IDPH
IOWA Department of PUBLIC HEALTH

IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

Iowa Guidance on Phased Easing of Restrictions for Long-Term Care Facilities

June 4, 2020

Beginning March 13, 2020, Iowa long-term care facilities began implementing guidance from the Centers for Medicare and Medicaid Services (CMS) that outlined recommended restrictions to normal operations in attempt to mitigate the entry and spread of COVID-19. This guidance has been further supported by additional Iowa agencies, such as, the Iowa Department of Inspections and Appeals (DIA) and the Iowa Department of Public Health (IDPH).

While public health mitigation efforts remain critically important, especially in long-term care settings where residents may be more vulnerable to virus exposure, the state acknowledges that it is equally important to consider the quality of life and dignity of the residents of long-term care facilities. Based on recent guidance from CMS, the state has collaborated with long-term care associations on how to responsibly ease restrictions in long-term care facilities while COVID-19 remains in communities across the state. This guidance is based on currently available best-practice recommendations and evidence and may be updated as additional information becomes available.

The guidance below is specifically targeted at long-term care facilities (e.g., nursing homes). Other facilities or congregate care settings, such as assisted living or residential care facilities, may choose to follow an independently developed framework for easing restrictions. Guidance from the Centers for Disease Control (CDC) for COVID-19 mitigation strategies for assisted living congregate settings is found at:

- https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
- https://www.cdc.gov/coronavirus/2019-ncov/community/shared-congregate-house/guidance-shared-congregate-housing.html

Phase 1

Phase 1 is designed for vigilant infection control during periods of heighted virus spread in the community and potential for healthcare system limitations, which may include factors such as staffing, hospital capacity, Personal Protective Equipment (PPE), and testing.

Consideration	Mitigation Steps
Visitation	Visitation generally prohibited, except for: • Compassionate care situations restricted to end-of-life and psycho-social needs; and • Under limited and controlled conditions, coordinated by the facility, in consideration of social distancing and universal source control (e.g., window visits). Note: these limited and controlled visits may be included in the facility's temporary visitation policy and are not mandated; but rather at the discretion of the facility. • Compassionate care visitors are screened upon entry and additional precautions are taken, including social distancing and

Consideration	Mitigation Steps
	hand hygiene. All visitors must wear a cloth face covering or facemask for the duration of their visit. The facility must provide a face mask to the visitor, in the event they do not have one, to ensure universal source control. Facility should have policies in place for virtual visitation, whenever possible, to include: • Access to communication with friends, family, and their spiritual community. • Access to the Long-Term Care Ombudsman.
Essential/Non-Essential Healthcare Personnel	• Restricted entry of non-essential healthcare personnel. Non-essential personnel may be allowed into the building following an infection control risk analysis by the facility. • All healthcare personnel are screened 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.

Non-Medically Necessary Trips	• Telemedicine should be utilized whenever possible.
	• Non-medically necessary trips outside the building should be avoided.
	• For medically necessary trips away from of the facility:
	  • The resident must wear a cloth face covering or facemask; 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 a facemask. Additional PPE may be required.
	  • Transportation equipment shall be sanitized between transports.
	  • Quarantine for 14 days upon return if asymptomatic and not in a positive COVID-19 status.

Communal Dining	• Communal dining not recommended but must be limited (for COVID-19 negative or asymptomatic residents only). • Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). • No more than 10 individuals in a dining area at one time. • If staff assistance is required, appropriate hand hygiene must occur between residents.
Screening	• Resident screening each shift. It should be clearly documented in the facility policies when shift screenings should occur and how it is tracked. • Staff screening at the beginning and end of each shift.
Universal Source Control	• All facility staff, regardless of their position, wear a cloth face

Consideration	Mitigation Steps
& Personal Protective Equipment (PPE)	covering or face mask while in the facility. • All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. • Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel). • New admissions or readmissions from a hospital setting should quarantine for 14 days.
Cohorting & Dedicated Staff*	• Dedicated space in facility and dedicated staff for cohorting and managing care for residents who are symptomatic or testing positive with COVID-19. • Plan to manage new admissions and readmissions with an unknown COVID- 19 status. • Plan to manage residents who routinely attend outside medically necessary appointments (e.g., dialysis).
Group Activities	• Restrict group activities but some activities may be conducted (for COVID-19 negative or asymptomatic residents only) with social distancing, hand hygiene, and use of a cloth face covering or facemask. • Engagement through technology is preferred to minimize opportunity for exposure. • Facilities should have policies in place to engage virtually, where possible, in activities that improve quality of life (e.g. church service, art classes, concerts, etc.).
Testing	• Facility shall report progress towards completion of baseline testing for staff and residents, as described in Appendix A. • Staff and residents shall be tested if any symptoms are detected or if a positive case of COVID-19 has been identified, as described in Appendix A.
Survey Activity	• Investigation of complaints alleging there is an immediate serious threat to the residents' health and safety (known as Immediate Jeopardy). • Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings. • Focused infection control surveys. • Initial survey to certify that the provider has met the required conditions to participate in the Medicare. • Any other survey as authorized or required by CMS. • State based priorities, such as hot spots.

IDPH
IOWA Department of PUBLIC HEALTH

IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

Phase 2

Facility may decide to initiate Phase 2 upon alignment with the following metrics:

- ☐ 14 days since last positive or suspected case identified. (See Appendix A regarding testing recommendations that should be completed prior to moving to Phase 2.)
- ☐ Adequate staffing levels.
- ☐ Adequate supply of PPE to adhere fully to CDC guidance for proper PPE use for infection control as described at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.
- ☐ Ability of local hospital to accept referrals/transfers.
- ☐ Capable of cohorting residents with dedicated staff in the case of suspected or positive cases.
- ☐ A downward trend in number of cases or the % positivity over the past 14 days in the county.
- ☐ Facility shall report their Phase status to the Regional Medical Coordination Center.
- ☐ Facilities may use discretion to be more restrictive in areas, where deemed appropriate through internal policies, even if they have moved to this Phase.

Consideration	Mitigation Steps

Visitation	• Visitation limited to compassionate care situations to include end-of-life and residents with significant changes in condition including psycho-social or medical issues.
	• Compassionate Care visits shall be limited as follows:
	  ◦ By appointment only as coordinated by the nursing home based on their ability to manage infection control practices and proper social distancing.
	  ◦ Only in designated areas to ensure safe distancing, proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors. Note: each facility must determine their capacity to manage limited visits, based on considerations, such as, staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits.
	  ◦ Facilities may limit the number of visitors for each resident per week and per occurrence.
	  ◦ Preference should be given to outdoor visitation opportunities like parking lot visits with distancing.
	• All Visitors are screened upon entry.
	• Visitors unable to pass the screening or comply with infection control practices like masks should refrain from visiting.
	• Types of visitation from the Phase 1 may continue under limited controlled conditions coordinated by the facility in consideration of social distancing and universal source control (e.g., window visits).
	
	Facility should have policies in place for virtual visitation, whenever

Consideration	Mitigation Steps
	possible, to include: • Access to communication with friends, family, and their spiritual community. • Access to the Long-Term Care Ombudsman.
Essential/Non-Essential Healthcare Personnel	• Limited entry of non-essential healthcare personnel based on risk analysis by the facility infection control team, including the entry of barbers and beauticians. If barbers and beauticians are determined a low risk for entry, the following mitigation steps should be followed. ◦ Salons may open so long as the beautician or barber is properly screened when entering the facility and must wear a mask for the duration of time in the facility. ◦ The beautician or barber must remain in the salon area and avoid common areas of the facility. ◦ Salons must limit the number of residents in the salon at one time to accommodate ongoing social distancing. ◦ Staged appointments should be utilized to maintain distancing and allow for infection control. ◦ Salons must properly sanitize equipment and salon chairs between each resident; and the beautician or barber must perform proper hand hygiene. ◦ No hand-held dryers. ◦ Salons must routinely sanitize high-touch areas. ◦ Residents must wear a face mask during their salon visit. • All healthcare personnel are screened 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.
Non-Medically Necessary Trips	• Telemedicine should be utilized whenever possible. • Non-medically necessary trips outside the building should be avoided. • For medically necessary trips away from of the facility: ◦ The resident must wear a cloth face covering or facemask; 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 a facemask. Additional PPE may be required. ◦ Transportation equipment shall be sanitized between transports. ◦ Quarantine for 14 days upon return if asymptomatic.
Communal Dining	• Communal dining limited. • Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). • A limited number of individuals in a dining area at one time, not to

Consideration	Mitigation Steps
	exceed 50 percent of capacity unless that would be less than 10 people. • If staff assistance is required, appropriate hand hygiene must occur between residents as well as use of appropriate PPE.
Screening	• Residents screening each shift. It should be clearly documented in the facility policies when shift screenings should occur and how it is tracked. • Staff screening at the beginning and end of their shift.
Universal Source Control & PPE	• All facility staff, regardless of their position, wear a cloth face covering or face mask while in the facility. • All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. • Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel), and remain in effect until further notice. • New Admissions should quarantine for 14 days.
Cohorting & Dedicated Staff*	• Dedicated space in facility for cohorting with dedicated staff and managing care for residents who become symptomatic or test positive with COVID-19; • Plan to manage new/readmissions with an unknown COVID- 19 status and residents who routinely attend outside medically necessary appointments (e.g., dialysis).
Group Activities	• Limit group activities. • Small group activities may occur with social distancing, hand hygiene, and use of a cloth face covering or facemask and no more than 10 people. • Facilities must restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss).
Testing	• See guidance for testing in Appendix A. • Facility shall report ongoing testing efforts to the Regional Medical Coordination Center as requested.
Phase Regression	• A facility will continue to monitor for the presence of COVID-19 in their buildings. This will occur through resident screening each shift, and staff screening before and after each shift, and leveraging the data points requested by the CDC as reported through the NHSN system. • The facility will continue to progress through the different phases of adjusting restrictions until one staff or resident is confirmed positive for COVID-19 and another has symptoms, at which time, the facility will return to the Phase 1. • If the facility must return to Phase 1, and 14 days have passed with no additional residents or staff testing positive for COVID-19, the

Consideration	Mitigation Steps
	facility has demonstrated the ability to mitigate the spread of COVID-19 and may return to Phase 2 of the reopening process.
Survey Activity	• Investigation of complaints alleging Immediate Jeopardy OR actual harm to residents. • Revisit surveys to confirm the facility has removed any Immediate Jeopardy findings or actual harm. • Focused infection control surveys. • Initial certification surveys. • Any other survey as authorized or required by CMS. • State based priorities, such as hot spots.

IDPH
IOWA Department of PUBLIC HEALTH

IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

Phase 3

Facilities may decide to initiate Phase 3 upon alignment with the following metrics:

- ☐ 14 days since last COVID-19 positive or suspected case identified.
- ☐ Adequate staffing levels.
- ☐ Adequate supply of PPE to adhere fully to CDC guidance for proper PPE use for infection control as described at https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html.
- ☐ Ability of local hospital to accept referrals/transfers.
- ☐ Capable of cohorting residents with dedicated staff in the case of suspected or positive cases.
- ☐ A downward trend in number of cases or the % positivity over the past 14 days in the county.
- ☐ Facility shall report their Phase status to the Regional Medical Coordination Center.
- ☐ Facilities may use discretion to be more restrictive in certain areas, where deemed appropriate through internal policies, even if they have moved to this Phase.

Consideration	Mitigation Steps

Visitation -	• All residents should have the ability to have limited visitation.
	• Each facility should develop a limited visitation policy which addresses the following, at minimum:
	  • Visitation schedule, hours, and location.
	  • Number of visitors and visits.
	  • Infection control practices including proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors and social distancing.
	  • Use of PPE.
	  • By appointment only as coordinated by the nursing home based on their ability to manage infection control practices and proper social distancing.
	  • Only in designated areas to ensure safe distancing, proper hand hygiene, universal source control, and overall facility supervision of safe practices related to visitors. Note: each facility must determine their capacity to manage limited visits, based on considerations, such as, staff availability to screen visitors, availability of supplies to support universal source control (e.g., face masks), monitoring for visitor compliance with safe visitation practices, and disinfection of area between visits.
	  • Facilities may limit the number of visitors for each resident per week and per occurrence.
	  • Preference should be given to outdoor visitation opportunities like parking lot visits with distancing.
	• All visitors are screened upon entry.
	• Visitors unable to pass the screening or comply with infection control practices like masks should refrain from visiting.

Consideration	Mitigation Steps
	• Types of visitation from Phase 1 may continue under limited controlled conditions coordinated by the facility in consideration of social distancing and universal source control (e.g., window visits).
Essential/Non-Essential Healthcare Personnel	• Limited entry of non-essential healthcare personnel to include barbers and beauticians. See salon guidance below for mitigation steps. • All healthcare personnel are screened 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.

Non-Medically Necessary Trips	• Non-medically necessary trips outside the building should be limited. It is recommended residents with high-risk co-morbidities continue to avoid non-medically necessary trips outside the building; with overall decisions made collaboratively by the resident, their representative, a nursing home representative, and the resident's physician.
	• For medically necessary and limited non-medically necessary trips away from of the facility:
	  ◦ The resident must wear a cloth face covering or facemask; 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 a facemask. Additional PPE may be required.
	  ◦ Transportation equipment shall be sanitized between transports.
	  ◦ Observe for 14 days upon return.

Communal Dining	• Modified Communal dining. • Residents may eat in the same room with social distancing (limited number of people at tables and spaced by at least 6 feet). • A limited number of individuals in a dining area at one time. No more than 2 people at a table. • If staff assistance is required, appropriate hand hygiene must occur between residents.
Screening	• Residents screening daily. It should be clearly documented in the facility policies when daily screening should occur and how it is tracked. • Staff screening at the beginning and end of their shift.
Universal Source Control & PPE	• All facility staff, regardless of their position, should wear a cloth face covering or face mask while in the facility. • All facility staff and essential healthcare personnel wear appropriate PPE when they are interacting with residents, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. • Additional universal source control recommendations can be found

Consideration	Mitigation Steps
	throughout this document (e.g., visitors, essential healthcare personnel), and will remain in effect until further notice.
Cohorting & Dedicated Staff*	• Dedicated space in facility for cohorting with dedicated staff and managing care for residents who become symptomatic or test positive with COVID-19; • Plan to manage new/readmissions with an unknown COVID- 19 status and residents who routinely attend outside medically necessary appointments (e.g., dialysis).
Group Activities	• Limit group activities. • Expanded group activities may occur with social distancing, hand hygiene, and use of a cloth face covering or facemask. • Facilities should restrict activities that encourage multiple residents to handle the same object(s) (e.g., ball toss).
Salons	• Salons may open so long as the beautician or barber is properly screened when entering the facility and must wear a mask for the duration of time in the facility. • The beautician or barber must remain in the salon area and avoid common areas of the facility. • Salons must limit the number of residents in the salon at one time to accommodate ongoing social distancing. • Staged appointments should be utilized to maintain distancing and allow for infection control. • Salons must properly sanitize equipment and salon chairs between each resident; and the beautician or barber must perform proper hand hygiene. • No hand-held dryers. • Salons must routinely sanitize high-touch areas. • Residents must wear a face mask during their salon visit.
Testing	• See guidance for testing in Appendix A. • Facility shall report ongoing testing efforts to the Regional Medical Coordination Center as requested.
Phase Regression	• A facility will continue to monitor for the presence of COVID-19 in their buildings. This will occur through resident screening daily and staff screening before and after each shift and leveraging the data points requested by the CDC as reported through the NHSN system. • The facility will remain in Phase 3 until one staff or resident is confirmed positive for COVID-19 and another has symptoms, at which time, the facility will return to the Phase 1. • If the facility must return to Phase 1, and 14 days have passed with no additional residents or staff testing positive for COVID-19, the facility has demonstrated the ability to mitigate the spread of COVID-19 and may return to Phase 2 of the reopening process.

Consideration	Mitigation Steps
Survey Activity	• All complaint and revisit surveys required to identify and resolve any non-compliance with health and safety requirements • Standard (recertification) surveys and revisits • Focused infection control surveys • Initial certification surveys • Any other survey as authorized or required by CMS. • State based priorities, such as hot spots.

*Many senior care communities that include assisted living programs that attached to nursing facilities or are a part of a continuing care retirement community or senior living campus have commonly shared kitchen facilities. In the current public health mitigation environment, facilities should not routinely share direct care, dietary, or environmental services staff who may have contact with residents or tenants in other segments of the senior living operations. If there are identified cases of COVID-19 in other service delivery areas of the campus, there should be no sharing of staff between those care systems.

IDPH
IOWA Department of PUBLIC HEALTH

IOWA DEPARTMENT OF
INSPECTIONS & APPEALS

Appendix A: Testing Guidance

On May 18, 2020, The Centers for Medicare and Medicaid Services (CMS) issued QSO-20-30-NH, Nursing Home Reopening Recommendations for State and Local Officials. The document provides guidance for State Survey Agencies and other state officials to determine how nursing facilities may begin to lift restrictions placed to mitigate the spread of COVID-19. CMS indicates in this QSO that testing will be a critical part of a facility lifting restrictions on operations.

The state agrees that it is important for all facilities to participate in baseline testing for all residents and staff prior to consideration of lifting restrictions. Baseline testing is critical to understand how the virus may exist in facilities especially among those without symptoms, so that informed decisions can be made and appropriate steps are taken for containment. Comprehensive testing of all staff and residents is encouraged as a baseline regardless of whether a case has been identified or not. At minimum facilities should meet the following testing metrics prior to moving to Phase 2 and also follow this guidance any time a single positive case is identified in a facility:

- If there were one or more positive cases previously in residents, at a minimum, all residents with shared hallways/unit or staff should have been tested. Offering testing to all residents when a positive case is recognized is advised.
- All staff, including administrative, should be offered testing regardless of contact with residents that have tested positive for COVID-19.
- Staff declining testing should be treated as having a positive or unknown COVID-19 status and appropriate PPE should be used.

For Phase 2 and 3, the state encourages testing to continue as outlined in previous guidance for residents and staff that:

- Are currently symptomatic.
- Have had close contact with an individual, either at work or in the community that has tested positive for COVID-19.
- Staff that meet either of the above two bullets and decline testing should be treated as having a positive or unknown COVID-19 status and excluded or use recommended PPE as appropriate.

Additionally, the state will be engaging in sentinel testing in facilities across the state during Phase 2 and 3. Sentinel testing will be conducted on a weekly basis with a limited number of facilities and will include a prescribed number of staff, as determined by the Iowa Department of Public Health in collaboration with a facility. Sentinel testing will be based on factors such as:

- Virus activity in the community.
- Geographic representation.
- Availability of testing in the community.
- Findings from infection control surveys.
- Reporting of testing efforts and resources by the facility.

The state will work with local public health entities and facilities to access supplies or appropriate funding for baseline testing in Phase 1 as well as case-directed and sentinel testing in Phase 2 and 3.

Facilities should report their baseline testing numbers (Phase 1) for residents and staff through their Regional Medical Coordination Centers (RMCC).

For ongoing testing efforts in Phase 2 and 3, facilities should report through their RMCC once reporting surveys are ready to accept data. Definitions for all requested data will be available as part of the RMCC reporting process.