LTC Information Update: April 29, 2020

ANNOUNCEMENT

❖ First Phase of "Show Me Strong Recovery" Plan and Economic Reopening Order

Goes into effect at 12:01 a.m., Monday, May 4, 2020
Statewide Stay-at-Home Order still applies until then.

We have received several questions regarding the impact the Economic Reopening Order has on long-term care communities. The order addresses long-term care communities, specifically in paragraph #3 of the order, which states, "In accordance with the guidelines from the President, the CDC, and the Centers for Medicaid and Medicare Services, people shall not visit nursing homes, long-term care facilities, retirement homes, or assisted living homes unless to provide critical assistance or in end-of-life circumstances. Elderly or otherwise vulnerable populations should take enhanced precautionary measures to mitigate the risks of contracting COVID-19."

The guidances below issued by the Department on March 13th and March 17th continues to be in place.

Missouri Department of Health and Senior Services
P.O. Box 570, Jefferson City, MO 65102-0570 Phone: 573-751-6400 FAX: 573-751-6010
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Randall W. Williams, MD, FACOG
Director

Michael L. Parson
Governor

TO: All Long-Term Care Facilities

FROM: Director Randall Williams, MD, FACOG

DATE: March 13, 2020

RE: COVID-19 Visitor Restrictions

The Missouri Department of Health and Senior Services (DHSS) is dedicated to protecting the health and safety of our citizens. This especially includes those Missourians that make their home in residential care facilities, assisted living facilities, intermediate care facilities, skilled nursing facilities, and intermediate care facilities for individuals with intellectual disabilities.

In response to the COVID-19 concern DHSS is instructing facilities to impose restrictions on visitors. These recommendations include but are not limited to the following:

- 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.

- For individuals that enter 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 of the visitor (including clergy, bereavement counselors, etc.) for fever or respiratory symptoms. Those with symptoms of a respiratory infection (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.

- Exceptions to restrictions:
    - Health care workers: Health care workers, such as hospice workers, EMS personnel, or dialysis technicians, that provide care to residents, **should be permitted to come into the facility as long as they meet the CDC guidelines for health care workers** found at https://www.cdc.gov/coronavirus/2019-nco v/hcp/guidance-risk-assesment-hcp.html. Facilities should frequently review the CDC website dedicated to COVID-19 for health care professionals (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html).

- Additional guidance:
    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 non-essential 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, etc.) 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.
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.

The DHSS encourages facilities to view the information at the following link for the most up-to-date information:

https://health.mo.gov/living/healthcondiseases/communicable/novel-coronavirus/

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Randall W. Williams, MD, FACOG
Director

Michael L. Parson
Governor

TO: All Long-Term Care Facilities

FROM: Shelly Williamson, SLCR Administrator

DATE: March 17, 2020

RE: SLCR Guidance on Residents Leaving the Facility

This is guidance from SLCR; it is not a mandate but rather provides facilities with an avenue to protect the health and safety of residents.

It is appropriate for facilities to ask residents not to leave the facility, unless for a necessary medical reason that cannot be addressed in the facility. For those insistent on taking residents out of the facility, SLCR recommends the following:

- Only legally authorized persons may remove a resident from the facility. This may be a durable power of attorney for healthcare (if the DPOA has been enacted), a legal guardian or the resident themselves.
- Before a resident leaves, the facility should follow the discharge regulations to the extent possible so that the resident receives appropriate care while away from the facility.
- Upon leaving the facility, the resident, their legal representative and all those required by regulation should be given a **written emergency discharge notice**. It is imperative that the notice contain the required elements stated in regulation, including the reason for discharge (as permitted in regulation) and the location to which the resident is being discharged.
- Those taking the resident out of the facility are to be informed that the resident **will not** be permitted to return until the restrictions currently in place are lifted. When appropriate, residents may be required to obtain clearance from their medical provider which may include proof of a negative COVID-19 screening.

For residents, primarily in RCFs and ALFs, who leave the facility on a frequent basis, the facility will need to determine at what point those outings pose a risk to the health and safety of the residents in the facility. This includes, but is not limited to, the location the resident is going, whether there are positive COVID-19 cases in the community, whether there is community transmission of the virus, etc. This guidance does not require facilities to issue an emergency discharge notice every time a resident leaves a facility. The resident and their legal guardian, when applicable, should discourage outings, attempt to meet the needs of residents without them leaving the facility, clearly communicate the expectations to residents (including any screening required upon return) and work together should the need arise to give an emergency discharge notice.

The DHSS encourages facilities to view the information at the following link for the most up-to-date information:

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