Safe Start for Long Term Care Recommendations and Requirements:

Nursing Homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities

July 1, 2021 Updates to the Safe Start for LTC Recommendation and Requirements Document.

1. **The information contained in this Safe Start for Long Term Care (LTC) document is *independent of any other Washington State reopening plan*.**
2. Facilities and homes are required to follow these Safe Start for LTC Recommendations and Requirements.
3. The impact of COVID-19 vaccines on community transmission rates may allow for future changes to the recommendations and requirements in the Safe Start for LTC.

Contents

Introduction

Safe Start for Long-Term Care (LTC) Facility Recommendations and Requirements

The Department of Social and Health Services (DSHS) and the Department of Health (DOH) are presenting the updated safe start plan for licensed and certified long-term care facilities and agencies. Given the critical importance of limiting COVID-19 exposure in long-term care residential care settings and certified supported living agencies, decisions on relaxing restrictions are be made:

- With careful review of various unique aspects of the different facilities and communities in which they reside;
- In alignment with the Governor's Proclamations; and
- In collaboration with state and local health officials.

This approach will help keep residents and clients healthy and safe.

Because the pandemic is affecting communities in different ways, DSHS, DOH and the Governor's Office regularly monitor the factors for the Safe Start for LTC and adjust the Washington plans accordingly.

Residential Care Setting Safe Start Requirements

1. *Follow the Centers of Disease Control and Prevention (CDC), Department of Health (DOH), and local health jurisdictions' (LHJs) (when applicable) infection control guidelines to slow COVID-19 spread. If there is a difference between state and federal guidance follow the more restrictive guidance*
2. *Cooperate with the local health officer or his/her designee in the conduct of an outbreak investigation, including compliance with all recommended or ordered infection prevention measures, testing of staff, and testing of residents.*
3. *Follow this DSHS and DOH Safe Start for LTC document. This document is guidance for LTC and is not included in any other Washington State reopening plan*
4. *Individual facility types have state statute or rules that requires a facility to impose actions to protect the residents by activating their infection control* plan.
5. *The LHJ or DOH have the authority to return a facility to more restrictive operations in response to any infectious disease and/or COVID-19 outbreak. Examples that may require a facility to return to a more restrictive phase of the Safe Start for LTC include but are not necessarily limited to new outbreaks of COVID-19 in their facility, as determined by the LHJ or DOH. The LHJ and DOH under WAC 246-101-505 and WAC 246-101-605 have the authority to conduct public health investigations and institute control measures and, pursuant to WAC 246-101-305, LTCs are obligated to cooperate with these investigations. Please refer to the DOH definition of an outbreak found here: Interim COVID-19 Outbreak Definition for Healthcare Settings*

All facilities and agencies must be prepared for an outbreak and make assurances they have;

1. The facility must maintain access to COVID-19 testing for all residents and staff:

a. Aiming for fast turnaround times, ideally less than 48 hours,
b. Testing all clients with signs and symptoms of COVID-19 or with identified exposures,
c. Working with local and state public health to coordinate repeat and outbreak testing, and
d. Capacity to conduct ongoing, serial testing of clients and staff according to federal, state and local guidance;
e. Testing includes point of care antigen testing and PCR lab testing.
f. Nursing Homes follow CMS guidance in QSO memo 20-38 or DOH or LHJ guidance, whichever is more stringent.

2. A response plan to inform cohorting and other infection control measures;
3. A plan to actively screen all staff following the symptom screening strategies that can be found here: Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC and to screen all visitors using the DOH Supplemental Guidance for Long-term Care Facility Visitors.
4. Dedicated space for cohorting and managing care for residents with COVID-19 or if unable to cohort residents, and a plan which may include transferring a person to another care setting;
5. A plan in place to care for residents with COVID-19, including identification and isolation of residents. The facility or agency plan must describe the identification, care and isolation of residents or clients may be requested by DSHS, DOH or the LHJs to conduct an outbreak investigation. Technical assistance for development of these plans can be received from LHJs.
6. Protected and promoted resident and client rights while following standards of infection control practices including when a resident or a client requires quarantine or isolation due to individual disease status or an outbreak in a residential facility or client home.

CMS Key Visitation Principles (QSO Memo 20-39) (*Facilities should utilize this guidance as appropriate. If State guidance is more restrictive, the State guidance must be followed.)

Visitation, in conjunction with LTC Safe Start Recommendations, 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: QSO-20-39-NH REVISED (cms.gov).

Core Principles of COVID-19 Infection Prevention

- Active 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)
- 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 COVID-19 care)

- Resident and staff testing conducted as required at 42 CFR 483.80(h) (see QSO-20- 38-NH)

These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for nursing homes and should be adhered to at all times. 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 using physical barriers (e.g., clear Plexiglas dividers, curtains). Also, providers should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance

Screening

- Actively screen residents daily.
- Actively screen 100% of all persons (residents, staff, visitors, etc.) entering/re-entering the facility including: temperature checks, questionnaire about symptoms and potential exposure, observation of any signs or symptoms, and ensure all people entering the facility or home have cloth face covering or face mask.
- Maintain a screening log for 30 days.
- Do not screen EMTs or law enforcement responding to an emergent call.

PPE and Source Control

Providers will ensure visitors and those providing compassionate care wear proper source control (e.g., well-fitting cloth mask or facemask) at all times when in the facility, except as outlined in the DOH source control guidance. Visitors and those providing compassionate care will continue to wear source control during the indoor visit in the resident room or designated visiting area or during outdoor visits if either the resident or visitor is not fully vaccinated or the vaccination status of either party is unknown. Visitors will wear all PPE recommended when indicated by standard or transmission-based precautions. Facilities have the flexibility to safely manage visitation and may deny a visitor access if they are unwilling to wear appropriate PPE. If the visitor is denied access, they will be given the Regional Long-Term Care Ombuds or the Developmental Disability Ombuds contact information (or both if appropriate to the situation), and Local Health Jurisdiction contact information. They must also be given information regarding the steps they can take to resume the visits, such as agreeing to comply with infection control practices and Washington Safe Start Guidelines.

All staff, essential, and non-essential personnel must wear appropriate source control or PPE at all times regardless of vaccination status, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. If the county case count is greater than 25 per 100,000, staff must wear eye protection for all resident encounters and when social distancing is unable to be maintained. County Case Counts

For additional guidance, refer to DOH PPE chart located at Contingency Strategies for PPE use during COVID-19 Pandemic and DOH/L&I Respirator and PPE Guidance for Long-Term Care.

Access to Ombuds and Resident Right Advocates

As stated in previous CMS guidance QSO-20-28-NH (revised), see https://www.cms.gov/files/document/qso-20-28-nh.pdf, 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 Ombuds with immediate access to any resident. ICF/IID facilities must work with the DD Ombuds to allow access to any resident per RCW 43.382.005. During this 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. We note that representatives of the Office of the Ombuds should adhere to the core principles of COVID-19 infection prevention. If in-person access is not advisable, such as the Ombuds or the resident having signs or symptoms of COVID-19, facilities must, at a minimum, facilitate alternative resident communication with the Ombuds, 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 Ombuds to examine the resident's medical, social, and administrative records as otherwise authorized by State law.

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 probably 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.

Providers will work with Ombuds to coordinate and identify private meeting space that meets infection controls standards if visitation in the resident's room is not possible.

Federal and State Disability Laws

Providers 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.co

Medical Necessary Providers, Service and Health Care Workers Principles

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 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.

- All essential healthcare personnel, including healthcare personnel addressed in Dear Provider letter 20-062, are allowed into the facility/home at all times
- All non-healthcare personnel are allowed in the building if the facility/home is not in outbreak status. If the facility/home has cohorted COVID positive residents to one unit and the rest of the building is open, the non-healthcare personnel may visit areas not in outbreak status. Because non-healthcare personnel have the potential for contact with unvaccinated staff or residents, they must wear source control and physically distance at all times while in the building regardless of their own vaccination status.
- All personnel participate in active screening upon entry and additional precautions are taken, including hand hygiene, donning of appropriate PPE, as determined by the task; and at a minimum wearing a face mask for the duration of their visit.
- The Beautician/Barber/Hair Stylist/Nail Technician must have a designated space.

Communal Activities and Dining Principles

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur, including disinfection of dining or activity area and any shared items between uses. The facility/home must ensure that they continue to comply with Resident Rights requirements. The facility/home must utilize the following criteria to determine the best approach to communal activities and dining:

- *Group activities*:
  - If all residents participating in the activity are fully vaccinated, then they may choose to have close contact and to not wear source control during the activity.
  - If unvaccinated residents are present, then all participants in the group activity should wear source control and unvaccinated residents should physically distance from others.
- *Communal dining*:
  - Fully vaccinated residents can participate in communal dining without use of source control or physical distancing.
  - If unvaccinated residents are dining in a communal area (e.g., dining room) all residents should use source control when not eating and unvaccinated residents should continue to remain at least 6 feet from others.
- *"Cohort" activities/dining based on vaccination status:*
  - The facility/home may host separate activities/dining based on vaccination status

Who must not participate in communal activities?

- Vaccinated and unvaccinated **residents with SARS-CoV-2 infection, or in isolation because of suspected COVID-19,** until they have met criteria to discontinue Transmission-Based Precautions.
- Vaccinated and unvaccinated **residents in quarantine** until they have met criteria for release from quarantine.

What infection prevention and control practices are recommended when planning for and allowing communal activities?

Determining the vaccination status of residents/healthcare professional (HCP) at the time of the activity might be challenging and might be subject to local regulations. When determining vaccination status, the privacy of the resident/HCP should be maintained (e.g., not asked in front of other residents/HCP). For example, when planning for group activities or communal dining, facilities might consider having residents sign up in advance so their vaccination status can be confirmed and seating assigned. **If vaccination status cannot be determined, the safest practice is for all participants to follow all recommended infection prevention and control practices including maintaining physical distancing and wearing source control.**

Offsite Visits and New Admissions

Providers must use the Risk Assessment Template to assess each resident for any COVID-19 exposure prior to and after returning from offsite visits to determine if the resident is low or high risk. Automatic quarantine should not be the standard practice upon returning from a trip into the community. Decisions about precautions taken with a resident based on the assessment must be documented in the resident's care plan. Telemedicine should be encouraged when available.

- For medically and non-medically necessary trips away from the facility:
    - The resident must be encouraged to wear a cloth face covering or face mask when the trip will involve entering spaces where source control is still required unless medically contraindicated; and
    - The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment.
    - Transportation staff, at a minimum, must wear source control. Additional PPE may be required.
    - Transportation equipment shall be sanitized between transports.

- Residents can make trips outside of the building and into the community, including non-medically-related trips, to locations that are open to the public. However, residents are encouraged to limit or avoid trips where appropriate precautions are not being followed.
    - Nursing homes please see Dear Administrator letter NH 2020-041 for details regarding residents leaving the facility for non-medically necessary trips.
    - ICF/IID Please see Dear Provider Letter ICF/IID 2020-021 for details regarding clients leaving the facility for non-medically necessary trips.

  Provide a letter to Families and residents outlining potential risks involved in community activities when residents/clients are preparing for an outing. Upon the resident return to the facility/home complete a risk assessment. Both the letter and the assessment can be found here: Risk Assessment Template to Assess COVID-19 Exposure Risk and letter to Resident/Clients and Families

If the resident/client or family has already reviewed the risk letter for previous outings, it is not necessary to provide a new letter with each trip into the community unless the information has changed.

A home should use the Interim Guidance for Transferring Residents between Long-Term Care and other Healthcare Settings to determine if a newly admitted resident would require a quarantine. This guidance takes into account the vaccination status of a resident, along with other mitigating factors.

Care Plans

Because person-centered care is key, providers will document in the resident care plan medically necessary care, compassionate care, and designated person care delivery.

Continuing Care Retirement Communities (CCRC) and Independent Living Campuses

State licensed homes that reside on the same campus as CCRCs and independent living settings, must follow these Safe Start Long Term Care Recommendations.

Visitation

All facilities and agencies are required to provide accommodations to allow access for in person visitation for all residents and clients in accordance with CMS guidance outlined in revised QSO-20-39-NH (03/10/2021), with the exception of following the COVID-19 positivity rate determination. If State or LHJ guidance is stricter, the stricter guidance must be followed. Facilities will utilize the current case rate determination as outline above in this document. Each facility must have a written visitation protocol in accordance with QSO-20-39-NH REVISED (cms.gov) and it must be shared with visitors who agree to abide by the protocol.

Visitation will be accommodated when such visits are by phone, remote video technology, window visits.

Outdoor Visitation Principles

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 or an individual resident's health 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. See Outdoor Visitation Guidance for Long-term Care Settings.

**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.*

Outside Safety Related to Structures

Providers must follow state fire marshal requirements for safety related to tent use or other temporary shelter structures: proper installation and suitable anchoring, flame resistant product use, protection of residents, tents, and surrounding grounds must be free of combustible materials, not obstruct fire hydrants, smoke free

and equipped with smoke free signs, comfortable temperatures, fire marshal approved only heater use, no open fires/flames within or around tents, fire marshal approved only lighting sources, clear unobstructed path for egress, easily opened doors and zippers, hard packed walking surfaces with no tripping hazards, and illumination of operating in dark hours. Providers must ensure resident wear proper clothing for outdoor climate and promote outside safety and comfortable temperatures via a structured shelter, parking lot, patio, or courtyard venue. (Outdoor Visitation Guidance for Long-term Care Settings.)

Holiday Guidance

Providers should follow CDC guidelines for holidays. Where State or LHJ guidance provides stricter measures, providers must follow the stricter guidance. This guidance does not replace state proclamation requirements, DOH, and CDC link: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/holidays.html. Providers must follow all guidelines for visitation within this document with strict adherence to infection control principles to prevent the spread and transmission of VOCID-19.

CMS Indoor Visitation Principles

Facilities should accommodate and support indoor visitation, based on the following guidelines:

- The facility has followed outbreak testing criteria outlined in QSO 20-38 and the visitation guidelines for outbreak visitation in QSO 20-39.
- Visitors should be able to adhere to the core principles;
- 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.

NOTE: 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.

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. **Compassionate care* visits should be permitted at all times**, including during the times outlined below when regular visitation is curtailed. These scenarios for limiting indoor visitation include:

- Unvaccinated residents, if the 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.

How do I determine visitation status for unvaccinated residents?

To determine if unvaccinated residents are able to have visitors, follow the pathway below:

1) Is your facility in a county where the positivity rate is less than 10%? Check here.
   If yes, indoor visits may occur with core infection prevention principles in place.
   If no, go to #2.

2) Is the resident vaccination rate in your facility greater than 70%?
   (To determine vaccination rate – take number of residents fully vaccinated and divide by total number of residents in the home then multiply this number by 10. For example:
   7 vaccinated residents divided by 10 total residents = 0.7
   0.7 multiplied by 10 = 70% vaccination rate)
   If yes, indoor visitation may occur with core infection prevention principles in place.
   If no to both, then indoor visits should be limited to compassion care visits for residents who are not fully vaccinated.

In setting up indoor visitation, the NH and ICF/IID need to consider the following:

- The facility/home must establish policies and procedures outlining 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. The facility must also take into consideration work schedules of visitors and include allowances for evening and weekend visits.
- The facility will post at the entrance, and with the visitor log, vaccination requirements for visitation, as well the Governor's Proclamation regarding visitation under certain circumstances if the resident is unvaccinated.
- The Facility/home must establish policies and procedures around tours of the home for the purpose of screening for prospective new residents. The policies and procedures should include when tours will occur, screening process before entry of visitor(s) into the home, movement about the facility during the tour, and adherence to 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.

- Visitors must be actively screened for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and 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) will be denied entry.
- Visitors must sign in, including contact information, in a visitor's log. Visitors must acknowledge they have reviewed the notice about the Governor's Proclamation regarding unvaccinated residents and visitation under certain circumstances. The log of visitors must be kept for 30 days.**
- 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.
- If both the resident and the visitor are fully vaccinated, while alone in the resident's room or the designated visitation area, residents and their visitor(s) can choose to have close contact (including touch) and to not wear source control. The resident and visitor may also eat together in the private area.
- If either the resident or the visitor has not been fully vaccinated, the safest approach is for resident and their visitor to maintain physical distancing (maintaining at least 6 feet between people). If the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing well-fitting source control.
- When moving about the facility and during encounters with staff or residents other than the person they are visiting, the visitor must wear source control.
- Visitors and residents should practice hand hygiene before and after the visitation.

CMS Compassionate Care Principles

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." 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. 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.

At all times, visits should be conducted using social distancing and visitors will wear PPE appropriate to the situation. Visitors should coordinate visits with the provider, thus allowing the provider the ability to take the compassionate care visit into consideration when applying the facility policies and procedures for visitation during that period of time (i.e. how many people overall are in the building, how long visitors are in the building, how much PPE is required). 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.

Visitation during an Outbreak

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. Facilities should consider visitation, group activities, and communal dining limitations based on status of COVID-19 infections in the facility. Facilities have flexibility to determine what is best for resident and staff safety to manage visitation. The facility will take into consideration the scope of residents in isolation and quarantine status. For example, the facility may not allow communal dining, group activities, and visitors, compassionate care, and designated visitors if active COVID-19 throughout the entire physical plant. Or, they may restrict these activities and visitation on particular wings/units with COVID-19 spread and allow on non-COVID units. (Outdoor Visitation Guidance for Long-term Care Settings.)

An outbreak exists when a new facility/home onset of COVID-19 occurs that meets the outbreak definition found here: Interim COVID-19 Outbreak Definition for Healthcare Settings. 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 can be contained to a single area (e.g., unit) of the facility/home or the LHJ is able to assist with recommendations, dependent on the layout of the setting:

- When a new case of COVID-19 is identified and the facility meets the outbreak definition found in the Interim COVID-19 Outbreak Definition for Healthcare Settings, a facility should immediately begin outbreak testing and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:
    - If the first round of outbreak testing reveals **no additional COVID-19 cases in other areas (e.g., units) of the facility**, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the

facility meets the criteria to discontinue outbreak testing. For example, if the first round of outbreak testing reveals two more COVID-19cases 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.
- Compassionate care visits should be allowed **at all times**, for any resident (vaccinated or unvaccinated) regardless of outbreak status.
- Window visits and visits using technology are not restricted or prohibited. Providers will permit window visits depending on grounds safety, resident privacy and choice, and facility capacity, case mix, and staffing. Providers will also assist with the use of technology to support continued social engagement during an outbreak.
- 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

For Nursing Facilities: *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.*

Visitor Log Information

Visitor's log information will include date, time in, name of visitor and their contact information, including phone number and email address if available. DOH Visitor Screening, Log, and Letter can be found here: https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/VisitorsLog.pdf.

Additional Resources

Influenza vs COVID-19

https://www.cdc.gov/flu/symptoms/flu-vs-covid19.htmTransfershttps://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/LTCTransferRecs.pdfRisk Assessment Template (quarantine for the purpose of this document is per template context)

https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/riskassessment_communityvisit.pdf

LHJ and DOH Assessment Teams

Consider an onsite or virtual LHJ/DOH COVID-focused Infection Control Assessment. This is a non-regulatory support to enhance facilities' internal infection control program.

Vaccination Resources