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KANSAS DEPARTMENT FOR AGING AND DISABILITY SERVICES COVID-19 GUIDANCE

DATE: March 15, 2021 ***Revised 10/07/2022***

TO: State & Local Officials, Adult Care Home Operators/Owners/Administrators, Stakeholders, Industry Associations, General Public

FROM: Secretary Laura Howard

SUBJECT: Visitation Guidance for Long Term Care Settings

EFFECTIVE: Immediately

The Centers for Medicare and Medicaid Services (CMS) updated its September 17, 2020 guidance (QSO-20- 39-NH) regarding visitation in nursing homes. KDADS recognizes other long-term care settings in Kansas are not subject to the guidance issued by CMS for certified nursing facilities. Using the guidance of CMS, Center for Disease Control and Prevention (CDC) and Kansas Department of Health and Environment (KDHE); KDADS updated its visitation guidelines for all long-term care settings in Kansas including Assisted Living, Board Care Home, Home Plus, Nursing Facility and Residential Health Care Facilities.

KDADS recognizes the prolonged separation of long-term care residents from their loved ones has taken a significant toll on the health of everyone involved; as well as the need to continue to protect this vulnerable population. Visitation is a right for residents in adult care homes and facilities should make best efforts to facilitate visitation for residents and their loved ones or preferred visitors.

Acknowledging that many residents and staff of adult care homes have been vaccinated, the updated guidance on visitation promotes connecting residents and their loved ones. The guidance also continues to emphasize the importance of strong infection control practices, testing for the presence of the COVID-19 virus, and effective responses to outbreaks of COVID-19 in adult care homes. The vaccine provides an additional level of protection from COVID-19 infection but must be balanced with maintaining and practicing the core principles of infection control that have been in place throughout the pandemic.

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

- *Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).*

- Appropriate hand hygiene (use of alcohol-based hand rub is preferred).

- Face covering or mask (covering mouth and nose) in accordance with CDC guidance.

- The facility must have 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 coverings or masks, 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 when COVID-19 infections are identified (e.g., separate areas dedicated to COVID-19 care).

These core principles are consistent with the CDC guidance for nursing homes and *assisted living (please note the link for assisted living has been updated).* and should be adhered to at all times.

Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. Facilities should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the guidance below.

To ensure resident rights are not violated and that visitation plans are person-centered and able to be executed by the resident, facility and visitor, KDADS has created the Resident Visitation Preferences Template to identify the types of questions and issues that should be discussed to facilitate visitation. All long-term care facilities should utilize the template found at the end of this guidance or a form of their own that captures the same information showing that a discussion has been held between a staff member and resident, resident's representative, or resident's family. The conversations should be made in conjunction with the facility and resident or resident's representative. The conversation should be informed by the facilities capacity to conduct different visitation options. This information should be completed for each resident (as of 01/31/2021) and updated regularly.

It is important facility owners or operators communicate their current status for visitation based on risk factors present within the facility and surrounding community to residents and their friends and family members who would be affected by visitation restrictions. Families and residents should have a clear

understanding of the facility's ability to allow visitation and the conditions when visitation can occur.

Compassionate Care Visits

While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care situations" does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to:

- A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.
- A resident who is grieving after a friend or family member recently passed away.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

Allowing a visit in these situations or similar circumstances is 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. Knowing that many residents and staff of adult care homes have been vaccinated, and the updated CMS guidance for nursing facilities, KDADS is updating our guidance to support connecting residents and their loved ones.

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. If the resident is fully vaccinated*, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits. The need for compassionate care visits should be clearly documented in the residents' plan of care or service agreement.

Essential Care Giver

Family members and other close, outside caregivers have a critical role in the care and support of residents, including advocating for their health and well-being. It is strongly recommended Adult Care Homes (ACH) develop a process to designate essential caregivers (EC).

An Essential Caregiver is an individual, including clergy members, who has been given consent by the resident, or their guardian or legal representative, to provide health care services or assistance with activities of daily living to help maintain or improve the quality of care or quality of life of a facility resident as well as positively influencing the behavior of the resident. Care or services provided by the Essential Caregiver must be included in the plan of care or service plan for the resident and may include assistance with bathing,

dressing, eating, and/or emotional support.

ACH's are not required to implement an EC program, but this guidance provides recommendations for facilities that choose to. The goal of designating ECs is to help ensure high-risk residents continue to receive individualized, person-centered care. KDADS will consider essential caregiver visits as a type of compassionate care visit. While not required, KDADS encourages facilities in counties with medium or high levels of community transmission to test visitors, if possible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly). Facilities also may encourage visitors to be tested on their own. The guidance below provides guidelines and suggestions for the implementation of an EC program in an ACH.

- Facilities must establish policies and procedures for designating a resident's essential care giver and how EC's can be included in a resident's activities.

- Residents, guardians, or legal representatives should consult the facility's Administrator, Director of Nursing, Social Services Director, or other designated facility staff to help determine who meets the criteria of an EC.

- Residents may want to designate more than one EC, based on their past involvement, and needs (e.g., more than one family member previously split time to provide care for the resident). In these unique situations, facility staff should work cooperatively with the resident and family to create a schedule to accommodate the ECs.

- EC's should complete facility-designated infection prevention and control training.

- Facilities should have EC's sign a consent form acknowledging completion of the facility-designated infection prevention and control training, an understanding of the facility's visitation and infection prevention and control policies, and the risk created by frequency and duration of close contact.

- Consider having EC's complete nurse aid training courses.

- Consider hanging posters throughout the facility that demonstrate key instructions to reinforce safe practices for infection control and proper PPE usage.

- The EC must wear all necessary personal protective equipment (PPE) while in the building and must wash or sanitize their hands regularly.

- The facility should ensure hand sanitizing stations and alcohol-based hand rubs are accessible.

- EC's should inform the facility if they develop a fever or symptoms consistent with COVID-19 within fourteen (14) days of a visit to the resident(s).

- *Recommend that* the facility maintain EC logs noting the names of EC's, who they visited, staff that assisted the during the visit, dates of visit, and contact information in the event of a subsequent COVID-19 outbreak among staff or residents.

- The facility should work with the EC to establish a mutually agreeable schedule that addresses the facility obligations, including the numbers of EC's in the building at the same time, and is person-centered. This includes working with an EC by including scheduling during evening and weekends, to accommodate work or childcare barriers.

- After attempts to mitigate concerns, the facility should restrict or revoke visitation if the EC fails to follow infection prevention and control requirements or other COVID-19-related rules of the facility.

- While an EC visit is considered compassionate care, KDADS recommends that the EC not provide high-contact care activities during a resident's quarantine or isolation period.

- Facilities should not restrict visitation without a reasonable clinical or safety cause. Prior to any restriction, the facility, EC, and resident should discuss any concerns

Outdoor Visitation

Outdoor visits pose a lower risk of transmission due to increased space and airflow and can be implemented without the consideration of county *transmission* rates**. Outside visits may be limited by 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, quarantine status). Facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, facilities should consider the following criteria:

- Adequate staff available to allow for help with outdoor transition of residents, and to assist with wiping down any visitation areas as necessary.

- Staff should be able to maintain visual observation but provide as much distance as necessary to allow for privacy of the visit conversation *(as necessary).*

- Must have a system to ensure visitors are *at least passively* screened for signs and symptoms of COVID-19 *as well as a system to follow-up with those visitors who do not meet the screening criteria.*

- Outdoor visitation spaces must be designed to be accessible without visitors having to walk through the facility.

- Provide alcohol-based hand sanitizer to persons visiting residents and provide signage or verbal reminders of correct use.

- *Recommend that facilities maintain* a detailed visitor log with the date and time of visitation, resident and staff encountered during visitation as well as contact information for the visitor.

- Facilities may establish additional guidelines as needed to ensure the safety of visitations and their facility operations.

Indoor Visitation

Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.

Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. During peak times of visitation and large gatherings (e.g., parties, events) facilities should encourage physical distancing. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission.

Face Coverings and masks during visits

If the nursing home's county COVID-19 community transmission is high, everyone in a healthcare setting should wear face coverings or masks.

If the nursing home's county COVID-19 community transmission is not high, the safest practice is for residents and visitors to wear face coverings or masks, however, the facility could choose not to require visitors wear face coverings or masks while in the facility, except during an outbreak. The facility's policies regarding face coverings and masks should be based on recommendations from the CDC, state and local health departments, and individual facility circumstances.

Regardless of the community transmission level, residents and their visitors when alone in the resident's room or in a designated visitation area, may choose not to wear face coverings or masks and may choose to have close contact (including touch). Residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit. If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.

Additional information on levels of community transmission is available on the CDC's COVID-19 Integrated County View webpage.

NOTE: CDC states that Community Transmission is the metric currently recommended to guide select practices in healthcare settings to allow for earlier intervention, before there is strain on the healthcare system, including its workforce, and better protect the vulnerable individuals seeking care in these settings. The Community Transmission metric is different than the COVID-19 Community Level metric used for non-healthcare settings.

Nursing homes should use the Community Transmission Level metric not the Community Level metric.

While not recommended, residents who are on transmission-based precautions (TBP) or quarantine can still receive visitors. In these cases, visits should occur in the resident's room and the resident should wear a well-fitting facemask (if tolerated). Before visiting residents, who are on TBP or quarantine, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to the core principles of infection prevention. Facilities may offer well-fitting facemasks or other appropriate PPE, if available; however, 5 facilities are not required to provide PPE for visitors.

Indoor Visitation during an Outbreak

An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. To swiftly detect cases, we remind facilities to adhere to CMS regulations and guidance for COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately (but not earlier than 24 hours after the exposure, if known) begin outbreak testing in accordance with CMS QSO 20-38-NH REVISED, KDADS Adult Care Home Testing Guidance and CDC guidelines.

While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits and visits should ideally occur in the resident's room. While an outbreak investigation is occurring, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility.

Rather, they should go directly to the resident's room or designated visitation area. Also, visitors should physically distance themselves from other residents and staff, when possible. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.

Communal Activities and Dining

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission. *The safest approach is for everyone, particularly those at high risk for severe illness, to wear a face covering 8 or mask while in communal areas of the facility. For more information, see the Implement Source Control section of the CDC guidance "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic."*

Facilities must permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices such as wearing a face covering or mask, especially for those at high risk for severe illness and when community transmission is high, performing hand hygiene and encouraging those around them to do the same.

Upon the resident's return, nursing homes should screen residents upon return for signs or symptoms of COVID-19:

- *If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, see the CDC's guidance for residents who have had close contact for next steps regarding testing and quarantine.*

- *If the resident develops signs or symptoms of COVID-19 after the outing, see the CDC's guidance for residents with symptoms of COVID-19.*

In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) except in certain situations, described in the CDC's empiric transmission-based precautions guidance.

Residents who leave the facility for 24 hours or longer should generally be managed as a new admission, as recommended by the CDC in the Managing admissions and residents who leave the facility section.

Entry of Healthcare Workers and Other Providers of Services

All healthcare workers must be permitted to come into the facility as long as they are not subject to a work exclusion or showing signs or symptoms of COVID-19. In addition to health care workers, personnel educating and assisting in resident transitions to the community should be permitted entry consistent with this guidance. We note that EMS personnel do not need to be screened, so they can attend to an emergency without delay. We remind facilities that all staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements

Visitor Testing and Vaccination

While not required, we encourage facilities located *in high transmission rate counties* to offer testing to

visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days).

Similarly, we encourage visitors to become vaccinated when they have the opportunity. While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation.

Access to the Long-Term Care Ombudsman

Regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid- certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. K.A.R. 26-39-102(g)(4) also has this same requirement that all Adult Care Homes must follow. During the public health emergency, in-person access may be limited due to infection control concerns and/or transmission of COVID-19, however, in-person access may not be limited without reasonable cause. Representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention as described above. If in-person access is deemed inadvisable (e.g., the Ombudsman has signs or symptoms of COVID-19), facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident's medical, social, and administrative records as otherwise authorized by State law as are all Adult Care Homes per K.S.A. 39-1406.

Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs

Section 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to "investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system or if there is probable cause to believe the incidents occurred." 42
U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes "the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person." 42 CFR § 51.42(c); 45 CFR § 1326.27.

Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). For example, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention.

We believe the guidance above represents reasonable ways an adult care home can facilitate in-person visitation. Except for on-going use of virtual visits, facilities may still restrict visitation due to the COVID-

19 county positivity rate, 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 factor related to the COVID-19 Public Health Emergency (PHE.) However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with 26-39-103(m)***. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 26-39-103(m) and the facility would be subject to citation and enforcement actions.

Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. However, this restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described above.

If facilities have questions regarding the KDADS visitation guidance, contact KDADS.reopening@ks.gov.

***Please use the county positivity data located on the Kansas Department of Health and Environments webpage under Nursing Home Metrics (https://www.coronavirus.kdheks.gov/160/COVID-19-in-Kansas) or the color-coded positivity classification, which can be found on the COVID-19 Nursing Home Data site. Regardless of source facilities should remain consistent in which source their facility is utilizing. Facilities may also monitor other factors to understand the level of COVID-19 risk, such as rates of COVID-19-Like Illness, visits to the emergency department or the positivity rate of a county adjacent to the county where the nursing home is located.*

****Federally Certified Nursing facilities are also subject to compliance of 42 CFR 483.10(f)(4) and 42 CFR 483.80(h).*