STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185341	A. BUILDING _____ B. WING _____	12/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN ACRES HEALTHCARE	**402 W. FARTHING STREET MAYFIELD, KY 42066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Emergency Preparedness Survey was initiated on 12/16/2020 and concluded on 12/18/2020. There was no deficient practice identified with 42 CFR 483.73 related to E-0024 (b)(6).	E 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 01/17/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185341	A. BUILDING _____ B. WING _____	R 03/29/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN ACRES HEALTHCARE	402 W. FARTHING STREET MAYFIELD, KY 42066

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An Onsite Revisit conducted on 03/29/2021 determined the facility was in compliance on 03/14/2021, as alleged in the acceptable POC.	{F 000}		

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	185341	A. BUILDING _____ B. WING _____	R 03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREEN ACRES HEALTHCARE	**402 W. FARTHING STREET MAYFIELD, KY 42066**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An Onsite Revisit conducted on 03/11/21 for the 12/18/2020 survey, determined the facility remained out of compliance at a Scope and Severity of an "E".	{F 000}		
{F 880} SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	{F 880}		3/14/21

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Electronically Signed | 03/18/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 880}	Continued From page 1 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of door signage and facility Isolation Resident list, review	{F 880}	F 880	

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{F 880}	Continued From page 2 of facility Plan of Correction (POC),and facility provided memo, it was determined the facility failed to take appropriate action to contain the spread of COVID-19 for four (4) of five (5) sampled residents (Resident #1, #2, #3, and #5). Observations on 03/11/2021, revealed staff failed to remove (doff) gown and shield prior to exiting Resident #3's room (on isolation) and entering Resident #1's room (on isolation); to obtain vital signs. In addition, further observation revealed staff failed to put on (don) gown, gloves, and shield and use designated equipment when obtaining Resident #2's and Resident #5's (not on isolation) vital signs. The findings include: Review of Cabinet for Health and Family Service, Office of Inspector General, Provider Guidance Memo: Admission, Discharge, and Transfer for Long-Term Care Facility Residents", dated 08/28/2021, which was provided by Director of Nursing when asked for policy on new admissions, readmissions, and residents who leave facility for appointments/dialysis, revealed residents should be quarantined and monitored for COVID-19 signs or symptoms for fourteen (14) days. Further review revealed staff were to wear facemask, and perform hand hygiene for all care giver-resident interactions. Add gown and gloves for any activity involving close contact with the resident or the resident's environment. Review of the facility list kept at nursing stations titled, "Isolation Residents", dated 03/11/2021, revealed the following: 1. Resident #3 went out to emergency room and	{F 880}	This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Residents #1, 2, 3 & 5 have been assessed using the infection/Covid assessment with no negative outcomes. Plans of care have been reviewed and updated as needed. On 3/11/21 the Director of Nursing (DON) provided 1:1 re-education to State Registered Nurse Aide (SRNA) #1 and #2. Re-education included wearing Personal Protective Equipment (PPE) when providing hands on resident care and facility policy on isolation precautions, including but not limited to when, where and how to don PPE, when where and how to doff PPE and obtaining vital signs on residents requiring isolation. Upon notification of alleged deficit practice, vital signs equipment throughout facility were sanitized by Regional Director of Clinical Services (RDCS), the DON and Assistant Director of Nursing (ADON) of a sister facility. 2. All residents are at risk of being	

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{F 880}	Continued From page 3 returned to facility on 03/01/2021, and was placed on isolation with a discontinue date of 03/15/2021. 2. Resident #1 was a dialysis resident and would stay on isolation. 3. Resident #2 was a new admit on 03/01/2021 and was placed on isolation and would remain on isolation until 03/15/2021. Review of the facility's acceptable PoC, submitted on 01/07/2021, revealed re-education would be provided by the DON and would include but not be limited to wearing PPE when providing hands on resident care, facility policy including but not limited to isolation precautions, which residents were placed on isolation including but not limited to new admissions, re-admissions and dialysis residents, PPE accessibility, and restocking of PPE. However, the following observations were made related to staff not donning and doffing the appropriate PPE prior to entering and exiting residents rooms, who were on isolation related to COVID-19. Observations on 03/11/21 at 8:15 AM, revealed Personal Care Aide (PCA) #1 donned a gown, gloves, face shield and booties and obtained a dedicated stethoscope and blood pressure cuff from the two-drawer container outside Resident #3's room. A sign on the door read, "Isolation, please check with nurse before entering. Isolation protocol must be followed." PCA #1 then entered the resident's room and obtained the resident's vital signs. She exited the room without doffing the gown, gloves, booties, and face shield, then entered Resident #1's room who was also on Isolation, and obtained his/her vital signs. PCA	{F 880}	affected by this alleged deficit practice. On 3/11/21 the DON and ADON of a sister facility completed Infection/Covid assessments on current in-house residents with no signs or symptoms of infection noted. 3. On 3/11/21 the Regional Director of Operations (RDO) and RDCS provided re-education to the Interdisciplinary Team (IDT). The IDT consists of the Nursing Home Administrator (NHA), DON, ADON, MDSC (Minimum Data Set Coordinator), BOM (Business Office Manager), Dietary Manager (DM), Central Supply and Therapy Manager. Re-education included but was not limited to wearing PPE when providing hands on resident care, to include obtaining vital signs on residents requiring isolation. Re-education also included facility policy on when to don PPE, how to don PPE, where to don PPE, how to doff PPE, when to doff PPE, where to doff PPE. On 3//11/21 the DON initiated re-education for facility staff on the above education. No staff will be allowed to work after the facility□s date of compliance until re-education has been provided. This education will be added to the facility□s new hire orientation program. On 3/12/21 an ad hoc Quality Assurance meeting was held per telephone with the Medical Director, NHA, DON, RDO and RDCS to discuss the alleged deficit practice and the plan of correction. 4. Beginning 3/14/21, a multiple-choice query sheet was implemented and will be	

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{F 880}	Continued From page 4 #1 was then observed to come out on hall without doffing shield and gown, untied gown; then removed shield and placed shield on counter in nurse's station, and walked into room with "bath" sign on door. She exited the "Bath" room with gown folded in hand, then entered "Soiled" room. She then exited the room no longer having gown. Interview with PCA #1, on 03/11/2021 at 12:11 PM, revealed there were red signs outside residents' rooms that were on isolation and a list at the nurses' station that listed the residents who were on isolation, when initiated, why, and when come off. PCA #1 stated staff were supposed to put on gown, gloves, face shield, mask, and booties when entering resident's room and remove all but mask prior to exiting room. She revealed there were trash barrels in the rooms with lids to place the used gown, gloves, and booties in. Continued interview revealed when she obtained Resident #3's vital signs that morning, she heard Resident #1 calling her name and hurried to enter room. However, this Surveyor did not hear the resident call her name and observed her obtain Resident #1's vital signs. She stated she was educated to remove the gown, gloves, and shield prior to exiting room and to don new gown, gloves, and booties prior to entering Resident #1's room and the failure to do so could have resulted in the spread of COVID-19. Observations on 03/11/2021 at 10:20 AM, revealed Certified Nurse Aide (CNA) #1 was in Resident #2's room, squatted down to resident who was laying on mattress, and obtained the resident's vital signs. CNA #1 was not wearing a gown, shield, or gloves and was using a non-designated stethoscope and blood pressure	{F 880}	completed by the IDT. The query sheet will include a query of staff on where, when and how to don and doff PPE, how to obtain vital signs on residents requiring isolation as well as observation of staff donning, doffing and wearing appropriate PPE while providing resident care and obtaining vital signs. This audit will be completed on 5 staff members daily x 2 weeks and then 5 times weekly x 3 months. A resident observation/rounding audit has been revised and implemented to ensure that staff are utilizing appropriate PPE for resident care per policy, to include donning, doffing and obtaining vital signs. The DON, ADON and NHA will complete the care observation audit on 3 residents requiring isolation daily x 2 weeks and then 3 times weekly x 3 months. Any identified non-compliance will result in 1:1 re-education with progressive discipline for further identified non-compliance. 5. Results of audits will be forwarded monthly to the Quality Assurance Performance Improvement Committee (QAPI) for further review and recommendations as deemed appropriate until sustained compliance is achieved. The QAPI Committee consists of the NHA, DON, ADON, MDS, DM, Maintenance Director, BOM and Medical Director. 03/14/2021	

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{F 880}	Continued From page 5	{F 880}		

cuff. She exited the room, and then entered Resident #5's room that was not on isolation, and obtained his/her vital signs using the same blood pressure cuff and stethoscope.

Interview with CNA #1, on 03/11/2021 at 1:00 PM, revealed staff were supposed to don gown, shield, and gloves prior to entering room, and use designated vital sign equipment when obtaining vital signs from residents that were on isolation. She stated the residents on isolation had signs and drawers outside their rooms and there was a list of residents kept at nursing station. Continued interview revealed she was educated to do this and knew to do this but failed to do so. She stated the failure to do so could have resulted in the spread of infection to include COVID-19.

Interview with the Director of Nursing, on 03/11/2021 at 1:08 PM, revealed all staff were educated to don gown, gloves, and mask, then knock on door, provide needed care, then doff everything and place in barrels in room, sanitize hands, and then exit room. She stated that new hires were also educated. The DON further revealed the supplies were on doors and in drawers outside each resident's room, and there were barrels in room for doffed Personal Protective Equipment (PPE). Continued interview revealed these residents also have designated vital sign equipment stored on doors or in drawers outside of room that should be used to obtain vital signs. She stated they had been monitoring to ensure staff were donning and doffing PPE and using designated equipment, and had not identified any concerns. She stated the staff's failure to don and doff the appropriate PPE when entering and exiting resident rooms,

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{F 880}	Continued From page 6 and failure to use designated vital sign equipment to obtain vital signs could have resulted in the spread of COVID-19.	{F 880}		

Green Acres Healthcare Facility
DPOC 3/18/2021

The attached information has been reiterated by one-on-one presentation to each of our staff, to include licensed nurses, CNA's, contracted therapy, environmental, and dietary service providers, to ensure comprehension regarding the importance, requirements, reasons, and the methods of isolation and infection control.

This information has been provided to each employee via one-on-one re-education, as well as hard copies remaining in binders for referencing at each nurse station. Written re-education with signature validation was obtained for each employee at the time of training to confirm the receipt and comprehension of the information communicated. A 5-question and answer quiz was also given to each employee to further establish understanding of infection control policies.

Moving forward, there will be random and on-going post-testing until compliance is achieved. The informative posters remain adhered to the walls in high visibility areas. The compliance audits will be performed as stated in the materials. The PPE station filling will be performed by third shift as part of the nightly assignments. The red signage (picture attached) has been placed on the wall under the isolation resident's ID plate for the isolation status to be more obvious to the attendants. The employees are also being presented and reminded of this information in their staff meetings for 6 months, with the YouTube video site being made available on our educational television the week of March 13-18, 2021; the site will also be shared with them again to allow for independent viewing. It will be shown again in a mandatory meeting in 2 months in May. There will be a current listing of isolation residents at the nurses station with resident name, room #, reason, and end date. The DON and/or ADON will be responsible for keeping this list current; however, each charge nurse is required to review it with the attendants during report and assignments. The administrator will be given a current copy daily.

Since it is concluded that ineffective teaching of proper infection control, along with the importance of following policy, and the rationale that mandates it, is the primary root cause of our deficit, these changes should rectify the problem and keep the facility compliant with isolation protocol. These changes were discussed and validated in a QAPI meeting on March 12, 2021 with the medical director, Dr. Wayne Williams, present via conference call, NHA, DON, RDO, and RDCS and are now integrated into the QAPI program and will be reviewed as stated in the attachments.

Submitted by Cynthia A. Cox, LPN, LNHA
Green Acres Healthcare Facility

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F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control Survey was initiated on 12/16/2020 and concluded on 12/18/2020. The facility was found not to be in compliance with 42 CFR 483.80 infection control regulations and has not implemented the Centers for Medicare & Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Total census 54.	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		1/23/21

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F 880	Continued From page 1	F 880		

but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation, record review, interview, and facility policy review it was determined the facility failed to implement an effective infection control program for eight (8) of eight (8) sampled residents (Residents #1, #2, #3, #4, #5, #6, #7, and #8). Residents #1 through #7 were on isolation precautions and/or received dialysis offsite; however, there was no personal protective equipment (PPE) available in room/on the door/or outside the door for easy access. In addition, a staff failed to don gown, gloves, and shield per facility policy while providing Occupational Therapy to Resident #3 (dialysis) and care for Resident #8 at the time he/she was readmitted to the facility. Furthermore, staff failed to set up PPE for Resident #8 outside resident room when readmitted from acute care facility. The findings include: Review of facility policy titled, "Guidelines for Care of In-House Residents with Known or Suspected COVID-19", not dated, revealed residents with known or suspected COVID-19 would be placed in droplet isolation and should be housed in the same room for the duration of stay to minimize room transfers and decrease spread of infection. Resident doors should remain closed as safety of the resident allows and the curtain be pulled between those who are sharing a room at all times. The designated unit shall have designated equipment such as blood pressure cuff, thermometer, pulse oximeter, etc.;	F 880	F880 This Plan of Correction is the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. 1. Residents # 1,2,3,4,5,6,7,8 have been assessed using the infection/Covid assessment with no negative outcomes. Plans of care have been reviewed and updated as needed. Certified Nurse Aide (CNA) #2, Licensed Practical Nurse (LPN) # 4 and the Occupational Therapist continue to be employed by the facility and have received 1:1 re-education regarding wearing Personal Protective Equipment (PPE) when providing hands on resident care, facility policy including but not limited to isolation precautions, PPE accessibility, and restocking of PPE. 2. All residents are at risk of being affected by this alleged deficit practice. A medical record review including review of	

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	185341	A. BUILDING _____ B. WING _____	12/18/2020

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F 880	Continued From page 3 and be properly cleaned between use. Review of facility documents titled, "Provider Guidance Memo: Admission, Discharge, and Transfer for Long-Term-Care Facility (LTCF) Residents", dated 08/28/2020 revealed if resident was without a history of COVID-19 and without COVID-19 symptoms, quarantine and monitor the resident for COVID-19 signs and symptoms for fourteen (14) days following admission. Wear facemask, eye protection and perform hand hygiene for all caregiver-resident interactions; and gowns and gloves for any activity involving close contact with the resident or the resident's environment. Review of facility policy titled "Guidelines for All Masks and other PPE", not dated, revealed full PPE should be worn per Center for Disease Control (CDC) guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE. Review of facility documentation of Use of Personal Protective Equipment (PPE) when caring for patients with confirmed or suspected COVID-19 from the CDC dated 03/03/2020, revealed PPE must be donned before entering the patient area, and must remain in place and be worn correctly for the duration of work in potentially contaminated areas. Review of facility documents titled, "Interim Infection Prevention and Control Recommendation for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings from the CDC (Section #5), not dated, revealed heath care professionals (HCP) who enter the room of a	F 880	Progress Notes and Covid assessments for past 30 days has been completed by Director of Nursing (DON), Administrator (NHA), Assistant Director of Nursing (ADON) to identify residents with possible infections. No residents were identified. 3. A re-education meeting has been scheduled on 01/22/2021 for Nursing and Therapy staff. Re-education will be provided by the DON and will include but not be limited to wearing PPE when providing hands on resident care, facility policy including but not limited to isolation precautions, which residents are placed on isolation including but not limited to new admissions, re-admissions and dialysis residents, PPE accessibility, and restocking of PPE. The Interdisciplinary Team (IDT) consisting of the NHA, DON, ADON, MDS, BOM, Dietary Manager (DM), Central Supply, Therapy Manager, will discuss any new admissions, re-admissions or newly diagnosed residents requiring isolation in the Morning Stand-Up Meeting. Based on information provided from the Stand-Up Meeting, the ADON will be responsible to initiate isolation precautions including but not limited to setting up of PPE so it is accessible to staff. Central Supply staff will be responsible for completing rounds on residents requiring isolation PPE two times daily, 5 times weekly to ensure that appropriate PPE is available and easily accessible to staff. Central Supply will be responsible for any required restocking of PPE as a result of these rounds. Central	

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F 880	Continued From page 4 patient with known or suspected COVID-19 should adhere to Standard Precautions and use a respirator or facemask, gown, gloves, and eye protection. When available respirators instead of face masks were preferred. Dedicated medical equipment should be used when caring for patients with known or suspected COVID-19. 1. Review of the facility Center for Medicaid Services (CMS) 802 revealed Residents #1, #2, #3, #4, #5, and #6 were on transmission based precautions. In addition, the CMS 802 revealed Resident #1, #2, and #7 received Hemodialysis offsite. However, observation on initial tour on 12/16/2020, beginning at 11:25 AM, revealed there was no PPE at entrances to Residents #1, #2, #3, #4, #5, #6, and #7's rooms to provide easy access to the supplies needed. Further observation revealed there were trash bins in the rooms with red trash bags in them. Further observation on 12/16/2020 at approximately 12:32 PM, while at Resident #2 (dialysis patient) and Resident #3's room with Certified Nurse Aide (CNA) #1, revealed an Occupational Therapist was providing hands on therapy with Resident #3 while wearing only a mask. She had no gown and/or gloves on. There was no PPE outside or inside room and interview with CNA #1 at that time, revealed when there was no PPE at door of rooms, staff had to go to Central Supply to get PPE, and had to sign it out. Interview and observation, on 12/16/2020 at 12:40 PM, with Central Supply (CS) personnel, revealed she unlocked the supply room door with her keys. Review of the sign-out clipboard in the room revealed there had been no PPE (gowns, gloves, shoes, disinfectant wipes, or shoe covers)	F 880	Supply and the ADON will review each nurse□s station 5 times weekly to ensure that an adequate back-up supply of PPE is available to staff. Central Supply will be responsible for re-stocking the back-up supply of PPE as needed. 4. An audit/observation sheet has been implemented and will be completed by the IDT. Audit will include observation of PPE to ensure there is an adequate supply that is easily accessible to staff and will be completed daily x 2 weeks and then 5 times weekly x 3 months. A resident care observation audit has been implemented to ensure that staff are utilizing PPE for resident care per policy. The DON, ADON and NHA will complete the care observation audit on 3 residents requiring isolation daily x 2 weeks and then 3 times weekly x 3 months. Any identified non-compliance will result in 1:1 re-education with progressive discipline for further identified non-compliance. 5. Results of audits will be forwarded to the Quality Assurance Performance Improvement Committee (QAPI) for further review and recommendations as deemed appropriate. The QAPI Committee consists of the NHA, DON, ADON, MDS, DM. 01/18/2021	

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signed out for use that day. She stated if there were residents on isolation she would have expected there to be some PPE signed out for use, but there was not. In addition, the CS personnel and State Surveyor observed an empty PPE storage bin on Resident #7's door (a dialysis patient). The CS personnel stated the storage bin needed restocking of gowns and gloves.

Interview with the Occupational Therapist (OT), on 12/16/2020 at 2:25 PM, revealed she thought since Resident #3 had been at the facility for a long time it was not necessary to wear the PPE (gown, gloves, shield).

Interview with Rehab Director on 12/16/2020 at approximately 3:26 PM revealed she expected her staff to wear proper PPE (gown , gloves, face-shield, and mask). She stated she expected the PPE to be readily available for usage at the room.

Interview on 12/16/2020 at approximately 12:20 PM with CNA #1 revealed Resident #1 was a new admit and on isolation precautions for fourteen (14) days in case he/she has COVID-19. She stated staff have to gown up (wear PPE such as gown, gloves, and mask) prior to entering room and the PPE was supposed to be on door or staff should obtain from hallway closet. Observation of closet on hallway revealed storage bins tossed behind a linen cart and some storage bins tossed against a back wall with no PPE available within them.

Interview on 12/16/2020 at 2:15 PM, with Certified Medication Technician (CMT) #1, revealed PPE was the responsibility of the charge nurse and if there was none in the linen closet they would

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have to go with the charge nurse to central supply for PPE.

Interview with Licensed Practical Nurse (LPN) #1, on 12/16/2020 at 12:55 PM, revealed Resident #1, #2, #6, and #7 were on isolation precautions due to dialysis. LPN #1 stated it was the nurses/or the admitting nurses responsibility to fill the PPE storage bins with the needed PPE and it had not been done that day. She revealed the PPE should be used upon entrance into the dialysis/or new admits room. Additionally, LPN #1 stated the equipment used for vital signs (stethoscope, blood pressure cuff, pulse oximeter, thermometer) should be in the room and/or outside the door to check vital signs (VS), because of precautions for infection control.

2. Observation on 12/16/2020 at 2:05 PM, revealed Resident #8 being brought into his/her room by Emergency Medical Technicians (EMT) via a stretcher. LPN #4 and CNA #2 were going in and out of the room only wearing masks. At approximately 2:15 PM, LPN #4 and CNA #2 were observed straightening bed linens for Resident #8 to get into bed with just masks being worn. The LPN and CNA were not wearing gowns and there was no PPE on or outside the resident's room.

Further observation on 12/16/2020 at 4:30 PM, revealed Resident #8's room still had no PPE on door, in the storage bin, or within the perimeter of Resident #8's room.

Interview with CNA #2, on 12/16/2020 at 2:50 PM, revealed the nurses had to unlock the Central Supply door to get PPE for staff. CNA #2 stated if resident had signs or symptoms of COVID 19,

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then the resident needed to be on isolation. She revealed Resident #8 had been to the hospital and was just coming back to the facility.

Interview with LPN #4, on 12/16/2020 2:00 PM, revealed Resident #8 was a readmit. He stated a new admit was supposed to quarantine for fourteen (14) days and he was supposed to put gowns, gloves, blood pressure cuffs, and stethoscope on door for readmits related to the possibility of being COVID positive. He revealed he was not sure about dialysis residents. LPN #4 stated he had not been told what kind of precautions residents were on so he assumed droplet and that was about all he knew.

Interview with LPN #2/Charge Nurse, on 12/18/2020 at 2:29 PM, revealed residents that came to the facility as new admits, or go out to the emergency room and return were placed on isolation for fourteen (14) days. LPN #2 stated if residents go out of facility for dialysis they stayed in isolation. She revealed Resident #8 should have been on isolation when he/she arrived. LPN #2 revealed there was an inservice for this the night of the initial FICS (Focused Infection Control Survey). She revealed she did not know why the PPE was not available on the doors for the staff to provide care to the residents; and this could result in possible transmission of infections. LPN #2 stated the charge nurse was responsible for hanging PPE on the door, if not available, and she had tried to keep up with it, but with no PPE on the doors she stated it looked like a fail to her. LPN #2 stated the ADON, the DON, and the Administrator would be who monitored to ensure the Charge Nurse was keeping the items restocked.

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Interview with Assistant Director of Nursing (ADON), on 12/16/2020 at 1:30 PM, and on 12/18/2020 at 3:09 PM, revealed PPE and the equipment should be available to staff to prevent staff from getting an infectious disease from the resident and the resident from getting one from staff. The ADON stated the admitting nurse should have ensured the needed PPE and equipment was available in the room or on the door. She revealed there was no Infection Control Nurse (IFCN) and no one assigned to perform the ICFN's duties. She stated a couple of nurses have tried to work on it, out of the kindness of their hearts, but no one was overseeing infection control, at this point and time. Additionally, the ADON stated when a resident returned to the facility he/she should be placed on isolation precautions and PPE placed on resident's door at that time.

Interview and observation tour on 12/16/2020 at 1:02 PM, and at 12/18/2020 at 1:29 PM, with acting Director of Nursing (DON), revealed if a resident was on dialysis or was a new admit, they should have PPE in the storage bin or on the door (gown, gloves, and face-shield). The acting DON stated it was the charge nurse or the admitting nurse's responsibility. She revealed there should be equipment in the rooms to take the residents vital signs for each resident on isolation, and these things should always be there because of the possibility of cross-contamination. The DON stated there was no IFCN and she was not covering those duties. The DON further revealed residents on transmission based isolation precautions required staff to wear PPE anytime they provided care to the resident. She stated the PPE should be on door or just inside the door. The DON stated the IFCN was responsible to

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ensure PPE hung on doors, but the facility did not have one at this time, so the responsibility fell on herself or the ADON. She revealed this failure could result in something contagious being spread to staff and residents. The DON stated the monitoring should be a group effort with CNA's, therapy, etc. reporting when there was no PPE available at the doors to nurse.

Interview upon entrance to the facility on 12/16/2020 at 11:15 AM and on 12/17/2020 at 3:04 with Administrator revealed the facility had no IFCN. The Administrator stated an IFCN and new DON would be starting in two (2) weeks. She revealed the ADON was doing the tracking and trending of infections since IFCN left and LPN #2 was helping with oversight along with the ADON, since the SDC left approximately two months ago.

Isolation – Categories of Transmission-Based Precautions

Policy Statement

1. Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others.

2. The facility shall make every effort to use the least restrictive approach to managing individuals with potentially communicable infections. Transmission-Based Precautions shall only be used when transmission cannot be reasonably prevented by less restrictive measures.

Policy Interpretation and Implementation

1. Transmission-Based Precautions will be used whenever measures more stringent than Standard Precautions are needed to prevent or control the spread of infection.

2. Based on CDC definitions, three types of Transmission-Based Precautions (airborne, droplet and contact) have been established.

Airborne Precautions

3. In addition to Standard Precautions, implement Airborne Precautions for anyone who is documented or suspected to be infected with microorganisms transmitted by airborne droplet nuclei (small-particle residue [5 microns or smaller in size] of evaporated droplets containing microorganisms that remain suspended in the air and can be widely dispersed by air currents within a room or over a long distance).

2. ***If the facility does not have an Airborne Infection Isolation (AII) room, Airborne Precautions cannot be provided. Any resident suspected of having an Airborne Infectious Disease shall be masked and transported to a facility with an AII room.***

3. Examples of infections requiring Airborne Precautions include, but are not limited to:
   a. Measles
   b. Varicella (including disseminated zoster)
   c. Tuberculosis

4. Resident Placement

a. If necessary and if such a room is available, place the resident in a private room that meets the following criteria:
   (1) Monitored negative air pressure in relation to the surrounding areas;
   (2) Six (6) to twelve (12) air changes per hour;
   (3) Appropriate discharge of air outdoors or monitored high efficiency filtration of room air before the air is circulated to other areas of the facility.
   b. Keep the room door closed and the resident in the room.
   c. If there is not a room in the facility that meets these criteria, then cohort the individual with someone else who is infected with the same microorganism.

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d. If isolation in a negative pressure room is essential to prevent transmission of the illness (for example, with active TB), transfer the individual to a setting that can provide the appropriate kind of isolation room.
e. If facility does not have a negative air pressure room and if a resident has positively been confirmed as having TB, the resident will be masked and placed in a room with the door closed until the resident can be transferred to acute care setting.

5. Respiratory Protection

a. All individuals must wear approved respiratory protection when entering the room.
b. Anyone who is susceptible (i.e., not immune) to measles (rubeola) or varicella (chickenpox) may not enter the room of someone who has, or is suspected of having, these infections.

6. Resident Transport

a. The resident should only leave an isolation room when absolutely essential.
b. Someone who is on Airborne Precautions, should wear a mask when leaving the room or coming into contact with others. Depending on the organism, a special filtration mask may be necessary.
c. If the resident is transported to another unit within the facility or to another facility, the Infection Preventionist (or designee) will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions.

7. Resident-Care Equipment

a. When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, bedside commode, or electronic rectal thermometer to a single resident (or cohort of residents) to avoid sharing between residents.
b. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident.

8. Signs – The facility will implement a system to alert staff to the type of precaution resident requires.

a. This facility utilizes the following system for identification of Airborne Precautions _____.
b. The facility will also ensure that the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident.

Contact Precautions

1. In addition to Standard Precautions, implement Contact Precautions for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The decision on whether precautions are necessary will be evaluated on a case by case basis.

2. Examples of infections requiring Contact Precautions include, but are not limited to:

a. Infections with multi-drug resistant organisms (determined on a case by case basis);
b. Diarrhea associated with Clostridium difficile;
c. Enterohemorrhagic Escherichia coli 0157:H7;
d. Shigella;
e. Hepatitis A;
f. Diarrhea associated with Rotavirus;
g. Heavily draining wounds with noncontained drainage;
h. Pediculosis;
i. Scabies;

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3. Resident Placement

a. Place the individual in a private room if possible.
b. If a private room is not available, the Infection Preventionist will assess various risks associated with other resident placement options (e.g., cohorting, placing with a low risk roommate).

4. Gloves and Handwashing

a. In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room.
b. While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage).
c. Remove gloves before leaving the room and perform hand hygiene.
d. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room.

5. Gown

a. Wear a disposable gown upon entering the Contact Precautions room or cubicle.
b. After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces.

6. Resident Transport

a. For individuals with skin lesions, excretions, secretions, or drainage that is difficult to contain, maintain precautions to minimize the risk of transmission to other residents and contamination of environmental surfaces or equipment.
b. If the resident is transported to another unit within the facility or to another facility, the Infection Preventionist (or designee) will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions.

7. Resident-Care Equipment

a. When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, bedside commode, or electronic thermometer to a single resident (or cohort of residents) to avoid sharing between residents.
b. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident.

8. Signs – The facility will implement a system to alert staff to the type of precaution resident requires

a. This facility utilizes the following system for identification of Contact Precautions for staff and visitor: placement of sign to alert staff and visitors to see nurse prior to entering room.
b. The facility will also ensure that the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident.

Droplet Precautions

2. In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in size] that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning).

3. Examples of infections requiring Droplet Precautions include, but are not limited to:

a. Invasive *Haemophilus influenzae* type B disease including meningitis, pneumonia and epiglottitis;
b. Invasive *Neisseria meningitidis* disease, including meningitis, pneumonia, and sepsis;
c. *Mycoplasma pneumonia*;
d. *B. pertussis*;
e. Influenza;
f. Mumps;
g. Rubella.
h. SARs-CoV-2

4. Resident Placement

a. Place the resident in a private room if possible.
b. When a private room is not available, residents with the same infection with the same microorganism but with no other infection may be cohorted.
c. When a private room is not available and cohorting is not achievable, use a curtain and maintain at least 3 feet of space between the infected resident and other residents and visitors.
d. Special air handling and ventilation are unnecessary and the door to the room may remain open.

5. Masks

In addition to Standard Precautions, put on a mask when entering the room or cubicle. An N-95 mask (if available) should be worn during any aerosol generating activities ie; (tracheostomy care, respiratory treatments).

6. Gloves and Handwashing

e. In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room.
f. While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage).
g. Remove gloves before leaving the room and perform hand hygiene.
h. After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room.

7. Gown

i. Wear a disposable gown upon entering the Contact Precautions room or cubicle if you will have direct contact with the resident or environmental services.
j. After removing the gown, do not allow clothing to contact potentially contaminated environmental surfaces.

8. Resident Transport

a. Limit movement of resident from the room to essential purposes only.
b. Residents with presumptive or confirmed diagnosis of SARs-Cov-2 will be transported from room for essential purposes only.
c. If transport or movement from the room is necessary, place a mask on the infected individual and encourage the resident to follow respiratory hygiene/cough etiquette to minimize dispersal of droplets.
d. If the resident is transported to another unit within the facility or to another facility, the Infection Preventionist (or designee) will notify the unit or facility of the type of precautions the resident is on and the resident's suspected or confirmed type of infection. The facility is also responsible for notifying transport staff of residents that require special care due to infectious conditions.

9. Resident-Care Equipment

a. When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer, bedside commode, or electronic rectal thermometer to a single resident (or cohort of residents) to avoid sharing between residents.

b. If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident.

10. Signs – The facility will implement a system to alert staff and visitors to the type of precaution the resident requires.

11. This facility utilizes the following system for identification of Droplet Precautions: placement of sign alerting staff and visitors to see nurse prior to entering room.

12. The facility will also ensure that the residents care plan and care specialist communication system indicates the type of precautions implemented for the resident

continues on next page

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Review	
Date of Clinical Team Review	3/26/2020
Other References	*CDC Guideline for Isolation Precautions* (See Centers for Disease Control and Prevention's website at: http://www.cdc.gov/hicpac/2007IP/2007isolationPrecautions.html

GREEN ACRES

POC EDUCATION

F880

1. **PPE**
   a. PPE on the non-Covid unit will be readily accessible to staff and will be placed on the residents room door or in the PPE designated containers located throughout the hall or outside of the isolation room.
   b. Back-up PPE supplies will be kept at the nurses station. Supplies will be audited by Central Supply and the ADON 5 times weekly to ensure there are adequate back-up supplies. Central Supply will restock the back-up supplies as needed based on this audit. **PPE does not include red bags for trash or laundry. Red bags are only recommended for items saturated with visible blood.**
   c. PPE containers/door hangers will be audited 2 times daily 5 days per week by Central Supply. Central Supply will restock supplies as needed based on the audits.
   d. The ADON will be responsible for the initial set up of isolation precautions **Monday thru Friday** on new admissions, re-admissions and residents newly diagnosed as needing isolation. The ADON will be responsible for the initial isolation set-up for any **known** weekend admissions/re-admissions. In the event of an emergency **weekend** admission/re-admission or resident with a new dx requiring isolation the Licensed Nurse in charge of the admitting resident is responsible for setting up the initial isolation.
   e. Per recommendations of the Graves Co. Health Department: in the event that a facility has an active Covid unit, it is recommended that staff throughout the facility wear eye coverings.
   f. When admitting or re-admitting a resident, **staff are to don PPE prior to having any physical contact with the resident, for example: assisting the new resident to transfer from the gurney to the bed, assisting the new resident to turn and reposition, placing a gown on the resident, covering the resident with blankets, etc**
   g. When receiving or assisting a resident returning from an essential appointment (MD, dialysis) **staff are to don PPE prior to having any physical contact with the resident, for example: assisting the new resident to transfer from the gurney to the bed, assisting the new resident to turn and reposition, placing a gown on the resident, covering the resident with blankets, etc**

2. **ISOLATION GUIDANCE/CATEGORIES**
   a. Per current CDC and CMS guidance, new admissions and re-admissions are considered as possibly being exposed to Covid-19 and must be placed in

transmission based precautions for 14 days. Clearview uses **Droplet Precautions** in these instances. **(see handout on isolation categories).**

b. Per current CDC and CMS guidance, any resident leaving the facility for an essential appointment must be placed in 14 day transmission based precautions. In the event that a resident receives dialysis, that resident would be placed in continual transmission based precautions. Clearview uses **Droplet Precautions** in these instances.
c. When a resident is receiving therapy and is in isolation **for any reason,** the therapist is to follow the facility policy for transmission based precautions and must wear the appropriate PPE when providing therapy services. **Remember, the resident is in isolation because they either have an infectious process at present or has been possibly exposed to an infectious process.**

3. **HAND HYGIENE**
   a. **(hand hygiene handouts)**

INFECTION CONTROL OBSERVATIONAL AUDIT ROUNDS

F880

Name	Glove Useage Appropriate	Hand Washing Appropriate	PPE Use Appropriate (items, donning, removal)	Signage Present For Isolation Rooms

Observe staff for: wearing gloves/PPE during personal care, accu checks, therapy etc. Observe that gloves are changed as needed and hands are washed or sanitized at appropriate time & in appropriate manner.

DON/ADON/SDC/NHA
Observe 3 residents requiring isolation daily x 2 weeks
3 residents weekly x 3 months

INFECTION CONTROL PPE SUPPLY AUDIT ROUNDS
IDT

F880

Date	Adequate supply of PPE on hall/rooms YES	NO	Comments		Adequate supply of PPE in storage at nurses station YES	NO	Comments	

_____
Auditor Signature

To be completed by IDT members
Daily x 2 weeks
5 x weekly x 3 months

INFECTION CONTROL PPE SUPPLY AUDIT ROUNDS

F880

Date	Adequate supply of PPE on hall/rooms		PPE on hall/rooms restocked on AM audit		Adequate supply of PPE in storage at nurses station		PPE in nurses station storage restocked	
	AM	PM	YES	NO	YES	NO	YES	NO

Auditor # 1 **Auditor # 2**

To be completed by Central Supply and ADON 5 times weekly

CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Andy Beshear
Governor

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Eric C. Friedlander
Secretary

Adam Mather
Inspector General

Provider Guidance Memo: Admission, Discharge and Transfer for Long-Term Care Facility Residents

August 28, 2020

On March 6, 2020, Governor Andy Beshear signed Executive Order 2020-215 declaring a state of emergency in the Commonwealth due to the novel coronavirus (COVID-19) pandemic. Therefore, in accordance with the authority of KRS Chapter 39A, KRS 194A.025, and KRS 214.020, the Cabinet for Health and Family Services, Office of Inspector General, in collaboration with the Department for Public Health, hereby issues the following directive that shall remain in effect until Governor Beshear rescinds the state of emergency under Executive Order 2020-215.

On April 22, 2020, the Cabinet for Health and Family Services (CHFS), Office of Inspector General (OIG), in collaboration with the Kentucky Department for Public Health (KDPH), issued a Guidance Memorandum concerning the determination of the most appropriate setting for care of a resident of a long-term care facility who exhibits symptoms of - or tests positive for - the COVID-19 virus. On May 11, 2020, the same agencies collaboratively issued supplemental guidance to health care providers.

This Provider Guidance Memo replaces guidance previously provided on this subject. The primary goals are to foster safe an effective navigation across the state's health care continuum, facilitate the sharing of high-impact practices, and support the health care provider community. It is based on the most current, evidence-based recommendations from the Centers for Disease Control and Prevention (CDC), Centers for Medicare and Medicaid Services (CMS), White House Coronavirus Task Force, and the CHFS Long-Term Care Advisory Task Force. Adherence to this guidance is expected to reduce the likelihood of transmission of COVID-19, but will not eliminate the risk to the health providers' residents/patients, staff or visitors.

1) **Definitions**

a. ***Guidance***: Recommended course of action; *not* a regulation or directive.
b. ***Isolation*****:** Separating infected (both sick and asymptomatic) people from healthy, non-infected people.
c. ***Long-Term Care Facility (LTCF):*** Nursing Facility, Nursing Home, Intermediate Care Facility, Intermediate Care Facility for Individuals with Intellectual Disabilities, Personal Care Home, Assisted Living Community, Family Care Home, or Continuing Care Retirement Community.
d. ***Quarantine*****:** Keeping someone who was exposed or potentially exposed to COVID-19 away from others.
e. ***Standard Precautions (SP)*:*** Assumes that all blood, body fluids, secretions, excretions

(except sweat), non-intact skin, and mucous membranes *may* contain transmissible infectious agents. Applies to all patients, regardless of suspected or confirmed infection status, and includes hand hygiene, use of Personal Protective Equipment (gloves, gown, mask, eye protection or face shield) as indicated for the activity or interaction, and safe injection practices. Equipment or items in the patient room must be handled in a manner to prevent transmission of infectious agents, such as wearing gloves for direct contact and properly cleaning and disinfecting reusable items and equipment between uses.

f. ***Transmission-Based Precautions (TBP)****: When the route of transmission is not completely interrupted using Standard Precautions alone, one or more of the following may be necessary; private room strongly preferred.
   i. ***Contact Precautions (CP)****: Wear at least gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in his/her environment, donning PPE outside the room prior to entry and doffing (except for N95 mask) PPE inside the room prior to exiting; doff mask after patient contact if damp or soiled.
   ii. ***Droplet Precautions (DP)****: Wear mask for close contact with potentially infectious patient, donning PPE outside the room prior to entry and doffing (except for N95 mask) PPE inside the room prior to exiting; doff mask after patient contact if damp or soiled; if transported outside of the room, patient should wear a mask and follow Respiratory Hygiene/Cough Etiquette.

(*) More complete guidance on operationalizing the listed precautions is available from the CDC at:

- https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html and
- https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html
- https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html

2) **Admission/Transfer to a Hospital of a LTCF resident with suspected or confirmed COVID-19 is advised if:**
   a. The resident needs acute care interventions, such as airway management or breathing support;
   or
   b. The LTCF is unable to cohort-locate the resident in a COVID-19-specific area that meets CMS Guidelines.
   and
   c. Transfer does not contradict the resident's established goals of care or advance directives.

In collaboration with the LTCF's medical director (if applicable), local health department (list available at: https://chfs.ky.gov/agencies/dph/dafm/LHDInfo/AlphaLHDListing.pdf), and KY Department of Public Health (toll-free at 800-722-5727), the resident's primary care physician orders the transfer.

3) **Admission of a new or returning resident to a Long-Term Care Facility (LTCF) from an Acute Care Provider (Hospital),** apply the following:

   a. Resident is without a history of COVID-19 and without COVID-19 symptoms:
      i. Resident should not require a negative COVID-19 test result prior to transition to a LTCF from an acute care provider. If tested, a negative COVID-19 result prior to transition to a LTCF is not necessary; the Hospital and LTCF should collaborate in advance of transfer concerning how test results can best be shared as soon as available.
      ii. Quarantine and monitor the resident for COVID-19 signs or symptoms for 14 days following admission. Wear facemask, eye protection and perform hand hygiene for all caregiver-resident interactions; add gown and gloves for any activity involving close contact with the resident or the resident's environment.

b. Resident previously tested positive for COVID-19:
    i. Resident does not require a negative COVID-19 result prior to transition to a LTCF.
    ii. For a resident who is
        1. Immunocompromised or had severe to critical illness with the COVID-19 infection staff should follow Transmission-Based Precautions (TBP) until
            i. at least 20 days after symptoms first appeared, and
            ii. at least 24 hours have passed since the last fever without the use of fever-reducing medications; and
            iii. symptoms (e.g., cough, shortness of breath) have improved.
        2. Not severely immunocompromised and was asymptomatic or had mild to moderate illness with his or her COVID-19 infection, staff should follow TBP until at least 14 days after symptoms first appeared.
    iii. Consistent with KDPH Guidelines for Release from Isolation (available at: https://chfs.ky.gov/agencies/dph/covid19/Guidanceforreleasefromisolation.pdf), at this time there is insufficient medical evidence to support the requirement for repeat diagnostic testing as a condition for the admission or return of a COVID-19 person to a LTCF. KDPH concurs with the CDC, and advises the use of a time-based strategy.

c. If the LTCF is unable to adequately meet the person's post-acute needs, he/she should remain hospitalized or transfer to a LTCF with that capability.

4) **Testing for COVID-19 Following Recovery from Illness and Release from Isolation.**
    a. For a resident previously diagnosed with COVID-19 who remains asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset (date of testing, if asymptomatic) for the initial COVID-19 infection. Quarantine is not recommended in the event of close contact with an infected person during the same period.
    b. For a resident who develops new symptoms consistent with COVID-19 during the 3 months after initial infection, if a health care provider cannot identify an alternative etiology, then the resident may warrant retesting. Consultation with an infectious disease or infection control expert is recommended. Isolation may be considered during this evaluation, especially in the event COVID-19 symptoms develop within 14 days after close contact with an infected person.

The current public health emergency has resulted in a rapidly changing environment. The Cabinet for Health and Family Services will continue to provide information and updates to healthcare providers.

Eric Friedlander	Adam Mather	Victoria Elridge
Secretary	Inspector General	DAIL Commissioner

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Eric C. Friedlander
Secretary

Provider Guidance Update: Phased Reduction of Restrictions for Long Term Care Facilities
November 16, 2020

On March 6, 2020, Governor Andy Beshear signed Executive Order 2020-215 declaring a state of emergency in the Commonwealth due to the outbreak of the novel coronavirus (COVID-19). The current public health emergency has resulted in a rapidly changing environment. The Cabinet for Health and Family Services will continue to provide information and updates to healthcare providers.

This guidance is provided in accordance with the phased approach to resuming currently suspended services encouraged by the Centers for Medicare and Medicaid Services (CMS) in its "Nursing Home Reopening Recommendations for State and Local Officials, QSO-20-30-NH" (available at: https://www.cms.gov/files/document/qso-20-30-nh.pdf-0) and its "Nursing Home Visitation – COVID-19, QSO-20-39-NH" (available at https://www.cms.gov/files/document/qso-20-39-nh.pdf). It is intended to offer clarifying information to facility-based long-term care providers (herein referred to as "Providers") concerning the resumption of specified services when the described conditions are met, beginning on or after the dates indicated. There is an inherent risk of exposure to COVID-19 in any place where people are present. Residents of Long-Term Care Facilities (LTCFs) are at high risk of becoming seriously ill with COVID-19.

The guidelines are based on what is currently known about the transmission and severity of COVID-19. Compliance with these guidelines can reduce the risk of transmission of COVID-19 but *will not eliminate* the risk to the LTCF's residents, staff or visitors. By entering the LTCF, visitors are acknowledging the inherent risk of exposure to COVID-19 to themselves and to LTCF's residents, staff and other visitors.

Key Updates to October 7, 2020 Guidance

- Definitions: Elective Off-Site Familial Visit, Essential Off-Site Medical Appointment, Fever, Physical (fka Social) Distancing, Symptoms – COVID-19 (per CDC).
- Infection Control: Information about the KDPH's Health Healthcare-Associated Infection / Antibiotic Resistance (HAI/AR) Prevention Program.
- Group Activities and Communal Dining: Clarification regarding key determinants to consider.
- Off-Site Travel (fka Appointments).
- On-Site Resident Visits: Indoors and Outdoors.

DEFINITIONS

CDC Guidelines: Reference materials available from the Centers for Disease Control and Prevention, available at: https://www.cdc.gov/ and specific extension sites listed at the end of this guidance.

Cleaning: Removal of dirt and impurities, including germs, from surfaces. Cleaning alone does not kill germs, but it decreases their number and therefore the risk of spreading infection.

Compassionate Care: Consistent with guidelines from the Centers for Medicare and Medicaid Services, available at: https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf.

Disinfecting: Cleaning with an EPA-registered disinfectant chemical according to the manufacturer's directions for use. This process does not necessarily clean dirty surfaces, but killing germs remaining on a surface after cleaning further reduces the risk of spreading infection.

Elective Off-Site Familial Visit: Off-site, single day visit with a resident's family or support person(s).

Essential Off-Site Medical Appointment: Physician-ordered, off-site appointment for diagnostic or treatment services performed by a licensed health care provider, such as for dental or podiatric care, imaging services or renal dialysis; ***Provider should first try to utilize telehealth and alternate on-site options.***

Fever: Registering a body temperature of at least 100° F, confirmed by an infrared thermometer. (Older or immuno-compromised adults can have a lower fever threshold.)

Guidance: Recommended course of action; not a regulation or directive.

LTCF: Congregate residential settings serving predominantly older or disabled adults, whether a Nursing Facility (NF), Nursing Home (NH), Intermediate Care facility (ICF), Intermediate Care Facility for Intellectually Disabled (ICF-IID), Personal Care Home (PCH), Assisted Living Community (ALC) or Family Care Home (FCH).

PPE: Personal Protective Equipment, including but not limited to disposable gloves, gowns, face masks, shields or goggles.

Physical Distancing (fka Social Distancing): Maintaining a distance of at least six feet between people.

Staff Extender: A health professional engaged in a participant's care, vendors or contractors delivering goods or services, public agency (including the Long-Term Care Ombudsman and the CHFS Office of Inspector General) or emergency personnel conducting official duties.

Symptoms – COVID-19: Fever, cough, shortness of breath, difficulty breathing, chills, rigors, headache, sore throat, congestion or runny nose, muscle or body aches, change in sense of smell or taste, or gastrointestinal symptoms (i.e. diarrhea, vomiting, etc.); CDC definition available at: https://wwwn.cdc.gov/nndss/conditions/coronavirus-disease-2019-covid-19/case-definition/202

Infection Control

If the Office of Inspector General (OIG) conducted a focused Infection Control survey since March 1, 2020 that resulted in a statement of deficiency concerning infection control, the Provider should receive written confirmation that its Plan of Correction has been accepted prior to resuming any of the services included in this guidance.

An Assisted Living Community should receive from the Department of Aging and Independent Living (DAIL) written confirmation that its COVID Preparedness Plan has been accepted prior to resuming any of the services included in this guidance.

The Kentucky Department for Public Health (KDPH), Infectious Disease Branch's "Healthcare-Associated Infection / Antibiotic Resistance (HAI/AR) Prevention Program" aims to eliminate and prevent HAIs and AR organisms in healthcare settings. A Provider can – and is encouraged to – receive consultation on infection control and prevention from the HAI/AR team of specialized health professionals. To better assist in the response to the COVID-19 pandemic, the department has recently added regional infection preventionists. Ten

regional IPs work with Providers to help respond to and control the spread of COVID-19 in the healthcare setting. Find more information at: https://chfs.ky.gov/agencies/dph/dehp/idb/Pages/hai.aspx.

Group Activities

Key determinants for deciding to resume recreational and therapeutic group activities, **beginning November 16, 2020 for all LTCFs**, should include 1) adhering to established physical distancing guidelines of at least six feet between any two residents and 2) no new resident or staff COVID-19 cases within the past 14 days - from the date when relevant symptoms were first observed or reported (or the date of testing, if asymptomatic) for the most recently identified resident or staff facility-onset COVID-19 case.

Other conditions that a Provider should address in its plan for resuming recreational and therapeutic group activities include:

- (Note: Update on 12/1/2020) Group size should not exceed eight (8) residents.
- Resident should
    - Have never contracted or have fully recovered from COVID-19 (not currently under isolation for observation for suspected or confirmed COVID-19);
    - Wear a mask (as tolerated or capable); and
    - Wash (or sanitize) hands before and after the activity.
- Staff should
    - Perform a health screening for each participating resident prior to entering the activity area, indicating: no symptoms consistent with suspected COVID-19;
    - Configure seating to comply with physical distancing guideline;
    - Discourage the use of high-touch items (i.e., playing cards, board games, ball toss, etc.);
    - Disinfect applicable surfaces and equipment between uses; and
    - Wear appropriate PPE, consistent with CDC guidelines.
- Off-site: Until further notice, exclude group activities at off-site locations.

Communal Dining

Key determinants for deciding to resume communal dining, **beginning November 16, 2020 for all LTCFs**, should include 1) adhering to established physical distancing guidelines of at least six feet between any two residents and 2) no new resident or staff COVID-19 cases within the past 14 days - from the date when relevant symptoms were first observed or reported (or the date of testing, if asymptomatic) for the most recently identified resident or staff facility-onset COVID-19 case.

Other conditions that a Provider should address in its plan for resuming communal dining include:

- Resident should
    - Have never contracted or have fully recovered from COVID-19 (not currently under isolation for observation for suspected or confirmed COVID-19);
    - Wear a mask traveling to and returning from the communal dining setting; and
    - Wash (or sanitize) hands before and after the activity.
- Staff should
    - Perform a health screening for each participating resident prior to entering the communal dining area, indicating no symptoms consistent with suspected COVID-19;
    - Configure seating to comply with physical distancing guideline;

- Discourage the use of high-touch items (i.e., salt/pepper shakers; provide condiment packets upon request, etc.);
- Disinfect applicable surfaces and equipment between uses; and
- Wear appropriate PPE, consistent with CDC guidelines.

Off-Site Travel

Until further notice, off-site travel for any purpose other than an "Essential Off-Site Medical Appointment" (see Definitions, p. 2) **is *strongly* discouraged.**

There is an inherent risk of exposure to COVID-19 in any place where people are present. Residents of Long-Term Care Facilities (LTCFs) are at high risk of becoming seriously ill with COVID-19.
The scope and severity of the situation continue to broaden. The proportion of COVID-19-related deaths accounted for by congregate care settings is now approaching two out of three, and the statewide community test positivity rate has rapidly climbed in recent weeks to over 8%. As of this week, Kentucky has ZERO counties experiencing below 10 cases per 100,000 population for the 7-day average incidence (Tier I on the Kentucky Long-Term Care Facility COVID-19 Indicator, available at: https://chfs.ky.gov/cv19/LTCCountyMapLatest.pdf); only 39 counties in the Accelerated category (Orange or Tier II: 10 to 25 cases per 100,000); and all of the remaining 81 counties are now in a Critical situation (Tier III: greater than 25 cases per 100,000 population).

A. **Essential Off-Site Medical Appointment** (see Definitions, p. 2):
   - Resident should agree to:
     - Wear a mask; and
     - Wash (or sanitize) hands before and after the appointment.
   - Staff should:
     - Verify physician's order for the resident's essential medical service;
     - Arrange/verify safe transportation, consistent with CDC guidelines available at: https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/using-transportation.html;
     - Greet resident upon return and escort resident to room.
     - Return: The Provider's policies and procedures for admitting a new resident should be applied, including quarantine for 14 days,* consistent with the Provider Guidance available at: https://chfs.ky.gov/cv19/LTCAdmissionDischardXferGuidanceMemo.pdf
       (*) - Exception: Returning to a resident's *private* room.
   - Vehicle:
     - Resident and driver (and accompanying person(s), if other than driver) should
       - Be screened;
       - Wear a mask; and
       - Wash (or sanitize) hands before and after travel.
     - Staff should
       - Perform a health screening for the traveling resident prior to boarding and upon return, indicating no symptoms consistent with suspected COVID-19;
       - Wear appropriate PPE, consistent with CDC guidelines;
       - Disinfect frequently touched surfaces in the vehicle between trips with an Environmental Protection Agency (EPA) registered disinfectant. (Recommended Resource: CDC Guidelines for Disinfecting Transport Vehicles, available at): https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/disinfecting-transport-vehicles.html

B. **Elective Off-Site Familial Visit** (see Definitions, p. 2):

- **Until further notice, elective off-site familial visits (see Definitions, p. 2) are *strongly* discouraged.**
- Note: Additional guidance is expected from CMS, and will be added here when it becomes available.
- See: Holiday Season (p. 10).

Resident On-Site Visitation

A. On-Site, Indoor Visitation Beginning November 16, 2020: Any LTCF should develop a plan addressing the services included in this guidance memo; additional relevant resources are included on page 13.

Key determinants for deciding to resume limited on-site, indoor visitation should include:

1) The resident's health status and upholding principles of person-centered care by considering each resident's physical, mental and psychophysical well-being.
2) Ability of resident and visitor to adhere to established physical distancing guidelines of at least six feet between a resident and any other person.
3) NEW: The Provider's county is not currently listed as Red* on the Kentucky COVID-19 Current Incidence Rate Map, available at: https://govstatus.egov.com/kycovid19*
    a. Provider should check this resource weekly each Thursday for this purpose.
4) No new resident or staff COVID-19 cases within the past 14 days - from the date when relevant symptoms were first observed or reported (or the date of testing, if asymptomatic) for the most recently identified resident or staff facility-onset COVID-19 case.*
(*) – Exception: "Compassionate Care" situation (see p.7).

- Other conditions that a Provider should address in its plan for hosting indoor visitors include:

    - External Context: Assess the current environment and support network capacity in the Provider's surrounding community, including any adjacent in a bordering state, such as
        - COVID-19 *trending* in the county, as well as in contiguous counties (whether in-state or in a bordering state).
        - Acute care partners' capacity for providing assistance in the event of a rise in COVID-19 cases among the residents or staff.
        - Continuing access to PPE, cleaning and disinfecting supplies.
        - Continuing access to surveillance testing for COVID-19.

    - Logistics:
        - Effectively cohort residents (e.g., separate areas dedicated to COVID-19 care).
        - Monitor results of COVID-19 testing performed among residents and/or staff, conducted as required per 42 CFR 483.80(h) per QSO-20-38-NH.
        - Schedule each visit in advance for a duration – and frequency – that enables each resident an opportunity to receive a visit as equitably distributed as possible, following the Provider's policies and procedures for visiting hours.

- Limit the number of visitors per resident at one time.
- Limit the number of visitors present simultaneously (based on the size of the building and physical space) to support infection prevention actions.
- Post instructional signage throughout the facility and conduct appropriate visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable Provider practices (such as the use of face covering of mask, specified entries, exits and routes to designated areas, or hand hygiene).
- Accommodate and support visitation that offers an adequate degree of privacy and fosters visitation beyond compassionate care situations.
- Establish Indoor Options for visitation in a
  - Resident Room - Visitor proceeds to directly to the resident's room.
    a. Visiting a resident should ***not*** occur in the resident's room when he/she
       - Is under transmission-based precautions (TBP), or
       - Shares the room with another resident (exception: his/her health status prevents him/her from leaving the room, in which case the Provider should attempt to enable in-room visitation adhering to the core principles of COVID-19 infection prevention described in QSO-20-39-NH).
  - Designated Non-Resident Room that is near an entrance and does not require visitors to traverse though a residential area.

- Each Resident/Host of an indoor visit should
  - Wash (or sanitize) hands before and after the visit;
  - Wear a mask
    a. while traveling internally to and returning from the visit;
    b. during the visit (as tolerated or capable); and
  - Observe physical distancing.

- Each Indoor Visitor (including "Staff Extender") should
  - At entry:
    a. Not exhibit any symptoms consistent with COVID-19; and
    b. Sign an attestation reflecting negative responses to COVD-19 symptom screening questions (sample form attached on p. 12)
       - Visitor Testing: While not required, a qualified Provider is encouraged to test visitors for COVID-19, if feasible. Recommend:
         - Prioritize those who visit regularly (although any visitor can be tested).
         - Recognize documentation of a negative COVID-19 test result obtained privately elsewhere within 2-3 days preceding the visit.
         - Communicate that a negative test does not absolutely rule out infection or eliminate the need to practice prevention strategies such as physical distancing and mask wearing.
    c. Inability to complete ALL of the entry conditions should result in rescheduling the visit and recommending that the declined visitor consult with his/her primary care provider.
  - During an Indoor visit:
    a. Wash (or sanitize) hands before and after the visit;
    b. Wear a mask; and

c. Observe physical distancing.
d. Any indoor visitor who is unable to adhere to the Provider's visitation policies and procedures should not be permitted to visit or be asked to leave.

- Staff during an indoor visit should
  - Accompany the visitor;
  - Configure seating to comply with physical distancing guidelines;
  - Observe and enforce physical distancing compliance while providing auditory privacy;
  - Disinfect applicable surfaces and equipment (including adaptive utensils and assistive devices) between uses; and
  - Wear appropriate PPE according to the Provider's policies and procedures and consistent with CDC guidelines.

- Following the Indoor Visit: The Provider should encourage each visitor to monitor for symptoms associated with suspected COVID-19.
  - Anyone who visits indoors and develops signs or symptoms of COVID-19 within 2 days after visiting should immediately notify the Local Health Department and the Provider.
  - The Provider should immediately screen the individual(s) who had contact with the indoor visitor for the level of exposure and follow up with its medical director and the resident's primary care physician.

- Compassionate Care: Decisions about compassionate care visitation should be made on a case-by-case basis by the Provider, consistent with CMS guidelines. Through a person-centered approach, a Provider should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits.
  - End-of-life care visitation within a resident's room should expect the visitor to observe all appropriate precautions, consistent with CDC guidelines.
  - Other types of "Compassionate Care" include, but are not necessarily limited to:
    - A resident, who
      a) was living with family before recently entering a nursing home, is struggling with the change in environment and lack of physical family support.
      b) is grieving after a friend or family member recently passed away.
      c) needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
      d) 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).
      e) has an affinity for a familiar domestic pet and would likely benefit from engaging with it (single resident per pet visit).
    - Allowing a visit in these situations would be consistent with the intent of "compassionate care situations."

B. On-Site, <u>Outdoor</u> Visitation: Provider should establish outdoor options (preferred) for visitation.

Key determinants for deciding to resume limited on-site, outdoor visitation should include:

1) The resident's health status and upholding principles of person-centered care by considering each resident's physical, mental and psychophysical well-being.

2) Ability of resident and visitor to adhere to established physical distancing guidelines of at least six feet between a resident and any other person.

3) CMS clarified on 10/19/2020 that outdoor visits during a COVID-19 *facility* outbreak testing/status are permitted according to QSO memo 20-39-NH, as long as the Provider carefully considers how to do so safely.

Other conditions that a Provider should address in its plan for hosting outdoor visitors include:

- External Context: Same guidance as for indoor visits (see p. 5).

- Logistics:
  - Provider should designate an outdoor area that is accessible, safe and comfortable with appropriate protection from overexposure to the sun, inclement weather conditions or poor air quality.
    - Recommend: Civil Monetary Penalty (CMP) Fund Grants of up to $3,000/facility are available to enhance visiting environments, available at: https://chfs.ky.gov/agencies/os/oig/Pages/cmpfunds.aspx
  - Accommodate and support outdoor visitation that offers an adequate degree of privacy.
  - Schedule each outdoor visit in advance for a duration – and frequency – that enables each resident an opportunity to receive a visit as equitably distributed as possible, following the Provider's policies and procedures for visiting hours.
  - Limit the number of visitors present simultaneously to support infection prevention actions.

  - Visited/Host Resident should
    - Wash (or sanitize) hands before and after the visit;
    - Wear a mask
      a. traveling to and returning from the visit;
      b. during the visit (as tolerated or capable); and
    - Observe physical distancing.

  - Each Outdoor Visitor should
    - At entry:
      a. Not exhibit any symptoms consistent with COVID-19; and
      b. Sign an attestation reflecting negative responses to COVD-19 symptom screening questions (sample form attached on p. 12)
        - Visitor Testing: While not required, a qualified Provider is encouraged to test visitors for COVID-19, if feasible. Recommend:
          - Prioritize those who visit regularly (although any visitor can be tested).
          - Recognize documentation of a negative COVID-19 test result obtained privately elsewhere within 2-3 days preceding the visit.
          - Communicate that a negative test does not absolutely rule out infection or eliminate the need to practice prevention strategies such as physical distancing and mask wearing.

- Inability to complete ALL of the conditions should result in rescheduling the visit and recommending that the declined visitor consult with his/her primary care provider.

- During an outdoor visit:
  a. Wash (or sanitize) hands before and after the visit;
  b. Wear a mask; and
  c. Observe physical distancing.
  d. Any indoor visitor who is unable to adhere to the Provider's visitation policies and procedures should not be permitted to visit or be asked to leave.

- Staff during an outdoor visit should
  - Accompany the visitor;
  - Configure seating to comply with physical distancing guidelines;
  - Observe and enforce physical distancing compliance while providing auditory privacy;
  - Disinfect applicable surfaces and equipment (including assistive devices) between uses; and
  - Wear appropriate PPE according to the Provider's policies and procedures and consistent with CDC guidelines.

- Following the Outdoor Visit: The Provider should encourage each visitor to monitor for symptoms associated with suspected COVID-19.
  - Anyone who visits indoors and develops signs or symptoms of COVID-19 within 2 days after visiting should immediately notify the Local Health Department and the Provider.
  - The Provider should immediately screen the individual(s) who had contact with the indoor visitor for the level of exposure and follow up with its medical director and the resident's primary care physician.

C. Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs

- Section 483.10(f)(4)(i)(E) and (F) requires the Provider 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, 6 both formally and informally, by telephone, mail and in person." 42 CFR 51.42(c); 45 CFR 1326.27.

- Each Provider must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).
  - 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 Provider must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions.
    - This would not preclude the Provider 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.

D. Communication

Prior to resuming the services addressed in this guidance memo, the Provider should:

- Communicate in writing with each resident and his/her responsible party about the Provider's new policies and procedures regarding COVID-19;
    - Consider having the resident (or guardian) and visitor sign an acknowledgement form concerning
        - Receipt of this communication and agreement to abide by the new policies and procedures described; and
        - Acceptance of the risks associated with entering the facility, such as:
          There is an inherent risk of exposure to COVID-19 in any place where people are present. Residents are potentially at high risk of becoming seriously ill with COVID-19. Our policies and procedures are based on what is currently known about the transmission and severity of COVID-19. Compliance with these policies and procedures will reduce the risk of transmission of COVID-19, but will not eliminate the risk to the residents, staff or visitors. By entering the facility, the undersigned acknowledges the inherent risk of exposure to COVID-19 to himself/herself, other residents, staff and other visitors.

- Communicate in writing with each employee about the Provider's new policies, protocols and procedures regarding COVID-19.
    - The CDC has developed several free posters in a variety of languages, available at: https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html?Sort=Date%3A%3Adesc

- Communicate in writing with the Long-Term Care Ombudsman about the Provider's new policies, protocols and procedures regarding COVID-19 at nhoa@ombuddy.org.

- Holiday Season: Proactively inform residents and their respective responsible parties about ways in which this year's holiday season will likely require adjustments concerning gifts, activities, visitation and guest dining, etc. The Provider should consider:
    - Recruiting staff members to assist with supporting residents who do not leave and/or have visitors.
    - Establishing criteria and procedures for residents to safely accept
        - gifts or packages;
        - commercially prepared and appropriately packaged consumables (fruit or carry-out restaurant food); or
        - privately prepared and appropriately packaged consumables (such as baked goods, candy or holiday meal).

Additional Resources

CDC COVID-19 Guidance:

- Retirement Communities and Independent Living – Plan, Prepare and Respond, at https://www.cdc.gov/coronavirus/2019-ncov/community/retirement/
- Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities, at https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
- Considerations for Memory Care Units in Long-term Care Facilities, at https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html
- Resources for Businesses and Employers, at https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/businesses-employers.html
- Risk-Assessment Guidance: https://www.cdc.gov/coronavirus/2019-ncov/php/risk-assessment.html/

OHSA Guidance on Preparing Workplaces for COVID-19, at https://www.osha.gov/Publications/OSHA3990.pdf

KY COVID-19 Updates:
https://govstatus.egov.com/kycovid19

- *Sample* COVID-19 Screening Attestation Form – On-Site (attached)

Eric Friedlander
Secretary

Adam Mather
Inspector General

Victoria L. Elridge
DAIL Commissioner

SAMPLE VISITOR ATTESTATION FORM – ON-SITE

Purpose: Our organization is committed to a safe and secure environment.
Policy: All visitors pledge to self-monitor and self-report to avoid exposures to communicable diseases such as COVID-19.
Rationale: COVID-19 virus is extremely dangerous for older adults. Many populations outside of older adults do not show symptoms, but they may be able to transmit the virus to others. Because of this, we are asking for the following commitment from you:

We ask the following of visitors and others who are entering and interacting within the facility to commit to the following precautions and practices:

1. Handwashing: While you are here but also while you are not here, we ask you to wash your hands frequently. For example, before you leave one area and enter another wash your hands with soap and friction. Use hand sanitizer when soap is not available.
2. Avoid individuals who have any of the following COVID-19 symptoms:
    a. Feeling of fever
    b. Cough
    c. Shortness of breath
    d. Difficulty breathing
    e. Chills
    f. Rigors
    g. Headache
    h. Sore throat
    i. Congestion or runny nose
    j. Muscle or body aches
    k. Change in sense of smell or taste
3. Avoid individuals who have been in a setting where COVID 19 cases have been confirmed.
4. Avoid gatherings of people.
5. Not visit our facility if you or someone in your household is ill or has been diagnosed with COVID-19.
6. Not visit our facility if you been in contact with anyone who is ill or has been diagnosed with COVID-19.
7. Wear a mask when in our facility and when out in the community
8. Observe physical distancing when visiting with our residents and when out in the community.
9. Report contact with any individual with suspected or confirmed infection with COVID-19 to the director of the facility.

As a part of our protection activities, we ask for these practices to be attested to by your signature. In addition, we will be asking you to submit to having your temperature taken when you come to visit. We appreciate your commitment in protecting our community.

Signature_____ Date_____