EXCEPTIONAL FORESTERS INC.

"Creating Life Opportunities"

Policy and Procedure # 298

COVID Safe Start Plan for Exceptional Foresters, Inc. (EFI)

Approval: Dani Cook Digitally signed by Dani Cook DN: cn=Dani Cook, o=EFI, ou=admin, email=danicook@team-efi.org, c=US Date: 2024.05.08 09:49:40 -07'00' Effective Date: 5/8/24

This plan includes the written procedures and practices EFI has implemented to prevent the spread of COVID-19.

This plan adheres to all measures established by the Governor's guidance, the Department of Labor & Industries (L&I) Coronavirus (COVID-19) Prevention: General Requirements and Prevention Ideas for Workplaces, and the Washington State Department of Health Workplace and Employer Resources & Recommendations (DOH). This plan incorporates the latest industry guidance available from the State of Washington at https://www.governor.wa.gov/issues/issues/covid-19-resources/covid-19-reopening-guidance-businesses-and-workers

Given the critical importance of limiting COVID-19 exposure, decisions on relaxing restrictions should be made:

- With careful review of various unique aspects of the different settings and communities where clients reside;
- In alignment with the Governor's Proclamations; and
- In collaboration with state and local health officials.

This phased approach will help keep clients healthy and safe.

Core Principles of Safe Start and COVID-19

These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for long-term-care, and should be adhered to at all times. Additionally, visitation should be person-centered, consider the clients' physical, mental, and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear Plexiglas dividers, curtains). Also, EFI should enable visits to be conducted with an adequate degree of privacy whenever possible. 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. We may restrict or limit visitation due to COVID-19 county positivity rates in addition to facility COVID-19 status, a client's COVID-19 status, visitor symptoms, visitor lack of adherence to proper infection control practices, or other relevant factors related to the COVID-19 public health emergency. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the guidance outlined below:

Personal Protective Equipment (PPE)

EFI will ensure designated visitors and those providing compassionate care wear proper PPE that includes masking and facial shields/eye protection and full PPE when appropriate. EFI has the flexibility to safely manage visitation and may deny a visitor access if they are unwilling to wear appropriate PPE. If the visitor is denied access, they will be given the OMBUDS 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 Washington Safe Start Guidelines.

Key Visitation Principles

Visitation can be conducted through different means, based on a household/home's structure, community virus activity, and clients' needs, such as in clients' 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.

Infection Prevention

Infection prevention should entail the following basic concepts, at a minimum:

- Active screening of all who enter the home for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms), and denial of entry of those with signs or symptoms
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose), and use of eye protection if appropriate
- Social distancing at least six feet between persons
- Cleaning and disinfecting high frequency touched surfaces in the home, and designated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of clients (e.g., separate areas dedicated COVID-19 care) if possible

Outdoor Visitation Principles

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred and can also be conducted in a manner that reduces the risk of transmission. Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever

practicable. Aside from weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual client's health status (e.g., medical condition(s), COVID-19 status), or a household's outbreak status, outdoor visitation should be facilitated routinely. An accessible and safe outdoor space should be created for visitation, such as in courtyards, patios, or use of tents, if available. Each outdoor visitation should consider limiting the number of visitors and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing).

Indoor Visitation Principles

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

- Visitors should be able to adhere to the core principles;
- Each visitation should consider how the number of visitors per client at one time and the total number of visitors in the home 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, work with clients in scheduling visits for a specified length of time to help ensure all clients are able to receive visitors.

Access to Ombuds and Resident Right Advocates

Washington State laws and rules provide representatives of the Office of the State Long-Term Care Ombudsman and the Developmental Disabilities Ombuds with immediate access to any client. During this public health emergency, in-person access may be limited due to infection control concerns and/or transmission of COVID-19; however, in-person access may not be limited without reasonable cause. We note that representatives of the Ombuds should adhere to the core principles of COVID-19 infection prevention. If in-person access is not advisable, such as the Ombuds having signs or symptoms of COVID-19, EFI must, at a minimum, facilitate alternative client communication with the ombuds, such as by phone or through use of other technology.

Federal and State Disability Laws

EFI 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 client 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), EFI must allow the individual entry into the client's home to interpret or facilitate, with some exceptions. This would not preclude EFI 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.

Medically Necessary Providers, Service and Health Care Workers Principles

Health care workers who are not employees of EFI but provide direct care to the clients, 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 client's home 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 an active screening process. We note that EMS personnel do not need to be screened so they can attend to an emergency without delay. All staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention and must comply with COVID-19 testing requirements.

Communal Activities and Dining Principles

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Clients may eat in the same room with social distancing (e.g., limited number of people at each table and with at least six feet between each person). Consideration must be made for additional limitations based on status of COVID-19 infections in the clients' home. Additionally, group activities may also be facilitated (for clients who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among clients, appropriate hand hygiene, and use of a face covering. Activities may be offered while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.

Specialized Care Visitation

For clients on respiratory ventilation who are room bound, or any other client with specific medical conditions that place them bed bound. Follow DSHS and DOH guide for specialized care visitation.

Offsite Visits

The EFI Risk Assessment Template must be used to assess each client for any COVID-19 exposure prior to and after returning from offsite visits to determine if the client is low, medium 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 client as a result of the assessment must be documented in the client's care plan. All completed EFI Risk assessment sheets will be turned in to our Quality Assurance Supervisor for review every month.

Holiday Guidance

Follow CDC guidelines for holidays, where State or LHJ guidance provides stricter measures, follow the stricter guidance. This guidance does not replace state proclamation requirements, DOH, and CDC link: CDC recommendations for Holiday Celebrations and Small Gatherings. All guidelines for visitation within this document must be followed with strict adherence to infection control principles to prevent the spread and transmission of COVID-19.

Activities

Follow the DSHS and DOH guide for activities. Interim Supplemental Guidance for Allowing Group Activities and Communal Dining in Long-Term Care Facilities (LTCFs)

Section I – Safe Start

Phase 1

COVID 19 Risk Assessment Dashboard

Phase 1 is designed aggressive infection control during periods of heightened 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. Heightened virus spread (High COVID-19 activity) is defined as >75 cases/100,000 for two weeks. Check this dashboard to see what the metric is for your county. If your county is currently meeting the definition of heightened virus spread the facility will remain phase 1.

Consideration	EFI client homes with 4 or fewer clients
Visitation	See Section II
Essential/Non-Essential Healthcare Personnel	• Entry is restricted in SOLA's to essential healthcare personnel only. Please see Dear CCRSS Provider – ALTSA: CCRSS #2020-005. • Essential health care personnel such as Nurse Delegators will follow DOH guidance for nurse delegation. • Provider or program or home will make sure essential health care personnel participate in active screening upon entry and additional precautions are taken, including hand hygiene, wear appropriate PPE as needed or as determined

	by the task; and at a minimum wearing a face mask for the duration of their visit.
Medically and Non-Medically Necessary Trips	Telemedicine should be utilized whenever possible. For medically and non-medically necessary trips away from the client's home: • The client must be encouraged to wear a cloth face covering or facemask unless medically contraindicated. • The provider or program or home, must share the client's COVID-19 status with the transportation service and entity with whom the client has the appointment. • Transportation staff, at a minimum, must wear a facemask. Additional PPE may be required. • Transportation equipment shall be sanitized between transports. Clients can make trips outside of the home and into the community, including non-medically-related trips, to locations that are open to the public. However, clients are encouraged to limit or avoid trips where appropriate precautions are not being followed. • Please see Dear Provider letter CCRSS 2020-019 for details regarding clients leaving the home for non-medically necessary trips. • Use the Risk Assessment Template to Assess COVID-19 Exposure Risk for Residents and Clients prior to and after Community Visits and the Letter to Families when residents/clients are preparing for community activities.
Communal Dining	• Discourage COVID-19 positive or suspected COVID-19 clients from eating meals with housemates. • Communal dining is not recommended. • For clients who require staff assistance with feeding, appropriate hand hygiene must occur between clients and clients must be seated at least 6 feet apart. • Appropriate hand hygiene must occur for both clients and staff before and after meals. • Sanitize all eating areas with disinfectant before and after meals. • All staff must wear masks.
Screening	• Actively screen clients daily and/or during a provider's in-person interaction with the client, including interactions with clients receiving less than 24 hours a day service", by

	checking temperatures and questionnaire about symptoms and potential exposure, signs and symptoms of COVID-19. • Actively screen all staff and visitors entering a client's home by checking temperature and asking them for signs and symptoms. • Do not screen EMTs and law enforcement responding to an emergent call. • Maintain a screening log for 30 days.
Universal Source Control & Personal Protective Equipment (PPE)	• All staff, regardless of their position must wear a cloth face covering or face mask while in the client's home. • All staff and essential healthcare personnel must wear appropriate PPE when they are interacting with clients, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. Contingency Strategies for PPE use during COVID-19 Pandemic • Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel). • Follow the LHJ guidelines for when a client returns home from a hospital setting.
Cohorting & Dedicated Staff	• Plans must be in place to monitor: o Clients who engage in community activities or outings and attend outside medically necessary appointments (e.g., dialysis) o Staff who work with multiple clients and agencies by active screening, and asking for signs and symptoms o A client who tests positive and has housemates in the home.
Group Activities	• Encourage clients with housemates to practice social distancing and wearing face masks when they engage in group activities at home unless medically contraindicated. • Assist clients in engagement through technology to minimize opportunity for exposure. • Assist clients in finding individual activities through virtual or remote means, where possible, that improve quality of life (e.g. church service, art classes, concerts, etc.).
Testing/Contact Tracing	• Testing will occur based on CDC, DOH, and LHJ guidance. • The program or provider must maintain access to COVID-19 testing for all clients and staff at an established commercial laboratory.

	• If a case of COVID-19 is identified among a staff or client, the provider or certified SOLA program should reach out to LHJ the same day of notification to support contact tracing efforts to identify potential exposures and appropriate next steps and scope of interventions.

Phase 2

Entry Criteria:

EFI may begin implementing the criteria outlined in the grid below after meeting all of the following:

- EFI has reviewed the key metrics for the county at the COVID 19 Risk Assessment Dashboard and determined that moderate transmission is occurring in the community. Moderate transmission is defined as 25-75 cases/100,000 population for two weeks.
- 28 days have passed since the last positive or suspected client or 2 staff cases was identified in the household or households with shared staffing OR any timeline required by the LHJ, whichever is greater;
- Adequate staffing levels are in place;
    - If 28 days have not passed since the last positive client or staff case was identified in a household, that household and any household with shared staffing through utilization of contact tracing methods may not move to Phase 2 until 28 days have passed.
- EFI performs and maintains an inventory of PPE to assure at least a 14-day supply using the CDC PPE burn rate calculator: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html;
- EFI performs and maintains an inventory of disinfection and cleaning supplies for clients;
- There is assurance by the LHJ that local hospital(s) have the capacity to accept referrals/transfers;
- EFI is capable of cohorting clients with dedicated staff in the case of suspected or positive cases OR is able to transfer positive cases to a COVID-19 positive facility for care and recovery OR in the case of small homes, there is a plan in place for managing both positive and negative cases while mitigating the spread of infection.
- EFI may use discretion to be more restrictive, where deemed appropriate, through internal policies and in conjunction with the LHJ, even if they have moved to this Phase.

Consideration	EFI client homes

Visitation	See Section II
Essential/Non-Essential Healthcare Personnel	• All 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 the visit. • Essential health care personnel wear appropriate PPE as needed. • Essential health care personnel such as Nurse Delegators will follow DOH guidance for nurse delegation.
Medically and Non-Medically Necessary Trips	• Clients can make trips outside of the home and into the community, including non-medically-related trips, to locations that are open to the public. However, clients are encouraged to limit or avoid trips where appropriate precautions are not being followed. • Please see Dear Provider letter CCRSS 2020-019 for details regarding clients leaving the home for non-medically necessary trips. • Use the Risk Assessment Template to Assess COVID-19 Exposure Risk for Residents and Clients prior to and after Community Visits and the Letter to Families when residents/clients are preparing for community activities.
Communal Dining	• Discourage COVID-19 positive or suspected COVID-19 clients from eating meals with housemates. • Communal dining is not recommended but must be limited (for COVID-19 negative or asymptomatic clients only). • Appropriate hand hygiene must occur for both clients and staff before and after meals. • Sanitize all eating areas with disinfectant before and after meals.
Screening	• Actively screen clients daily and/or during a provider's in-person interaction with the client, including interactions with clients receiving less than 24 hours a day service", by checking temperatures and questionnaire about symptoms and potential exposure, signs and symptoms of COVID-19. • Actively screen all staff and visitors entering a client's home by checking temperature and asking them for signs and symptoms. • Do not screen EMTs and law enforcement responding to an emergent call. • Maintain a screening log for 30 days.

Universal Source Control & Personal Protective Equipment (PPE)	• All staff, regardless of their position must wear a cloth face covering or face mask while in the client's home. • All staff and essential healthcare personnel must wear appropriate PPE when they are interacting with clients, to the extent PPE is available, and in accordance with CDC PPE optimization strategies. Contingency Strategies for PPE use during COVID-19 Pandemic • Additional universal source control recommendations can be found throughout this document (e.g., visitors, essential healthcare personnel). • Follow the LHJ guidelines for when a client returns home from a hospital setting.
Cohorting & Dedicated Staff	• Plans must be in place to monitor: o Clients who engage in community activities or outings and attend outside medically necessary appointments (e.g., dialysis) o Staff who work with multiple clients and agencies by active screening, and asking for signs and symptoms o A client who tests positive and has housemates in the home.
Group Activities	• Encourage clients with housemates to practice social distancing and wearing face masks when they engage in group activities at home unless medically contraindicated. • Assist clients in engagement through technology to minimize opportunity for exposure. • Assist clients in finding individual activities through virtual or remote means, where possible, that improve quality of life (e.g. church service, art classes, concerts, etc.).
Testing/Contact Tracing	• Testing will occur based on CDC, DOH, and LHJ guidance. • The program or provider must maintain access to COVID-19 testing for all clients and staff at an established commercial laboratory. • If a case of COVID-19 is identified among a staff or client, the provider or certified SOLA program should reach out to LHJ the same day of notification to support contact tracing efforts to identify potential exposures and appropriate next steps and scope of interventions.

Phase 3

Entry Criteria:
EFI may begin implementing the criteria outlined in the grid below after meeting all of the following:

- EFI has reviewed the key metrics for the county at the COVID 19 Risk Assessment Dashboard and determined minimal transmission is occurring. Minimal transmission is defined as 10-25 cases/ 100,000 population for two weeks.
- 28 days have passed since the last positive or suspected client or 2 staff cases was identified in the household or household with shared staffing OR any timeline required by the LHJ, whichever is greater;
    - If 28 days have not passed since the last positive client or staff case was identified in a household, that household and any household with shared staffing through utilization of contact tracing methods may not move to Phase 3 until 28 days have passed.
- Adequate staffing levels are in place;
- EFI performs and maintains an inventory of PPE to assure at least a 14-day supply using the CDC PPE burn rate calculator: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html;
- EFI performs and maintains an inventory of disinfection and cleaning supplies for clients;
- There is assurance by the LHJ that local hospital(s) have the capacity to accept referrals/transfers;
- EFI is capable of cohorting clients with dedicated staff in the case of suspected or positive cases OR is able to transfer positive cases to a COVID-19 positive facility for care and recovery OR in the case of small homes, there is a plan in place for managing both positive and negative cases while mitigating the spread of infection.

Consideration	EFI client homes
Visitation	See Section II
Essential/Non-Essential Healthcare Personnel	• All 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 the visit. • Essential health care personnel such as Nurse Delegators will follow DOH guidance for nurse delegation. • The provider or program or home will make sure essential and non-essential health care personnel wear appropriate PPE, as needed.

	• Permitted to allow essential and non-essential healthcare personnel as long as all CDC and DOH safety practices are followed. • The provider or program or home will use discretion following policies for universal masking, social distancing, flexible scheduling, number of visitors, locations, and minimize client risk.
Medically and Non-Medically Necessary Trips	• Clients can make trips outside of the home and into the community, including non-medically-related trips, to locations that are open to the public. However, clients are encouraged to limit or avoid trips where appropriate precautions are not being followed. • Continue to follow Residential Care Services Dear Provider letter CCRSS 2020-019 for details regarding clients leaving the home for non-medically necessary trips. • Use the Risk Assessment Template to Assess COVID-19 Exposure Risk for Residents and Clients prior to and after Community Visits and the Letter to Families when residents/clients are preparing for community activities.
Communal Dining	• Discourage COVID-19 positive or suspected COVID-19 positive clients to eat meals with housemates. • Permitted if 6 ft. social distancing can be maintained, staff/clients/visitors have access to hand hygiene and they wear face covering when not eating/drinking, as tolerated, and while traveling to and from the dining area. • Communal dining is not recommended and must be limited (for COVID-19 negative or asymptomatic clients only). • Appropriate hand hygiene must occur for both clients and staff before and after meals. • Sanitize all eating areas with disinfectant before and after meals. • Limit the number of clients at the table and configure chairs at least 6 ft. away from each other.
Screening	• Actively screen clients daily and/or during a provider's in-person interaction with the client, including interactions with clients receiving less than 24 hours a day service", by checking temperatures and asking potential exposure and asking about signs and symptoms of COVID-19. • Actively screen all staff and visitors entering a client's home through temperature checks, asking about potential exposure and asking about signs and symptoms of COVID-19.

	• Do not screen EMTs and law enforcement responding to an emergent call. • Maintain a screening log for 30 days.
Universal Source Control & Personal Protective Equipment (PPE)	• All staff, regardless of their position, must wear a cloth face covering or face mask while in the client's home. • All staff and essential healthcare personnel must wear appropriate PPE when they are interacting with clients, to the extent PPE is available, and in accordance with CDC, DOH and LHJs guidance on PPE optimization strategies. Contingency Strategies for PPE use during COVID-19 Pandemic • Follow the LHJ guidelines for when a client returns home from a hospital setting.
Cohorting & Dedicated Staff	• Plans must be in place to monitor: o Clients who engage in community activities or outings and attend outside medically necessary appointments (e.g., dialysis) o Staff who work with multiple clients and agencies by active screening, and asking for signs and symptoms o A client who tests positive and has housemates in the home.
Group Activities	• Encourage clients with housemates to practice social distancing and wearing face masks when they engage in group activities at home unless medically contraindicated. • Assist clients in engagement through technology to minimize opportunity for exposure. • Assist clients in finding individual activities through virtual or remote means, where possible, that improve quality of life (e.g. church service, art classes, concerts, etc.).
Testing/Contact Tracing	• Testing will occur based on CDC, DOH, and LHJ guidance. • The program or provider must maintain access to COVID-19 testing for all clients and staff at an established commercial laboratory. • If a case of COVID-19 is identified among a staff or client, the provider or certified SOLA program should reach out to LHJ the same day of notification to support contact tracing efforts to identify potential exposures and appropriate next steps and scope of interventions.

Phase 4

Entry Criteria:
EFI is located in a county that has entered Phase 4 EFI may begin implementing the criteria outlined in the grid below after meeting all of the following:

- The Contracted Service Provider, certified SOLA program, Group Home or Group Training Home has reviewed the key metrics for the county at the COVID 19 Risk Assessment Dashboard and determined that sporadic transmission is occurring in the community. Sporadic transmission is less than 10 cases/100,000 population for two weeks.
- 28 days have passed since the last positive or suspected client or staff case was identified in the household or household with shared staffing OR any timeline required by the LHJ, whichever is greater;
    - If 28 days have not passed since the last positive client or staff case was identified in a household, that household and any household with shared staffing through utilization of contact tracing methods may not move to Phase 4 until 28 days have passed.
- Adequate staffing levels are in place;
- EFI performs and maintains an inventory of PPE to assure at least a 14-day supply using the CDC PPE burn rate calculator: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html;
- EFI performs and maintains an inventory of disinfection and cleaning supplies for clients;
- There is assurance by the LHJ that local hospital(s) have the capacity to accept referrals/transfers;
- EFI is capable of cohorting clients with dedicated staff in the case of suspected or positive cases OR is able to transfer positive cases to a COVID-19 positive facility for care and recovery OR in the case of small homes, there is a plan in place for managing both positive and negative cases while mitigating the spread of infection.
- EFI may use discretion to be more restrictive, where deemed appropriate, through internal policies and in conjunction with the LHJ, even if they have moved to this Phase.

Until the COVID public health threat has ended EFI will:

- Screen 100% of all persons, clients, and staff entering/re-entering the clients' home including: temperature checks, questionnaire about symptoms and potential exposure, observation of any signs or symptoms, and ensures all people entering the clients' homes have cloth face covering or facemask;
- Maintain a log of all visitors which must be kept for 30 days;
- Use PPE, as determined or recommended by CDC, DOH, LHJs, and CMS guidelines as warranted. Contingency Strategies for PPE use during COVID-19 Pandemic
- Universally mask;
- Maintain access to COVID-19 testing for all clients and staff at an established commercial laboratory.

Section II – Visitation

EFI is required to provide accommodations to allow access for visitation for all clients even if visitation is not allowed in-person due to the COVID status of an individual or the household. This access and accommodation may be by phone, remote video technology, window visits or outside visits, or some combination of access. Any equipment shared among clients should be cleaned and disinfected between uses according to manufacturer guidelines.

Outdoor Visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred even when the client 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 client's health status may hinder outdoor visits. For outdoor visits, facilities and homes 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.
*Fully vaccinated refers to a person who is ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons.

Indoor Visitation

EFI should allow indoor visitation, except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission. Either the visitor or client must be fully vaccinated for indoor visitation to occur. Compassionate care* visits should be permitted at all times, including during the times outlined below when regular visitation is curtailed. Indoor visitation should be permitted for all clients except as noted below:

- Unvaccinated clients, unless the visitor is fully vaccinated;
- Clients with confirmed COVID-19 infection, whether vaccinated or unvaccinated, until they have met the criteria to discontinue Transmission-Based Precautions; or
- Clients in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

In setting up indoor visitation, the following needs to be considered:

- The total number of visitors in a client home 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.
- Vaccination requirements for visitation, as well as notifying visitors should not visit if they are unvaccinated and the client is unvaccinated.
- Tours of the facility/home for the purpose of screening for prospective new clients will include when tours will occur, screening process before entry of visitor(s) into the

facility/home, movement about the facility/home during the tour, and adherence to core principles of infection prevention.

- If necessary, scheduling visits for a specified length of time to help ensure all clients are able to receive visitors.
- During indoor visitation, visitors should not walk around different halls of the facility/home. Rather, they should go directly to the client's room or designated visitation area.
- Visitors must be actively screened upon entry for symptoms or prolonged contact with someone with COVID 19 in the last 14 days.
- Visitors must sign in, including contact information, in a visitor's log. Visitors must acknowledge they have reviewed the notice about unvaccinated visitors. The log of visitors must be kept for 30 days.**
- Visits for client who share a room should not be conducted in the client's room, if possible. For situations where there is a roommate (shared bedroom) and the health status of the client prevents leaving the room, facilities/homes should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.
- The safest approach, particularly if either party has not been fully vaccinated, is for clients and their visitors to maintain physical distance (maintaining at least 6 feet between people). If the client is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing well-fitting source control. Visitors should physically distance themselves from other clients and staff in the facility/home.
- Visitors and clients should wear a well fitted cloth mask or face mask and practice hand hygiene before and after the visitation.

Indoor Visitation during an Outbreak

An outbreak exists when a new facility/home onset of COVID-19 occurs 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 setting:

- When a new case of COVID-19 among client or staff is identified, EFI will immediately work with the LHJ to begin outbreak testing and suspend all visitation until at least one round of facility-wide testing is completed.
- Visitation can resume based on criteria determined through coordination between the facility/home and the LHJ.
- Compassionate care visits should be allowed at all times, for any client (vaccinated or unvaccinated) regardless of outbreak status.
- Window visits and visits using technology are not restricted or prohibited. Facilities/homes will permit window visits depending on grounds safety, client privacy and choice, and facility capacity, case mix, and staffing. Facilities/homes 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.

***Compassionate Care Visits:**

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

- A client, who was living with their family before recently being admitted to a facility/home and is struggling with the change in environment and lack of physical family support.
- A client who is grieving the recent loss of a friend or family member.
- A client who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A client, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the client had rarely cried in the past).

Allowing a visit in these situations would be consistent with the intent of, "compassionate care situations." Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the client'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.

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/home 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/homes should work with clients, families, caregivers, client representatives, and the Ombudsman program to identify the need for compassionate care visits.

**** Visitors Log**

Visitor's log information will include date, time in, name of visitor and their contact information, including phone number and email address if available.