John Bel Edwards
GOVERNOR

Dr. Courtney N. Phillips
SECRETARY

State of Louisiana

Louisiana Department of Health

HEALTHCARE FACILITY NOTICE/ORDER
FOR IMMEDIATE RELEASE

TO: All licensed Nursing Facilities in Louisiana
All licensed Adult Residential Care Providers in Louisiana
All licensed Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DD)[1]

FROM: LDH Office of Public Health
Jimmy Guidry, M.D.
State Health Officer

RE: State Health Officer Order
(1) Nursing Home Visitation
(2) Adult Residential Care Provider Visitation
(3) ICF/DD Visitation

DATE: September 18, 2020

EFFECTIVE DATES: This Emergency Order shall be effective immediately, beginning 5:00 p.m. on September 18, 2020, and shall remain in effect until further notice from the State Health Officer.

RATIONALE AND LEGAL AUTHORITY:

On January 30, 2020, the International Health Regulations Emergency Committee of the World Health Organization declared the COVID-19 outbreak a "public health emergency of international concern" (PHEIC). On January 31, 2020, Health and Human Services Secretary Alex M. Azar II declared a public health emergency (PHE) for the United States, effective January 27, 2020. Pursuant to the Louisiana Health Emergency Powers Act, R.S. 29:760, *et seq.*, a state of public health emergency resulting from the outbreak of "coronavirus disease 2019" ("COVID-19") was declared to exist in the entire State of Louisiana by Proclamation Number 25 JBE 2020.

The COVID-19 outbreak in Louisiana continues. Measures are necessary to protect the health and safety of the public. The measures ordered herein are in line with the best guidance and direction from the Centers for Medicare and Medicaid Services (CMS).

[1] These facilities are also known as "intermediate care facilities for persons with intellectual disabilities".

The State Health Officer expressly finds that the measures ordered herein are necessary to help control and prevent further spread of COVID-19, a communicable, contagious, and infectious disease that represent a serious and imminent threat to the public health.

NOW THEREFORE, pursuant to the powers vested in me by L.R.S. 40:1 *et seq.*, particularly La. R.S. 40:4(A)(13) and La. R.S. 40:5(A)(2), I, Jimmy Guidry, M.D., State Health Officer, do hereby issue the following emergency order:

(1) All Nursing Facilities licensed in Louisiana, All Adult Residential Care Providers licensed in Louisiana, and all Intermediate Care Facilities for Persons with Developmental Disabilities (ICF/DDs) are mandated and directed to follow the provisions of the Centers for Medicare and Medicaid Services (CMS), QSO-20-39-NH, entitled "Nursing Home Visitation – COVID-19", as issued on September 17, 2020. A copy of such CMS Memorandum is attached.

(a) Each nursing facility, each adult residential care provider, and each ICF/DD shall revise its current visitation policy and procedure to reflect these new CMS provisions; such revisions shall include provisions in the facility's policies and procedures to maintain documentation, such as a visitor's log, that indicates, at a minimum, the following:

- **(i) Name of Resident receiving a visitor;**
- **(ii) Name of and contact number for Visitor(s);**
- **(iii) Date of the visit;**
- **(iv) Time of arrival and time of departure of the Visitor(s); and**
- **(v) Specific Location of the Visit on the facility's campus.**

(b) Each nursing facility is encouraged to enter the documentation/visitor log information noted in (1)(a)(i)-(v) into the LDH Office of Public Health electronic database. This will assist the nursing facilities with maintaining the documentation and will allow LDH to quickly provide assistance on infection control to the facility should the need arise.

(2) Any licensed-only (i.e., not certified for Medicare/Medicaid) nursing facility in Louisiana may impose stricter visitation policies than mandated in the CMS QSO-20-39-NH if the facility chooses, provided that the facility have a policy and procedure in place to address such visitation restrictions.

(3) Any adult residential care provider licensed in Louisiana may impose stricter visitation policies than mandated in the CMS QSO-20-39 if the facility chooses, provided that the facility have a policy and procedure in place to address such visitation restrictions.

(4) Any ICF/DD licensed in Louisiana may impose stricter visitation policies than mandated in the CMS QSO-20-39 if the facility chooses, provided that the facility have a policy and procedure in place to address such visitation restrictions.

(5) This State Health Officer Order replaces and supersedes any previously issued State Health Officer orders/notices to licensed nursing homes, licensed adult residential care providers, and licensed ICF/DDs regarding visitation.

Dr. Courtney N. Phillips

Dr. Courtney N. Phillips
Secretary

Jimmy Guidry, M.D

Dr. Jimmy Guidry, M.D.
State Health Officer

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: QSO-20-39-NH

DATE: **September 17, 2020**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Nursing Home Visitation - COVID-19

Memorandum Summary

- CMS is committed to continuing to take critical steps to ensure America's healthcare facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- **Visitation Guidance:** CMS is issuing new guidance for visitation in nursing homes during the COVID-19 PHE. The guidance below provides reasonable ways a nursing home can safely facilitate in-person visitation to address the psychosocial needs of residents.
- **Use of Civil Money Penalty (CMP) Funds:** CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar products) to create physical barriers to reduce the risk of transmission during in-person visits.

Background

Nursing homes have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality.[1] The vulnerable nature of the nursing home 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.

In March 2020, CMS issued memorandum QSO-20-14-NH providing guidance to facilities on restricting visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation. In May 2020, CMS released Nursing Home Reopening Recommendations, which provided additional guidance on visitation for nursing homes as their states and local communities progress through the phases of reopening. In June 2020, CMS also released a Frequently Asked Questions document on visitation, which expanded on previously issued guidance on topics such as outdoor visits, compassionate care situations, and communal activities.

[1] Information on outbreaks and deaths in nursing homes may be found at https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg.

While CMS guidance has focused on protecting nursing home residents from COVID-19, we recognize that physical separation from family and other loved ones has taken a physical and emotional toll on residents. Residents may feel socially isolated, leading to increased risk for depression, anxiety, and other expressions of distress. Residents living with cognitive impairment or other disabilities may find visitor restrictions and other ongoing changes related to COVID-19 confusing or upsetting. CMS understands that nursing home residents derive value from the physical, emotional, and spiritual support they receive through visitation from family and friends. In light of this, CMS is revising the guidance regarding visitation in nursing homes during the COVID-19 PHE. The information contained in this memorandum supersedes and replaces previously issued guidance and recommendations regarding visitation.

Guidance

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, 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:

Core Principles of COVID-19 Infection Prevention

- Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms), and denial of entry of those with signs or symptoms
- Hand hygiene (use of alcohol-based hand rub is preferred)
- 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 COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated 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. 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 Plexiglas dividers, curtains). Also, nursing homes 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.

Outdoor Visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred and can also be conducted in a manner that reduces the risk of transmission. Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever practicable. Aside from weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual resident's health status (e.g., medical condition(s), COVID-19 status), or a facility's outbreak status, outdoor visitation should be facilitated routinely. Facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing). We also recommend reasonable limits on the number of individuals visiting with any one resident at the same time.

Indoor Visitation

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

a) There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;
b) Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;
c) Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and
d) Facilities should limit movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room.

NOTE: 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 use the COVID-19 county positivity rate, found on the COVID-19 Nursing Home Data site as additional information to determine how to facilitate indoor visitation:

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

Facilities may also monitor other factors to understand the level of COVID-19 risk, such as rates of COVID-19-Like Illness[2] visits to the emergency department or the positivity rate of a county adjacent to the county where the nursing home is located. We note that county positivity rate does not need to be considered for outdoor visitation.

We understand that some states or facilities have designated categories of visitors, such as "essential caregivers," based on their visit history or resident designation. CMS does not distinguish between these types of visitors and other visitors. Using a person-centered approach when applying this guidance should cover all types of visitors, including those who have been categorized as "essential caregivers."

Visitor Testing

While not required, we encourage facilities in medium or high-positivity counties to test 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) with proof of negative test results and date of test.

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 would be consistent with the intent of, "compassionate care situations." Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident's needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included.

Lastly, at all times, visits should be conducted using social distancing; however, if during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following all appropriate infection prevention guidelines, and for a limited amount of time. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits.

---

[2] For information on COVID-19-Like Illness refer to https://www.cdc.gov/coronavirus/2019-ncov/covid-data/covidview/07102020/covid-like-illness.html.

Required Visitation

We believe the guidance above represents reasonable ways a nursing 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 PHE. However, facilities may not restrict visitation without a reasonable clinical or safety cause, consistent with §483.10(f)(4)(v). For example, if a facility has had no COVID-19 cases in the last 14 days and its county positivity rate is low or medium, a nursing home **must** facilitate in-person visitation consistent with the regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 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.

Access to the Long-Term Care 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; however, in-person access may not be limited without reasonable cause. We note that representatives of the Office of the Ombudsman should adhere to the core principles of COVID-19 infection prevention. If in-person access is not advisable, such as the Ombudsman having 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.

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 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.

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.

Entry of Health Care Workers and Other Providers of Services

Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or 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.

Communal Activities and Dining

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Residents may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). Facilities should consider additional limitations based on status of COVID-19 infections in the facility. Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and 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.

Survey Considerations

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance 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.

Use of CMP Funds to Aid in Visitation

Technology can help improve social connections for some residents by helping to support and maintain relationships with loved ones. CMS has previously approved the use of CMP funds (See QSO-20-28-NH) to purchase communicative devices, such as tablets or webcams, to increase the ability for nursing homes to help residents stay connected with their loved ones. To ensure a balanced distribution of funds, facilities are limited to purchase one communicative device per 7–10 residents, up to a maximum of $3,000 per facility.

Additionally, facilities may apply to use CMP funds to help facilitate in-person visits. CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar product) to create a physical barrier to reduce the risk of transmission during in-person visits. Funding for tents and clear dividers is also limited to a maximum of $3,000 per facility. NOTE: When installing tents, facilities need to ensure appropriate life safety code requirements found at 42 CFR 483.90 are met, unless waived under the PHE declaration.

To apply to receive CMP funds for communicative devices, tents, or clear dividers, please contact your state agency's CMP contact.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers, and the State/CMS Locations within 30 days of this memorandum.

/s/
David R. Wright

cc: Survey Operations Group