State of South Dakota Back to Normal Long-Term Care Reopening Plan
Revised April 1, 2021

Background

Long Term Care (LTC) facilities have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality. The vulnerable nature of the LTC population combined with the inherent risks of congregate living in a healthcare setting have required aggressive efforts to limit COVID-19 exposure and to prevent the spread of COVID-19 within Nursing Homes (NH) and Assisted Living Centers (ALCs).

On March 10, 2021 the Center for Medicare and Medicaid Services (CMS) revised guidance (QSO-20-39-NH) to allow visitation for the states vulnerable population that are served in LTC. The new CMS guidance is the basis for the **State of South Dakota Back to Normal Long-Term Care Reopening Plan**. This plan applies to all NHs and ALCs in South Dakota.

Since the release of QSO memorandum 20-39-NH on September 17, 2020, COVID-19 vaccines have received Emergency Use Authorization from the Food and Drug Administration. Millions of vaccinations have since been administered to LTC residents and staff, and these vaccines have been shown to help prevent symptomatic SARS-CoV-2 infection (i.e., COVID-19). **Therefore, CMS, in conjunction with the Centers for Disease Control and Prevention (CDC), is updating its visitation guidance accordingly, but emphasizing the importance of maintaining infection prevention practices, given the continued risk of COVID-19 transmission.**

The guidelines outlined in this plan to reopen South Dakota NH and ALC communities is a collaborative effort between the South Dakota Department of Health (SD DOH), South Dakota Department of Human Services (SD DHS), South Dakota Association of Healthcare Organizations, and the South Dakota Healthcare Association. The plan provides guidance to NH and ALC to allow for visitation. Visitation may occur safely and based on vaccines showing to help prevent symptomatic COVID-19 and the core principles of COVID-19 infection prevention. The reopening plan and the CMS guidance provides direction to the facility administrator and the governing board to allow visitation within the facility.

The information contained in the new State of South Dakota Back to Normal Long-Term Care Reopening Plan supersedes and replaces previously issued plans.

In Summary

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

- Unvaccinated residents, if the COVID-19 county positivity rate is greater than 10 percent and less than 70 percent of residents in the facility are fully vaccinated,
- Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated, until they have met the criteria to discontinue transmission-based precautions, or
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine

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

Fully vaccinated refers to a person who is ≥2 weeks following receipt of the second dose in a 2- dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons.

Lack of visitation in a facility without adequate reasoning may indicate non-compliance of Resident Rights.

Plan

The updated CMS visitation guidance considers all of the vaccinations which have occurred in residents and staff. In general, facilities should allow responsible indoor visitation at all times and for all residents, regardless of vaccination status of the resident, or visitor. Facilities must have a plan with policies and procedures in place to ensure person-centered visitation is available.

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission:

The Core Principles of COVID-19 Infection Prevention

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status)
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose)
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper visitor education on COVID19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO20- 38-NH)

These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for nursing homes, and should be adhered to at all times. Additionally, visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality

of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear Plexiglass dividers, curtains). NHs and ALCs 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 CMS guidance.

Outdoor Visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred even when the resident and visitor are fully vaccinated against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status) may hinder outdoor visits. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, all appropriate infection control and prevention practices should be adhered to.

Indoor Visitation

Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times). These scenarios include limiting indoor visitation for:

- Unvaccinated residents, if the nursing home's COVID-19 county positivity rate is >10% **and** <70% of residents in the facility are fully vaccinated;
- Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; or
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

Facilities should consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors. During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room, if possible. For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

CMS and CDC continue to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated.

However, we acknowledge the toll that separation and isolation has taken. We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. **Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after.** Regardless, visitors should physically distance from other residents and staff in the facility.

Indoor Visitation during an Outbreak

An outbreak exists when a new nursing home onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). This guidance is intended to describe **how visitation can still occur when there is an outbreak**, but there is evidence that the transmission of COVID-19 is **contained to a single area** (e.g., unit) of the facility. To swiftly detect cases, we remind facilities to adhere to CMS regulations and guidance for **COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing.** Outbreak testing should occur by following guidance outlined in the CMS memo QSO-20-38-NH.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:

- If the first round of outbreak testing reveals **no additional COVID-19 cases in other areas (e.g., units) of the facility**, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing.

For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.

- If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

While the above scenarios describe how visitation can continue after one round of outbreak testing, facilities should continue all necessary rounds of outbreak testing. In other words, this guidance provides information on how visitation can occur during an outbreak but does not change any expectations for testing and adherence to infection prevention and control practices. If subsequent rounds of outbreak testing identify one or more additional COVID-19 cases in other areas/units of the facility, then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.

Visitor Testing and Vaccination

While not required, we encourage facilities in medium- or high-positivity counties to offer testing to visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days). Similarly, we encourage visitors to become vaccinated when they have the opportunity. **While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation.** This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems, as described below.

Compassionate Care Visits

Compassionate care visits should be allowed at all times, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak.

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

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

Allowing a visit in these situations would be consistent with the intent of, "compassionate care situations." Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident's needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. Compassionate care visits, and visits required under federal disability rights law should be allowed at all times, regardless of a resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak.

Lastly, visits should be conducted using social distancing; however, if during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following appropriate infection prevention guidelines, and for a limited amount of time. Also, as noted above, **if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after**. Regardless, visitors should physically distance from other residents and staff in the facility. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits.

Required Visitation

Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f) (4) (v). A nursing home must facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR § 483.10(f) (4), and the facility would be subject to citation and enforcement actions.

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

Community (County) Test Positivity Rate

Facilities should use the COVID-19 community (county) positivity rate to facilitate indoor visitation. Community Test Positivity Rates must be obtained from a consistent formal official source using either the CMS COVID-19 Nursing Home or State Department of Health data.

Entry of Healthcare Workers and Other 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, essential caregivers, barber, beautician, 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 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 and must comply with COVID-19 testing requirements.

Essential Caregivers

An essential caregiver is an individual(s) whether family or friend who previously was actively involved with the resident and/or was committed to providing companionship or assisting in the activities of daily living of the resident. Using a person-centered approach when applying this guidance should cover all types of visitors, including those who have been categorized as "essential caregivers." This plan does not distinguish between these types of visitors and other visitors.

Communal Dining and Activities

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Residents may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). Facilities should consider additional limitations based on status of COVID-19 infections in the facility.

Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with

social distancing among residents, appropriate hand hygiene, and use of a face covering. 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.

Access to Surveyors and Survey Considerations

Federal and state surveyors are not required to be vaccinated and must be permitted entry into facilities unless they exhibit signs or symptoms of COVID-19. Surveyors should also adhere to the core principles of COVID-19 infection prevention and adhere to any COVID-19 infection prevention requirements set by state law.

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance at 42 CFR § 483.10(b), F550.
- For concerns related to a facility limiting visitors without a reasonable clinical and safety cause, surveyors should investigate for non-compliance at 42 CFR § 483.10(f)(4), F563.
- For concerns related to ombudsman access to the resident and the resident's medical record, surveyors should investigate for non-compliance at 42 CFR§§ 483.10(f)(4)(i)(C), F562 and 483.10(h)(3)(ii), F583.
- For concerns related to lack of adherence to infection control practices, surveyors should investigate for non-compliance at 42 CFR § 483.80(a), F880.

Access to Ombudsman

As stated in previous CMS guidance QSO-20-28-NH (revised), regulations at 42 CFR §483.10(f)(4)(i)(C) require that a Medicare and Medicaid- certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. During this PHE, in-person access may be limited due to infection control concerns and/or transmission of COVID-19, such as the scenarios stated above for limiting indoor visitation; however, in-person access may not be limited without reasonable cause. Representatives of the Office of the Ombudsman should adhere to the core principles of COVID19 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.

Access to Federal Disability Rights Laws and Protection and 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 or if there is probable cause to believe the incidents occurred.”

Create a Plan for Residents who leave the Facility

Residents who leave the facility should be reminded to follow all recommended Infection Prevention and Control (IPC) practices including source control, physical distancing, and hand hygiene and to encourage those around them to do the same. Individuals accompanying residents (e.g., transport personnel, family members) should also be educated about these IPC practices and should assist the resident with adherence.

For residents going to medical appointments, regular communication between the medical facility and the nursing home (in both directions) is essential to help identify residents with potential exposures or symptoms of COVID-19 before they enter the facility so that proper precautions can be implemented.

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) and do not have close contact with someone with SARS-CoV-2 infection.

- Quarantining residents who regularly leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.

Facilities might consider quarantining residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended IPC measures.

Residents who leave the facility for 24 hours or longer should generally be managed as described in the New Admission and Readmission section.

References and Resources:

Covid.sd.gov

CDC.GOV

Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes - Nursing Homes & Long-Term Care Facilities

Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination

Retirement Communities and Independent Living

Preventing the Spread of COVID-19 in Retirement Communities and Independent Living Facilities (Interim Guidance)

Strategies to Optimize the Supply of PPE and Equipment

Evaluating and Testing Persons for Coronavirus Disease 2019 (COVID-19)

Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings

Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19

Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)

Using Personal Protective Equipment (PPE)

SD DOH PPE REQUEST

Testing Guidance

CMS Memo QSO 20-39-NH

CMS Memo QSO 20-38-NH