

State of South Dakota Back to Normal Long-Term Care Reopening Plan

Revised September 25, 2020

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 September 17, 2020 new guidance from 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. This plan applies to all NHs and ALCs in South Dakota. The information contained in the new CMS memorandum supersedes and replaces previously issued guidance and recommendations regarding visitation. The new CMS guidance allows for visitation to be conducted through different means based on a facility's structure and residents' needs. Visitations may occur in resident rooms, dedicated indoor visitation areas, outdoors, and allowing for circumstances beyond compassionate care situations.

The guidance represents reasonable ways a NH and ALC can facilitate in-person visitation. Except for on-going use of virtual visits, facilities may still reasonably restrict visitation. Restrictions may be determined by the COVID-19 community (county) positivity rate, the facility's COVID-19 status, a resident's COVID-19 status, visitor symptoms, the lack of visitor adherence to proper infection control practices, or other relevant factors related to the COVID-19 Public Health Emergency (PHE).

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 relax the current visitor restrictions. Visitation may occur safely and must be based on the community (county) test positivity rate, the absence of COVID-19 within the facility, and the core principles of COVID-19 infection prevention. The reopening plan provides guidance to the facility administrator and the governing board to direct how visitation will be allowed within the facility.

Facilities must have a plan with policies and procedures in place to ensure person-centered visitation is reasonably allowed and will occur based on the core principles of COVID-19 infection prevention and the COVID-19 test positivity rate in the community (county).

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 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)
- **Frequent cleaning and disinfecting** of highly touched surfaces in the facility including designated visitation areas following each visit
- Appropriate 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

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.

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](#).

- 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 visits to the emergency department or the positivity rate of a county adjacent to the county where the NH or ALC is located.

Essential Caregivers

Using a person-centered approach when applying this guidance should cover all types of visitors, including those who have been categorized as “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.

Outdoor Visitation

While 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. **The community (county) positivity rate does not need to be considered for outdoor visitation.**

Indoor Visitation

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

- There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;
- 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;
- 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
- 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.

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.

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.

In situations where the provider and family are unable to come to agreement on compassionate care visitation, the situation should be brought to the Compassionate Care Visitation Team, composed of facility administration, Department of Health staff and the Department of Human Services Ombudsman Program who will objectively discuss the situation and cooperatively develop a solution.

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](#).

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

On site surveys and access into all healthcare facilities by surveyors is required though Federal requirements and SD Codified Law.

Access to Ombudsman

As stated in previous CMS guidance QSO-20-28-NH (revised), Facilities shall provide Ombudsman access to residents as required under Residents Rights. This is per 42 CFR § 483.10(f)(4)(i) and per the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). **Long Term Care facilities are required by law to provide the state ombudsman immediate access to any resident.** The Ombudsman shall abide by the core principles of COVID-19 infection principles.

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.”

Testing of Visitors

Testing of visitors is not required. Facilities should consider in medium or high-positivity counties to test visitors, if feasible. If it is decided to test visitors, 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. Surveyor, ombudsman and advocacy staff do not have to be tested or have proof of testing for COVID-19.

References and Resources:

[Covid.sd.gov](https://www.covid.sd.gov)

[CDC.GOV](https://www.cdc.gov)

[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](#)

[CMS Memo QSO 20-30-NH](#)

[CMS Memo QSO 14-20-NH \(revised\)](#)