkit guidance: COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf).
End-of-shift staff assessments	▪ Long-term care facilities should conduct end-of-shift assessments to identify personal protective equipment breaches and potential concerning exposures of staff to residents with COVID-19.

Category:	Guidance:
	▪ See Appendix G in the long-term care toolkit for a personal protective equipment breach log. COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf)
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 long-term care toolkit guidance: COVID-19 Toolkit (www.health.state.mn.us/diseases/coronavirus/hcp/ltctoolkit.pdf).
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 (www.health.state.mn.us/diseases/coronavirus/hcp/ltctestrec.pdf).
Resident testing	▪ Facilities should follow MDH's COVID-19 Testing Recommendations for Long-term Care Facilities (www.health.state.mn.us/diseases/coronavirus/hcp/ltctestrec.pdf).

Appendix C: Visitation guidance flowchart



Appendix C walks the reader through a flowchart to determine correct visitation guidance. Has the facility experienced a new facility-onset COVID-19 infection in the last 14 days? If yes, indoor visits should occur only for compassionate care and essential caregiver visits. If no, the facility has not experienced a new COVID-19 case in the last 14 days, the flowchart takes the reader to the next question. The question is: what is the facility's current COVID-19 county positivity rate? If the county positivity rate is low, less than 5%, indoor visits must be facilitated beyond compassionate care and essential caregiver visits. If the county positivity rate is medium, between 5% and 10%, indoor visits must be facilitated beyond compassionate care and essential caregiver visits. If the county positivity rate is high, greater than 10%, indoor visits should occur only for compassionate care and essential caregiver visits.

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