

October 07, 2021 Safe Start: LTC COVID Response Plan

1. **The information contained in this Safe Start: LTC COVID Response Plan is *independent of any other Washington State plan.***
2. Facilities and homes are required to follow this Safe Start: LTC COVID Response Plan.
3. The impact of COVID-19 vaccines on community transmission rates may allow for future changes to the recommendations and requirements in the Safe Start: LTC COVID Response Plan.

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Introduction

Safe Start: Long-Term Care (LTC) COVID Response Plan Recommendations and Requirements

The Department of Social and Health Services (DSHS) and the Department of Health (DOH) are presenting the updated safe start plan for licensed and certified long-term care facilities and agencies. Given the critical importance of limiting COVID-19 exposure in long-term care residential care settings and certified supported living agencies, decisions on relaxing restrictions are be made:

- With careful review of various unique aspects of the different facilities and communities in which they reside;
- In alignment with the Governor’s Proclamations; and
- In collaboration with state and local health officials.

This approach will help keep residents and clients healthy and safe.

Because the pandemic is affecting communities in different ways, DSHS, DOH and the Governor’s Office regularly monitor the factors for the Safe Start for LTC and adjust the Washington plans accordingly.

Residential Care Setting Safe Start Requirements

1. *Follow the Centers of Disease Control and Prevention (CDC), Department of Health (DOH), and local health jurisdictions’ (LHJs) (when applicable) infection control guidelines to slow COVID-19 spread.*
2. *If there is a difference between state and federal guidance follow the more restrictive guidance. For questions regarding guidance consult with the LHJ or email HAI-COVID@doh.wa.gov.*
3. *Cooperate with the local health officer or his/her designee in the conduct of an outbreak investigation, including compliance with all recommended or ordered infection prevention measures, testing of staff, and testing of residents.*
4. *Follow this DSHS and DOH Safe Start LTC COVID Response document. This document is guidance for LTC and is not included in any other Washington State plan*
5. *Individual facility types have state statute or rules that requires a facility to impose actions to protect the residents by activating their infection control plan.*
6. *The LHJ or DOH have the authority to institute infection prevention and control measures in response to any infectious disease and/or COVID-19 outbreak. The LHJ and DOH under WAC 246-101-505 and WAC 246-101-605 have the authority to conduct public health investigations and institute control measures and, pursuant to WAC 246-101-305, LTCs are obligated to cooperate with these investigations. Please refer to the DOH definition of an outbreak found here: [Interim COVID-19 Outbreak Definition for Healthcare Settings](#)*

All facilities and agencies must be prepared for an outbreak and make assurances they have:

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1. The facility must maintain access to COVID-19 testing for all residents and staff:
 - a. Aiming for fast turnaround times, ideally less than 48 hours,
 - b. Testing all residents/clients with signs and symptoms of COVID-19 or with identified exposures,
 - c. Working with local and state public health to coordinate repeat and outbreak testing, and
 - d. Capacity to conduct ongoing, serial testing of clients and staff according to federal, state and local guidance;
 - e. Testing includes point of care antigen testing and PCR lab testing.
 - f. Nursing Homes follow CMS guidance in QSO memo [20-38](#) or [DOH](#) or LHJ guidance, whichever is more stringent.
2. A response plan to inform cohorting and other infection control measures;
3. A plan to screen all staff following the symptom screening strategies that can be found here: [Infection Control Guidance | CDC](#) and to screen all visitors using the [DOH Supplemental Guidance for Long-term Care Facility Visitors](#).
4. Dedicated space for cohorting and managing care for residents with COVID-19 or if unable to cohort residents, and a plan which may include transferring a person to another care setting;
5. A plan in place to care for residents with COVID-19, including identification and isolation of residents. The facility or agency plan must describe the identification, care and isolation of residents or clients may be requested by DSHS, DOH or the LHJs to conduct an outbreak investigation. Technical assistance for development of these plans can be received from LHJs.
6. Protected and promoted resident and client rights while following standards of infection control practices including when a resident or a client requires quarantine or isolation due to individual disease status or an outbreak in a residential facility or client home.

CMS Key Visitation Principles (QSO Memo 20-39)

Visitation, in conjunction with LTC Safe Start Recommendations, can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission: [QSO-20-39-NH REVISED \(cms.gov\)](#).

Core Principles of COVID-19 Infection Prevention

- Screening of all who enter the facility for signs and symptoms of COVID-19 and denial of entry of those with signs or symptoms
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose)
- Social distancing at least six feet between persons
- Instructional signage throughout the facility and proper visitor education on COVID19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
- Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated COVID-19 care)
- Resident and staff testing conducted as required at 42 CFR 483.80(h) (see [QSO 20-38 NH](#)) and in [DOH LTC Facility Testing for Staff and Residents](#)

These core principles are consistent with the [Centers for Disease Control and Prevention \(CDC\) guidance for healthcare settings](#) and should be adhered to at all times. Visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced using physical barriers (e.g., clear Plexiglas dividers, curtains). Also, providers should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance

[Screening](#)

- Screen residents daily.
- Screen 100% of all persons (residents, staff, visitors, etc.) entering the facility including: questionnaire about symptoms and potential exposure and observation of any signs or symptoms
- Maintain a screening log for 30 days.
- Do not screen EMTs or law enforcement responding to an emergent call.

[PPE and Source Control](#)

Providers will ensure all persons entering the building use the appropriate source control or PPE in accordance with [DOH source control guidance](#) and in accordance with the [Washington State Face Covering Requirement](#). Facilities have the flexibility to safely manage visitation and may deny a visitor access if they are unwilling to wear appropriate source control or PPE. If the visitor is denied access, they will be given the [Regional Long-Term Care Ombuds](#) or the [Developmental Disability Ombuds](#) contact information (or both if appropriate to the situation), and [Local Health Jurisdiction](#) contact information. They must also be given information regarding the steps they can take to resume the visits, such as agreeing to comply with infection control practices and these Safe Start Guidelines.

For additional guidance, refer to DOH PPE chart located at [Contingency Strategies for PPE use during COVID-19 Pandemic](#) and [CDC PPE optimization strategies](#).

[Federal and State Disability Laws](#)

Providers must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA). For example, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention.co

[Medically Necessary Providers, Service and Health Care Workers Principles](#)

Beginning October 18, 2021, Washington State Governor Proclamation [21-14](#), mandates that all persons who provide services in the building must be fully vaccinated before working in a health care setting and all state employees must be fully vaccinated, with some exceptions related to religious or medical exemptions. Information regarding the proclamation can be found:

- [COVID-19 Vaccination Requirement For Health Care Providers, Workers, and Settings FAQ](#)
- [Provider letter regarding Vaccine Proclamation](#)

Health care workers who are not employees of the facility but provide direct care to the facility's residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or show signs or symptoms of COVID-19 after being screened. We note that EMS personnel do not need to be screened so they can attend to an emergency without delay. We remind facilities that all staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.

- All essential healthcare personnel, including healthcare personnel addressed in Dear Provider letter [20-062](#), are allowed into the facility/home at all times
- All non-healthcare personnel are allowed in the building if the facility/home is not in outbreak status. If the facility/home has cohorted COVID positive residents to one unit and the rest of the building is open, the non-healthcare personnel may visit areas not in outbreak status. Because non-healthcare personnel have the potential for contact with unvaccinated persons, they must wear source control and physically distance at all times while in the building.
- All personnel participate in screening upon entry and additional precautions are taken, including hand hygiene, donning of appropriate PPE, as determined by the task; and at a minimum wearing a face mask for the duration of their visit.
- The Beautician/Barber/Hair Stylist/Nail Technician must have a designated space.

[Communal Activities and Dining Principles](#)

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur, including disinfection of dining or activity area and any shared items between uses. The facility/home must ensure that they continue to comply with Resident Rights requirements. The facility/home must assure requirements outlined in the [PPE and Source Control](#) and [Core Principles of COVID-19 Infection Prevention](#) sections are followed during communal activities and dining. Residents would be able to remove the source control when actively eating/drinking.

Who must not participate in communal activities?

- Vaccinated and unvaccinated **residents with SARS-CoV-2 infection, or in isolation because of suspected COVID-19**, until they have met [criteria to discontinue Transmission-Based Precautions](#).
- **Residents in [quarantine](#)** until they have met criteria for release from quarantine.

Offsite Visits and New Admissions

Providers must use the [Risk Assessment Template](#) to assess each resident for any COVID-19 exposure prior to and after returning from offsite visits to determine if the resident is low or high risk. Automatic quarantine should not be the standard practice upon returning from a trip into the community. Decisions about precautions taken with a resident based on the assessment must be documented in the resident's care plan. Telemedicine should be encouraged when available.

- For medically and non-medically necessary trips away from the facility:
 - The resident must be encouraged to wear a cloth face covering or face mask when the trip will involve entering spaces where source control is still required unless medically contraindicated; and
 - The facility must share the resident's COVID-19 status with the transportation service and entity with whom the resident has the appointment.
 - Transportation staff, at a minimum, must wear source control. Additional PPE may be required.
 - Transportation equipment shall be sanitized between transports.
- Residents can make trips outside of the building and into the community, including non-medically-related trips, to locations that are open to the public. However, residents are encouraged to limit or avoid trips where appropriate precautions are not being followed.
 - Nursing homes please see Dear Administrator letter [NH 2020-041](#) for details regarding residents leaving the facility for non-medically necessary trips.
 - ICF/IID Please see Dear Provider Letter [ICF/IID 2020-021](#) for details regarding clients leaving the facility for non-medically necessary trips. Provide a letter to Families and residents outlining potential risks involved in community activities when residents/clients are preparing for an outing. Upon the resident return to the facility/home complete a risk assessment. Both the letter and the assessment can be found here: [Risk Assessment Template to Assess COVID-19 Exposure Risk and letter to Resident/Clients and Families](#)

If the resident/client or family has already reviewed the risk letter for previous outings, it is not necessary to provide a new letter with each trip into the community unless the information has changed.

A home should use the [Interim Guidance for Transferring Residents between Long-Term Care and other Healthcare Settings](#) to determine if a newly admitted resident would require a quarantine. This guidance takes into account the vaccination status of a resident, along with other mitigating factors.

Care Plans

Because person-centered care is key, providers will document in the resident care plan medically necessary care, compassionate care, and designated person care delivery.

Continuing Care Retirement Communities (CCRC) and Independent Living Campuses

State licensed homes that reside on the same campus as CCRCs and independent living settings, must follow these Safe Start: Long Term Care COVID Response Recommendations.

Access to Resident Right Advocates – LTC Ombuds, DD Ombuds, and DRW Advocates

Long-Term Care (LTC) Ombuds and DD Ombuds

State and federal laws govern the authority of LTC ombuds and the DD Ombuds to access facilities, residents, and records, as well as the rights of residents to access long-term care ombuds. The relevant laws govern visits by ombuds differently than visits from a resident's family or friends. Facilities must allow immediate access to residents by ombuds in the same manner that facilities must allow immediate access to residents by representatives of the federal or state government. Licensed long-term care facilities must provide ombuds with private, unimpeded, and immediate access to facilities and any resident. Residents retain the right to provide, withhold, or withdraw consent to a visit from any individual.

Disability Rights Washington (DRW) Advocates – Protection & Advocacy System

Section 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to “investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported or if there is probably cause to believe the incidents occurred.” 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes “the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person.” 42 CFR 51.42(c); 45 CFR 1326.27.

Infection Prevention Principles for All Resident Rights Advocates

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During this public health emergency, in-person access between LTC Ombuds, DD Ombuds, and DRW advocates and residents may be temporarily limited due to infection control concerns and/or transmission of COVID-19, such as the scenarios for limiting indoor visitation in specific circumstances. Note that these scenarios, while not exhaustive, are person-centered in that they pertain to the individualized circumstances of a given resident (e.g., confirmed COVID diagnosis, or in quarantine). In-person access may not be limited without reasonable cause.

All resident rights advocates should adhere to the core principles of COVID-19 infection prevention. If in-person access is not advisable, such as the advocate or the resident having signs or symptoms of COVID-19, facilities must, at a minimum, facilitate alternative resident communication with the advocate, such as by phone or through use of other technology

Providers will work with resident rights advocates to coordinate and identify private meeting space that meets infection controls standards if visitation in the resident's room is not possible.

Facilities should not request proof of vaccination from a resident rights advocates and ombuds prior to entering a facility or home. The current vaccination requirements pursuant to the governor's proclamation are applicable to the resident rights advocates and will be managed by those programs prior their entrance in a facility or home.

Visitation

Facilities shall not restrict visitation without a reasonable clinical or safety cause. A nursing home must facilitate in-person visitation consistent with the applicable CMS regulations.

Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual or through windows. In-person visits for compassionate care and essential support situations, with adherence to the transmission-based precautions, are also allowed in these instances. However, this visitation restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines.

Each facility must have a written visitation protocol in accordance with [QSO-20-39-NH REVISED \(cms.gov\)](#) and it must be shared with visitors who agree to abide by the protocol.

Visitation will be accommodated when such visits are by phone, remote video technology, window visits.

In certain situations, vaccination status of a resident/client or a visitor may play a role in the visitation guidance. When vaccination is a factor in how visitation occurs, a person is considered fully vaccinated:

- 2 weeks after their second dose in a 2-dose series, like the Pfizer or Moderna vaccines, or
- 2 weeks after a single-dose vaccine, like Johnson & Johnson's Janssen vaccine.

COVID-19 vaccines must be authorized for emergency use, licensed, or otherwise approved by the FDA or listed for emergency use or otherwise approved by the World Health Organization. If it has been less than 2 weeks since your final dose, or if you still need to get your second dose, you are NOT fully protected. Keep taking all prevention measures until you are fully vaccinated.

Outdoor Visitation Principles

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred *even when the resident and visitor are fully vaccinated against COVID-19*. Outdoor visits *generally* pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable. However, weather considerations or an individual resident's health status may hinder outdoor visits. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, all appropriate infection control and prevention practices should be adhered to. See [Outdoor Visitation Guidance for Long-term Care Settings](#).

Outside Safety Related to Structures

Providers must follow state fire marshal requirements for safety related to tent use or other temporary shelter structures: proper installation and suitable anchoring, flame resistant product use, protection of residents, tents, and surrounding grounds must be free of combustible materials, not obstruct fire hydrants, smoke free and equipped with smoke free signs, comfortable temperatures, fire marshal approved only heater use, no open fires/flames within or around tents, fire marshal approved only lighting sources, clear unobstructed path for egress, easily opened doors and zippers, hard packed walking surfaces with no tripping hazards, and illumination of operating in dark hours. Providers must ensure resident wear proper clothing for outdoor climate and promote outside safety and comfortable temperatures via a structured shelter, parking lot, patio, or courtyard venue. ([Outdoor Visitation Guidance for Long-term Care Settings](#).)

CMS Indoor Visitation Principles

Facilities should accommodate and support indoor visitation, based on the following guidelines:

- The facility has followed outbreak testing criteria outlined in [QSO 20-38](#) and the visitation guidelines for outbreak visitation in [QSO 20-39](#).
- Visitors should be able to adhere to the core principles;
- Facilities should consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors.

NOTE: Visits for residents who share a room should not be conducted in the resident's room, if possible. For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in- room visitation while adhering to the core principles of COVID-19 infection prevention.

Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission. **Compassionate care and essential support person visits should be permitted at all times**, including during the times outlined below when regular visitation is curtailed. These scenarios for limiting indoor visitation include:

- Visitation for unvaccinated residents, if the home's COVID-19 county transmission rate is high **and** <70% of residents in the facility are fully vaccinated;
- Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; or
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

How do I determine visitation status for unvaccinated residents?

To determine if unvaccinated residents are able to have visitors, follow the pathway below:

- 1) Is your facility in a county where the transmission rate is low, moderate, or substantial check [here](#) (Note – If the map is greyed out, click reset selections and wait a few seconds for the map to reset).

If yes, indoor visits may occur with core infection prevention principles in place.

If no (because your county has a high transmission rate), go to #2.

- 2) Is the resident vaccination rate in your facility greater than 70%?

(To determine vaccination rate – take number of residents fully vaccinated and divide by total number of residents in the home then multiply this number by 10. For example:

7 vaccinated residents divided by 10 total residents = 0.7

0.7 multiplied by 10 = 70% vaccination rate)

If yes, indoor visitation may occur with core infection prevention principles in place.

If no to both, then indoor visits should be limited to compassion care visits for residents who are not fully vaccinated.

In setting up indoor visitation, the NH and ICF/IID need to consider the following:

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- The facility/home must establish policies and procedures outlining how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. The facility must also take into consideration work schedules of visitors and include allowances for evening and weekend visits.
- The facility will post at the entrance, and with the visitor log, requirements for visitation, as well the Governor’s Proclamation regarding visitation under certain circumstances if the resident is unvaccinated.
- The Facility/home must establish policies and procedures around tours of the home for the purpose of screening for prospective new residents. The policies and procedures should include when tours will occur, screening process before entry of visitor(s) into the home, movement about the facility during the tour, and adherence to core principles of infection prevention,
- If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors. However, facilities should not put unreasonable time limits on visits for other reasons. Time limits should be applied only if needed to ensure that all residents can receive visitors.
- During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident’s room or designated visitation area.
- Visitors must be screened for signs and symptoms of COVID-19 (questions about and observations of signs or symptoms), and those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor’s vaccination status) will be denied entry.
- Visitors must sign in, including contact information, in a visitor’s log. Visitors must acknowledge they have reviewed the notice about the Governor’s Proclamation regarding unvaccinated residents and visitation under certain circumstances. The log of visitors must be kept for 30 days.**
- Visits for residents who share a room should not be conducted in the resident’s room, if possible. For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention. Compassionate Care and Essential Support Person visits can occur in the resident room as long as the roommate agrees and all infection prevention principles are followed.
- Visitors and residents should practice hand hygiene before and after the visitation.
- Visitors will need to follow the guidance found in the [PPE and source control](#) section.

[CMS Compassionate Care Principles](#)

While end-of-life situations have been used as examples of compassionate care situations, the term “compassionate care situations” does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to:

A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.

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A resident who is grieving after a friend or family member recently passed away.

A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.

A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past)

Allowing a visit in these situations would be consistent with the intent of, “compassionate care situations.” In addition to family members, compassionate care visits can be conducted by any individual that can meet the resident’s needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. Visits should be conducted using social distancing; however, if during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following all appropriate infection prevention guidelines, and for a limited amount of time. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits. Compassionate care visits are not limited to a single visitor and can allow for more than one person to visit at the same time as allowable in the space and in consideration of all infection prevention standards.

At all times, visits should be conducted using social distancing and visitors will wear PPE appropriate to the situation. Visitors should coordinate visits with the provider, thus allowing the provider the ability to take the compassionate care visit into consideration when applying the facility policies and procedures for visitation during that period of time (i.e. how many people overall are in the building, how long visitors are in the building, how much PPE is required). If during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following all appropriate infection prevention guidelines, and for a limited amount of time. Through a person-centered approach, facilities should work with residents, families, caregivers, resident representatives, and the Ombudsman program to identify the need for compassionate care visits.

Essential Support Person

The Essential Support Person (ESP) is established to assist during times when limitations are placed on visitation due to a public health emergency or other threats to the health and safety of residents and staff. Facilities must allow private, in-person access to residents by ESPs in the resident’s room. This right is subject to reasonable limitations that are tailored to protecting the health and safety of the ESPs, residents, and staff.

Requirements for the ESP

- If the ESP visit occurs during the following situations, the ESP must be fully vaccinated or provide proof of a negative COVID test** within the last 48 hours:
 - Visit with an unvaccinated resident when the county transmission rate is high and less than 70% of residents in the facility are vaccinated
 - If the resident is COVID positive
 - If the resident is in quarantine

- If the facility or unit where the resident resides is in outbreak status

**To meet the COVID testing requirement:

- For homes with testing capability this can be done at the facility using the rapid testing method
 - For homes without testing capability, the ESP will need to provide proof of a negative test within the last 48 hours
- The ESP must wear all PPE required according to [DOH's Recommendations for PPE in LTCFs](#) (specifically following the section pertaining to ESP)
 - An Essential Support Person (ESP) must be:
 1. At least 18 years of age;
 2. Designated by the resident, or by the resident's representative, if the resident is determined to be incapacitated or otherwise legally incapacitated; and
 3. Necessary for the resident's emotional, mental, or physical well-being during situations that include but are not limited to:
 - circumstances involving compassionate care
 - circumstances involving end-of-life
 - circumstances where visitation from a familiar person will assist with important continuity of care;
 - situations where visitation from a familiar person will assist with the reduction of confusion and anxiety for residents with cognitive impairments;
 - other circumstances where the presence of an essential support person will prevent or reduce significant emotional distress to the resident.

Requirements for the facility

- The facility or nursing home must allow private, in-person access to the resident by the essential support person in the resident's room. If the resident resides in a shared room, and the roommate, or the roommate's representative, if any, does not consent or the visit cannot be conducted safely in a shared room, then the facility or nursing home shall designate a substitute location in the facility or nursing home for the resident and essential support person to visit.
- The facility or nursing home shall develop and implement reasonable conditions on access by an essential support person tailored to protecting the health and safety of the essential support person, residents, and staff.
- The facility or home will provide the ESP with information around proper use of the PPE including offering the information on user seal checks for a tight fitting respirator (for example an N95 mask) that can be found [here](#).
- The facility or nursing home may temporarily suspend an individual's designation as an essential support person for failure to comply with these requirements or reasonable conditions developed and implemented by the facility or nursing home that are tailored to protecting that health and safety of the essential support person, residents, and staff.
 - Unless immediate action is necessary to prevent an imminent and serious threat to the health or safety of residents or staff, the facility or nursing home shall attempt to resolve the concerns with the essential support person and the resident prior to temporarily suspending the individual's designation as an essential support person.

- The suspension shall last no longer than 48 hours during which time the facility or nursing home must contact the department for guidance and must provide the essential support person
 - Information regarding the steps the essential support person must take to resume the visits, such as agreeing to comply with reasonable conditions tailored to protecting the health and safety of the essential support person, residents, and staff,
 - The contact information for the long-term care ombuds program and as appropriate, contact information for the developmental disabilities ombuds, as well as the contact information for Disability Rights Washington.

Visitation during an Outbreak

Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows. However, such resident must be allowed to receive in-person visitors for compassionate care and essential support situations, with adherence to transmission-based precautions. This restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described above.

Facilities should consider visitation, group activities, and communal dining limitations based on status of COVID-19 infections in the facility. The facility will take into consideration the scope of residents in isolation and quarantine status. For example, the facility may not allow communal dining, group activities, and visitors if active COVID-19 throughout the entire physical plant. Or, they may restrict these activities and visitation on particular wings/units with COVID-19 spread and allow on non-COVID units. ([Outdoor Visitation Guidance for Long-term Care Settings.](#)) **Please note** – Compassionate care and essential support person visits are still allowed in a COVID unit.

An outbreak exists when a new onset of COVID-19 occurs in the facility/home that meets the outbreak definition found here: [Interim COVID-19 Outbreak Definition for Healthcare Settings.](#) This guidance is intended to describe how visitation can still occur when there is an outbreak, but there is evidence that the transmission of COVID-19 can be contained to a single area (e.g., unit) of the facility/home or the LHJ is able to assist with recommendations, dependent on the layout of the setting:

- When a new case of COVID-19 is identified and the facility meets the outbreak definition found in the [Interim COVID-19 Outbreak Definition for Healthcare Settings](#), a facility should immediately begin outbreak testing and suspend all visitation in that unit or area where the positive test occurred (except that required under federal disability rights law), until at least one round of testing is completed. Visitation can occur based on the following criteria:
 - Compassionate care visits should be allowed **at all times**, for any resident (vaccinated or unvaccinated) regardless of outbreak status. Residents on the affected unit would be able to have one essential support person visiting.
 - Window visits and visits using technology are not restricted or prohibited. Providers will permit window visits depending on grounds safety, resident privacy and choice, and facility capacity, case mix, and staffing. Providers will also assist with the use of technology to support continued social engagement during an outbreak.

- In all cases, **visitors should be notified about the potential for COVID-19 exposure** in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings

For Nursing Facilities: *While the above scenarios describe how visitation can continue after one round of outbreak testing, facilities should continue all necessary rounds of outbreak testing. In other words, this guidance provides information on how visitation can occur during an outbreak, but does not change any expectations for testing and adherence to infection prevention and control practices.*

Visitor Log Information

Visitor's log information will include date, time in, name of visitor and their contact information, including phone number and email address if available. DOH Visitor Screening, Log, and Letter can be found here: <https://www.doh.wa.gov/Portals/1/Documents/1600/coronavirus/VisitorsLog.pdf>.

Additional Resources

Outbreak Definition

[Interim COVID-19 Outbreak Definition for Healthcare Settings](#)

Influenza vs COVID-19

[CDC Similarities and Differences between Flu and COVID-19](#)

[Interim Guidance for Transferring Residents between Healthcare Settings](#)

[Risk Assessment Template](#) (quarantine for the purpose of this document is per template context)

Indoor/Outdoor Visitation Guidance

[Outdoor Visitation Guidance](#)

LHJ and DOH Assessment Teams

Consider an onsite or virtual LHJ/DOH COVID-focused Infection Control Assessment. This is a non-regulatory support to enhance facilities' internal infection control program

