

Updated Guidance for MDH-Licensed Providers of Residential Settings with At-Risk Residents | COVID-19

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The Centers for Medicare/Medicaid Services (CMS) published updated guidelines for all Nursing Homes nationwide regarding visitation requirements in the CMS QSO memo 20 14 which can be read in its entirety here: [CMS QSO memo 20 14](https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf) (<https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf>)

The Health Regulation Division of the Minnesota Department of Health (MDH) is adopting this CMS guidance and any future revisions to apply to all providers licensed by MDH where *individuals at risk receive services*, such as:

- Housing With Services Establishments and their Arranged Home Care Providers
- Residential Hospices
- Licensed only Nursing Homes
- Licensed Supervised Living Facilities including Intermediate Care Facilities and PRTFs
- Licensed only (not certified) Boarding care homes
- Board and Lodge with Special Services providers

Restrictions for Visitors and Non-Essential Health Care Personnel:

Beginning immediately, facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In those cases, visitors will be limited to a specific room only. Facilities are expected to notify potential visitors to defer visitation until further notice (through signage, calls, letters, emails, etc.).

For visitors entering the facility in compassionate situations (e.g., end-of-life care), facilities should require visitors to perform hand hygiene and use Personal Protective Equipment (PPE), such as facemasks. Decisions about visitation during an end of life situation should be made on a case by case basis, which should include careful screening (review for symptoms of illness) of the visitor (including clergy, bereavement counselors, etc.) for fever or respiratory symptoms.

Those with symptoms of a respiratory infection (e.g., fever, cough, shortness of breath, or sore throat) should not be permitted to enter the facility at any time (even in end-of-life situations). Those visitors that are permitted, must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.

Additional Guidance can be located at the CDC website: [Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States](https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html) (<https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html>)

Exceptions to restrictions:

- Health care workers: Facilities should follow CDC guidelines for restricting access to health care workers found at [Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease \(COVID-19\)](https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html) (<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>).
- CDC guidance for health care workers in facilities also applies to other health care workers, such as hospice workers, EMS personnel, or dialysis technicians, who provide care to residents. They should be permitted to come into the facility as long as they meet the CDC guidelines for health care workers.
- Facilities should contact their local health department for questions, and frequently review the CDC website dedicated to COVID-19 for health care professionals [Information for Healthcare Professionals](https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html) (<https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>).

Additional guidance for providers includes:

1. Cancel communal dining and all group activities, such as internal and external group activities.
2. Implement active screening of residents and staff for fever and respiratory symptoms.
3. Remind residents to practice social distancing and perform frequent hand hygiene.
4. Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home.
5. For individuals allowed in the facility (e.g., in end-of-life situations), provide instruction, before visitors enter the facility and residents' rooms, provide instruction on hand hygiene, limiting surfaces touched, and use of PPE according to current facility policy while in the resident's room. Individuals with fevers, other symptoms of COVID-19, or unable to demonstrate proper use of infection control techniques should be restricted from entry. Facilities should communicate through multiple means to inform individuals and nonessential health care personnel of the visitation restrictions, such as through signage at entrances/exits, letters, emails, phone calls, and recorded messages for receiving calls.

6. Facilities should identify staff that work at multiple facilities (e.g., agency staff, regional or corporate staff) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19.
7. Facilities should review and revise how they interact vendors and receiving supplies, agency staff, EMS personnel and equipment, transportation providers (e.g., when taking residents to offsite appointments, etc.), and other non-health care providers (e.g., food delivery, etc.), and take necessary actions to prevent any potential transmission. For example, do not have supply vendors transport supplies inside the facility. Have them dropped off at a dedicated location (e.g., loading dock). Facilities can allow entry of these visitors if needed, as long as they are following the appropriate CDC guidelines for Transmission-Based Precautions.
8. In lieu of visits, facilities should consider:
 - a) Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).
 - b) Creating/increasing listserv communication to update families, such as advising to not visit.
 - c) Assigning staff as primary contact to families for inbound calls, and conduct regular outbound calls to keep families up to date.
 - d) Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, such as when it is safe to resume visits.
9. When visitation is necessary or allowable (e.g., in end-of-life scenarios), facilities should make efforts to allow for safe visitation for residents and loved ones. For example:
 - a. Suggest refraining from physical contact with residents and others while in the facility. For example, practice social distances with no hand-shaking or hugging, and remaining six feet apart.
 - b. If possible (e.g., pending design of building), creating dedicated visiting areas (e.g., "clean rooms") near the entrance to the facility where residents can meet with visitors in a sanitized environment. Facilities should disinfect rooms after each resident-visitor meeting.
 - c. Residents still have the right to access the Ombudsman program. Their access should be restricted per the guidance above (except in compassionate care situations), however, facilities may review this on a case by case basis. If in-person access is not available due to infection control concerns, facilities need to facilitate resident communication (by phone or other format) with the Ombudsman program or other advocates.
10. Advise visitors, and any individuals who entered the facility (e.g., hospice staff), to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility. If symptoms occur, advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the individuals they were in contact with, and the locations within the facility they visited. Facilities should immediately screen the individuals of reported contact, and take all necessary actions based on findings.

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