MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO
DEPARTMENT OF
HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

September 28, 2020

Dear Long-Term Care Providers and Administrators,

First, it has been a privilege to serve Governor Lujan Grisham as she leads New Mexico through one of the greatest public health challenges many of us will see in our lifetimes.

I am indebted to you all for your work with the largest at-risk population for illness and death by contracting the SARS-CoV-2 virus. I am also grateful for the work of the Secretary Hotrum-Lopez and the Aging and Long-Term Services Department, DOH's Division of Health Improvement, and the Epidemiology & Response Division, in their continued collaboration and leadership to the long-term care community and its residents.

The following directives and guidance are issued to align our testing efforts with the CMS requirements for nursing homes and provide safe flexibility for residents and their loved ones. The documents were developed with the understanding that staff, who are coming and going from long-term facilities, are generally the source of SARS-CoV-2 infections in our long-term care population.

Additionally, the residents in long-term care facilities have been suffering from intense social isolation which we know has a detrimental effect on both their mental and physical health. The visitation guidance document provides for more visits, indoor visits, broader definitions of compassionate care visits, as well as salon services instructions.

I am proud to issue this guidance which balances the effects of an ongoing pandemic and the well-being of our long-term care residents.

Warm regards,

Kathyleen M. Kunkel
Cabinet Secretary
Department of Health

NEW MEXICO LONG-TERM CARE FACILITY DIRECTIVES AND GUIDANCE

Issued and compiled by the New Mexico Department of Health, Division of Health Improvement and the New Mexico Aging and Long-Term Services Department.

This document includes compiled guidance, letters, and directives issued to long-term care facilities. The document will be updated as necessary to include the most up-to-date guidance, and remove no longer applicable directions.

Document	Date Issued
Testing Guidance for Nursing Homes	September 28, 2020
Indoor Visitation Guidance for Long-Term Care Facilities	September 28, 2020
Billing Guidance for COVID-19 Testing in Long-Term Care Facilities	September 28, 2020
Sample TriCore Requisition Form	September 28, 2020
DHI Memorandum re: Sick or Symptomatic Staff	September 11, 2020
DHI Letter re: Home Health/Hospice Care Workers in Long-Term Care Facilities	September 18, 2020
Admissions Guidance for Long-Term Care Facilities	September 28, 2020
Resuming Hair Salons in Long-Term Care Facilities	September 28, 2020
Compassionate Care and End-of-Life Visitation Guidance	September 11, 2020

COVID-19 TESTING GUIDANCE FOR NURSING HOMES

Issued: September 28, 2020

Effective October 15, 2020, New Mexico, in collaboration with CMS testing guidance, has adopted the following testing strategy and plan in long-term care facilities. Additionally, given the new CMS rule and the antigen testing machines, New Mexico is adapting its' testing guidance for nursing homes to align with CMS requirements.

Testing When a Staff Member or Resident Tests Positive/Hot Spot Testing

All "hot spot" testing requirements remain the same. Continue repeat viral testing of all previously negative residents and staff weekly, until the testing identifies no new cases of SARS-CoV-2 infection among residents or staff for a period of at least 14 days since the most recent positive result. Everyone will conduct at least 2 rounds of facility-wide testing.

NOTE: If a facility is considered a 'hot spot' and also in a red county, the facility must test staff twice a week pursuant to Table 1 below and residents once a week.

Ongoing Screening of Staff

Nursing homes should begin testing **all staff** at the frequency prescribed in Table 1: Routine Testing, based on the county positivity rate reported in the past week. Facilities should monitor their county positivity rate every other week and adjust the frequency of performing staff testing according to the table below. See CMS regulation QSO-20-38-NH. If a staff member is exposed or is exhibiting symptoms they should be tested and not permitted to work in any long-term care facility.

TABLE 1: Routine Testing Intervals Vary by Community COVID-19 Activity Level

County Positivity Rate	Testing Instructions
Low <5%	Request 25% of staff weekly on a rotating basis to ensure every staff person is tested once a month. Example: Facility has 152 staff, request 38 test kits per week.
Medium 5% - 10%	Request test kits for all staff on a weekly basis. Example: Facility has 152 staff and 6 residents who leave weekly for dialysis—facility requests 158 tests on a weekly basis.
High >10%	Request tests kits for all staff to be tested twice a week. Example: Facility has 152 staff and 6 residents who leave weekly for dialysis. Facility must request 310 test kits weekly – 304 for staff and 6 for the residents who regularly leave.

County positivity rates can be found on https://cv.nmhealth.org/ website. The positivity rates will updated twice a month. Each facility's county positivity rate will impact the testing frequency. Once the new positivity rate is identified, the facility must follow the above testing frequency to be in compliance.

Staff includes employees, consultants, contractors, volunteers, and caregivers who provide care and services to residents on behalf of the facility, and students in the facility's nurse aide training programs or from affiliated academic institutions. For the purpose of testing "individuals providing services under arrangement and volunteers," facilities should prioritize those who are regularly in the facility (e.g., weekly) and have contact with residents or staff.

NOTE: Previous staff or residents who tested positives through a laboratory test (NOT antigen) should not be retested for 90 days from the date they were identified as a positive.

Laboratory Obligations

TriCore Laboratory (TriCore) will distribute a testing capacity document on a bi-monthly basis consistent with the CMS county updates. This document will describe the testing capacity for the next two weeks and the percentage of test kits facilities can expect based upon whether they fall into a green, yellow, or red positivity rate county. Please keep this document on file. Facilities that have an increase in the number of staff must notify DOH and TriCore to ensure they will receive an adequate number of test kits.

Resident Testing - Laboratory or Antigen (See Table 2)

Resident testing should occur in the following circumstances:

1. Resident is symptomatic;
2. Resident has had a known contact with a positive;
3. Resident regularly or routinely leaves the facility for medical appointments (e.g. for dialysis or chemotherapy);
    a. Resident leaves once a week or more: test weekly
    b. Resident leaves any less than once a week per month: test twice a month
4. The facility has a new positive test and is considered a 'hot spot' requiring 100% testing of staff and residents for at least two consecutive weeks with no new positive tests identified.

Antigen Testing Guidance

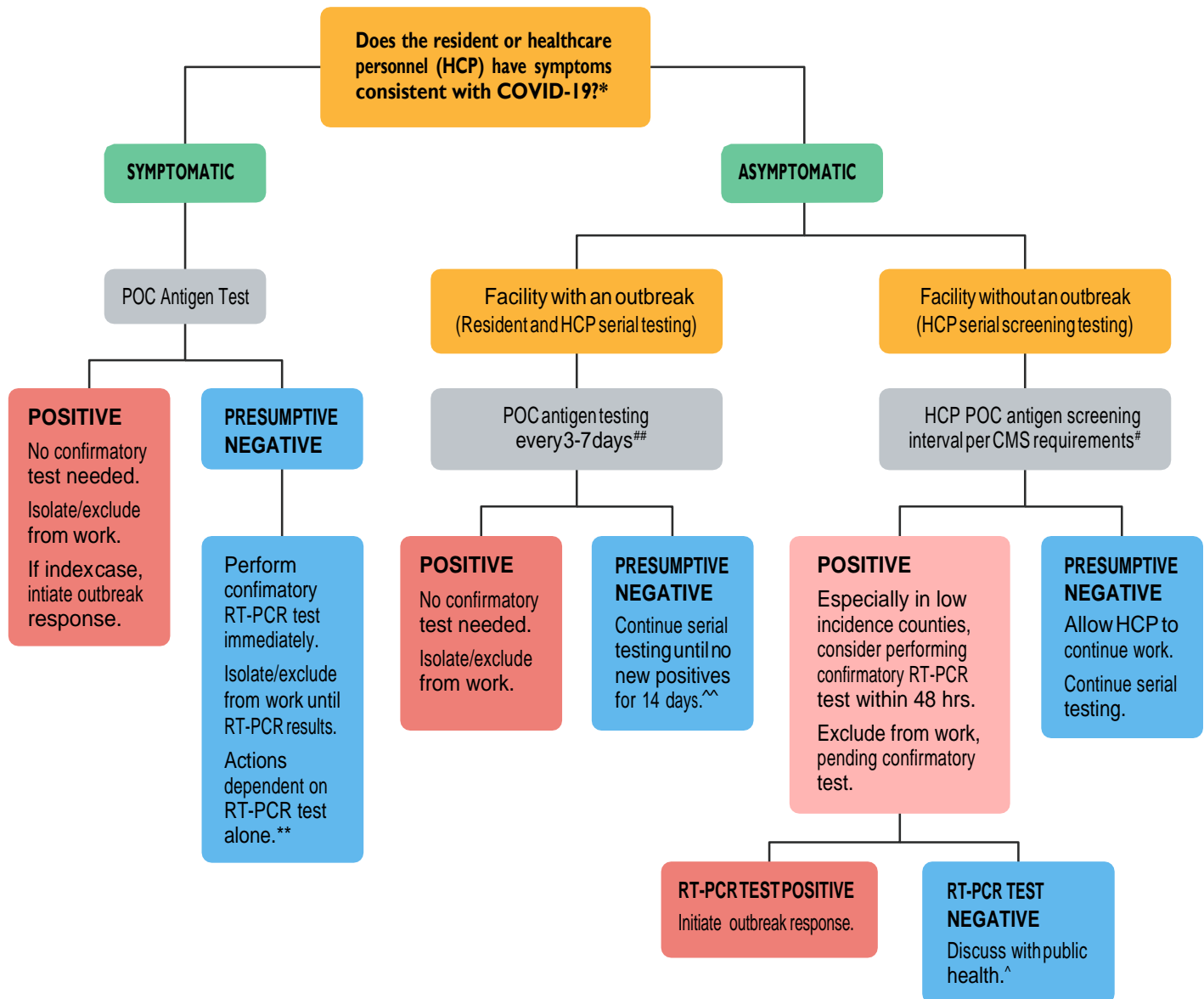Facilities should utilize antigen tests in the following circumstances (see Attachment A):
1. Symptomatic staff and resident; or
2. Exposed* staff or resident (this includes an exposed asymptomatic person).

➢ All SARS-CoV-2 laboratory results, whether positive or negative must reported along with related data to the new NHSN portal dedicated to antigen testing results within 24 hours of receiving the result. Reporting guidance will be updated as federal requirements are updated. In order to utilize the new Pathway to fulfill reporting requirements, nursing homes and other long-term care facilities who are NHSN users, will need to upgrade their NHSN Secure Access Management Service (SAMS) from Level 1 to Level 3.
➢ Contact the Informatics and Data Management Unit of the NMDOH Infectious Disease Epidemiology Bureau (IDEB) at DOH-ELR-Onboard@state.nm.us for technical assistance.

Table 2

Who	Testing Instructions	Type of Testing
New positive staff or resident (rapid response initiated, facility considered hot spot)	100% testing of all staff and residents until no new positives are identified for at least 14 days from the initial positive test, If located in a red county – staff testing must be twice a week.	RT-PCR specimen for transport to laboratory
Symptomatic staff or resident	Perform test of symptomatic staff or resident - If the antigen test indicates positive no confirmatory test needed.	Antigen test if available and/or RT-PCR specimen for transport to laboratory if LTC does not have an antigen test or if the antigen test result is negative
Resident who leaves the facility regularly (e.g.: dialysis or chemotherapy)	Residents who leave once a week or more: - Test weekly Residents who leave any less than once a week per month: - Test twice a month	RT-PCR specimen for transport to laboratory
Asymptomatic Staff	Test 100% of staff according Table 2 schedule above - Monthly - Weekly - Twice a week	RT-PCR specimen for transport to laboratory
Asymptomatic Residents	No testing unless resident leaves facility regularly, in response to an outbreak (rapid response, hot spot testing), or the resident had known close contact with someone other than a staff	RT-PCR specimen for transport to laboratory
Exposed Staff or Residents*	Immediate testing of directly exposed staff or residents when a new confirmed case is identified. Immediate results can identify other infected individuals, to isolate earlier and prevent further spread in the facility - If the antigen test indicates a negative result, the person should do a confirmatory PCR test. This person should be treated as if they were positive pending receipt of the PCR test result. - If the antigen test indicates positive no confirmatory test needed.	Antigen test and RT-PCR specimen for transport to laboratory

*Direct exposure is defined as close contact with an infected or COVID-positive person (less than 6 feet) for 3 minutes or longer.

CONSIDERATIONS FOR INTERPRETING ANTIGEN TEST RESULTS IN NURSING HOMES

Does the resident or healthcare personnel (HCP) have symptoms consistent with COVID-19?*

SYMPTOMATIC

ASYMPTOMATIC

POC Antigen Test

Facility with an outbreak
(Resident and HCP serial testing)

Facility without an outbreak
(HCP serial screening testing)

POSITIVE

No confirmatory test needed.

Isolate/exclude from work.

If index case, intiate outbreak response.

PRESUMPTIVE NEGATIVE

Perform confimatory RT-PCR test immediately.

Isolate/exclude from work until RT-PCR results.

Actions dependent on RT-PCR test alone.**

POC antigen testing every 3-7 days##

HCP POC antigen screening interval per CMS requirements#

POSITIVE

No confirmatory test needed.

Isolate/exclude from work.

PRESUMPTIVE NEGATIVE

Continue serial testing until no new positives for 14 days.^^

POSITIVE

Especially in low incidence counties, consider performing confirmatory RT-PCR test within 48 hrs.

Exclude from work, pending confirmatory test.

PRESUMPTIVE NEGATIVE

Allow HCP to continue work.

Continue serial testing.

RT-PCR TEST POSITIVE

Initiate outbreak response.

RT-PCR TEST NEGATIVE

Discuss with public health.^

This algorithm should be used as a guide, but clinical decisions may deviate from this guide if indicated. Contextual factors including community incidence, characteristics of different antigen testing platforms, as well as availability and turnaround times of RT-PCR, further inform interpretation of antigen test results.

RT-PCR: reverse-transcriptase polymerase chain reaction
POC: point-of-care
HCP: healthcare personnel
Index case: a newly identified case of SARS-CoV-2 infection in a resident or HCP in a nursing home facility with no known infections of SARS-CoV-2 infection in the previous 14-day period.
COVID-19 outbreak response in a nursing home is triggered when one nursing home-onset SARS-CoV-2 infection in a resident or one HCP SARS-CoV-2 infection.

* Asymptomatic individuals who have recovered from SARS-CoV-2 infection in the past 3 months and live or work in a nursing home performing facility-wide testing do not need to be retested. If an individual has recovered from SARS-CoV-2 infection in the past 3 months and develops new symptoms suggestive of COVID-19, alternative diagnoses should be considered prior to retesting for SARS-CoV-2.

** Some antigen platforms have higher sensitivity when testing individuals within 5 days of symptom onset. Clinical discretion should be utilized to determine if retesting by RT-PCR is warranted.

\# CMS recommendations for testing asymptomatic HCP in facilities without a case

\#\# CDC guidance on testing residents of nursing homes. CDC guidance on testing HCP

^ In discussion with the local health department, community incidence and time between antigen test and RT-PCR test can be utilized to interpret discordant results and determine when HCP can return to work.

^^ If an antigen test is presumptive negative in a facility with an outbreak, residents should be placed in transmission-based precautions or HCP should be allowed to continue working while monitoring for symptoms.

INDOOR VISITATION GUIDANCE FOR LONG-TERM CARE FACILITIES

September 28, 2020

Core Principles of COVID-19 Infection Prevention

1. Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms), screen for exposures to confirmed cases and test results pending. Those currently in isolation or quarantine should not visit and those with signs or symptoms should not enter.
2. Hand hygiene (use of alcohol-based hand rub is preferred).
3. Face covering or mask (covering mouth and nose).
4. Social distancing at least six feet between persons, 12 ft for those who cannot wear a mask due to medical condition.
5. Instructional signage throughout the facility and proper visitor education on COVID-19 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).
6. Cleaning and disinfecting high frequency touched surfaces in the facility often, and designated visitation areas after each visit.
7. Appropriate staff use of Personal Protective Equipment (PPE).
8. Effective cohorting of residents (e.g., separate areas dedicated COVID-19 care).
9. Resident and staff testing conducted as required at 42 CFR 483.80(h) (see QSO-20-38-NH and New Mexico State Guidance).

Indoor Visitation Plan

Outdoor visits are preferred. Visitation should only occur indoors when weather does not permit outdoor visits. Indoor visitation must meet the following requirements:

1. There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;
2. Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;
3. Facilities can only have 1 visitor per resident at a time; the facility must ensure the designated room is large enough to maintain appropriate social distancing and must limit the amount of visitors based on the size of the designated room;
4. Facilities must limit the duration of each visit to 1 hour;
5. Visitors are restricted from walking around the facility and can only go into the designated visitor room and immediately following the visit, must leave the facility through the designated exit; and
6. Visitation should occur ideally occur in a well ventilated room. Facility should get an HVAC assessment certifying the appropriate ventilation. If the building does not have an HVAC system, then look to open windows if/when possible to allow in outdoor air.

Where should indoor visits occur?

Indoor Visitation must occur in a single consistent room for indoor visitation; close to a facility entrance so that visitors do not transit extensively through residential living areas. The room must also be large enough to allow all visitors, resident, and staff to consistently maintain 6 feet of space between each other at all times. Visitation should not occur during meal times.

Except for compassionate care or end of life visits, routine visitation cannot occur in a resident's room for any reason. (Does not include compassionate care and end of life visits).

After the Visitation

Instruct visitors to monitor for symptoms of COVID-19 after their visit. Any individual who enters the LTCF and develops signs and symptoms of COVID-19 (as outlined above) within 2 days after visiting must immediately notify the LTCF. The visitor should inform the facility of the date of their visit, the individuals (both residents and staff) they were in contact with, and the locations within the facility they visited. Long-term care facilities should immediately screen the individuals who had contact with the visitor for the level of exposure.

When can our facility have indoor visits?

Facilities should use the COVID-19 county positivity rate, found on the www.cv.nmhealth.org website as additional information to determine how to facilitate indoor visitation.

Community (County) COVID-19 Positivity Rate	Visitation Instructions
Low <5%	Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)
Medium 5% - 10%	Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)
High >10%	Visitation should only occur for compassionate care situations according to the core principles of COVID-19 infection prevention and facility policies

Visitation Process Requirements

- ✓ Facilities must establish and maintain a schedule of visitation.
- ✓ Facilities must develop a process for screening all visitors for COVID-19 symptoms and risk factors for exposure prior to visitation (see details in section below).
- ✓ Locations for visitation (both indoor and outdoor) must be designated beforehand, and these locations must allow for at least 6 feet of space consistently between all visitors, staff, and resident at all times.
- ✓ Facilities must have adequate staff present to allow for safe transit of residents to the designated visitation location, in-person monitoring of visitation, and environmental cleaning and disinfection after visitation.
- ✓ Safe transport means that the resident should wear a facemask to prevent viral shedding and cannot be transported through any space where residents with suspected or confirmed COVID-19 are present.
- ✓ Monitoring visits is required and should be performed by a staff member trained in patient safety and infection control measures. Staff should be close enough to ensure compliance with visitation policy but also allow for privacy.

- ✓ Facilities should develop a process to inform and educate residents and visitors about the necessary precautions and periodically monitor visits for compliance.
- ✓ Facilities must have adequate personal protective equipment (PPE) to provide residents, staff, and visitors (who do not arrive with a cloth face covering) with a surgical facemask during the visit and during transit to/from the visitation site.
- ✓ Facilities should demarcate spaces for people to sit in the visitation area (both indoors and outdoors) and people may not move closer to each other while visiting. No physical contact is allowed. Mobile visitation (i.e., going on a walk or drive together) is not allowed.
- ✓ Staff must carry alcohol-based hand sanitizer with them to the visitation.
- ✓ Staff, resident, and visitor(s) must sanitize their hands before and after visitation, and after any touching of face or face covering/mask.
- ✓ Facilities must clean and disinfect all touched surfaces prior to and after each visit.
- ✓ Facilities must maintain a visitor log with contact information for all visitors (indoor or outdoor visitors) to enable accurate public health contact tracing should there be a need.
- ✓ Facilities are also encouraged to inquire prior to visits if the visitor is coming from a county with "high" positivity rate, and encourage visitation to occur when the county has a lower positivity rate.

Compassionate Care Visits

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.
- 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." Also, 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.

Lastly, at all times, 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

The State Long-Term Care Ombudsman Program should work closely with facilities to identify and facilitate compassionate care visits.

Non-Mobile Residents

May be permitted upon request, in private resident room, and if approved by the facility in its discretion.
- If visitation occurs in a resident's room, and the resident has a roommate, the roommate has the choice to stay in the room while the visit occurs, or the roommate can be directed to another area in the facility for the duration of the visit. While the visit is ongoing, the roommate, resident, and visitor must wear a facemask, and whenever possible, social distancing and physical barriers (e.g., curtain, Plexiglas) should be used.
- For residents identified as end of life, whenever possible, these residents should be moved to a single occupancy Room to accommodate private family visits.

	Low (<5%) = Visitation should occur according to the core principles of COVID 19 infection prevention and facility policies (beyond compassionate care visits)	Medium (5% – 10%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)	High (>10%) = Visitation should only occur for compassionate care situations according to the core principles of COVID-19 infection prevention and facility policies
Social Visitation Outdoors	Designated visitation space, facility determines the frequency of visits	Designated visitation space, once per month visits	Not allowed
Social Visitation Indoors	Designated visitation space, only when weather restricts outdoor visitation	Designated visitation space, only when weather restricts outdoor visitation	Not allowed
Compassionate Care and End of Life Visits	Yes	Yes	Yes
Communal Dining	Yes, residents should dine with or cohorted the other individuals in the unit or wing	Yes, residents should dine with or cohorted with the other individuals in the unit or wing	Not allowed
Outdoor Activities	Yes, limited to no more than 10 people with masking and physical distancing	Yes, limited to no more than 5 people with masking and physical distancing	Not allowed
Indoor Activities	Yes, no more than 5 at a time participating	Not allowed	Not allowed
Beauty Salon Services	Yes, follow the salons guidance	Yes, follow the salons guidance	Not allowed

Penalties

Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR 483.10(f)(4), and the facility would be subject to citation and enforcement actions.

BILLING GUIDANCE FOR COVID-19 TESTING IN LONG-TERM CARE FACILITIES

September 28, 2020

On May 27, 2020, the New Mexico Department of Health's Division of Health Improvement ("DHI") mandated testing for SARS-CoV-2 ("COVID-19") in all long-term care facilities ("LTC") in New Mexico, which includes Nursing Homes and Assisted Living Facilities. That directive remains in place. This directive supplements the May 27, 2020 directive to provide additional instructions to ensure that long-term care facilities maximize available resources to pay for such testing. To the extent the federal government imposes additional requirements, facilities must comply with those as well and be subject to potential penalties and effects to licensure for noncompliance.

Compiling Information to Facilitate Billing for Testing to Third-Party Payers

Effective May 27, 2020, DHI directed LTC facilities to register with TriCore Reference Laboratories (TriCore) and to contact TriCore on a weekly basis to order a sufficient number of test kits required to comply with that directive's requirement to conduct ongoing surveillance testing. Facilities were required to provide insurance information and to log information about testing of all staff and residents but many have not complied. This directive provides supplemental direction to facilities regarding providing adequate insurance information and logging testing.

- Facilities must compile all information necessary for TriCore – and, where used, other laboratories -- to comply with state and federal reporting requirements regarding all COVID-19 testing conducted by them. Facilities must also provide sufficient information about each person receiving a test to enable the laboratory to bill third-party payers, including Medicare, Medicaid, insurers, and employer-sponsored health plans.

- Facilities must track which residents and staff are tested each week and must complete all required information on TriCore's requisition form. Because these forms can take time to complete, DHI has arranged with TriCore for facilities to create pre-printed labels to affix on the lab requisition forms to make the testing process more efficient. By October 1, 2020, each facility must create a complete list (and pre—printed labels) of all residents and all staff with the following information:

    - Full Name (first, middle and last)

    - Date of Birth

    - Insurance Information, including:

        - name of insurer

        - member number

        - group number (if applicable).

        - For staff, if your organization is not the subscriber for the insurance, you must provide the subscriber name and ID number

    - State if the individual is uninsured. Do not write "N/A"; please write "uninsured."

    - Whether the individual is a resident or staff person

- TriCore has created preprinted requisition forms for each facility and listed the name of the ordering provider, where available. Preprinted forms may be used to provide the information listed above. A sample requisition form is attached. ***Each facility must do the following for each test:***

    - ***Provide all the information listed above to be included on a preprinted label affixed to the requisition form; facilities may choose to manually enter that information for each person being***

> > ***tested.***

- - ***Circle the name of the ordering provider. If the name of the ordering provider is missing or inaccurate, you must fill in the name and the provider's NPI number.***

- - ***Mark the box for "COVID" or write the word "COVID" for the type of test.***

- - ***Write the Z20.828 diagnostic code.   Instructions for which code applies in different circumstances is attached to this directive, after the TriCore sample requisition form. TriCore cannot provide any instructions or directions regarding which diagnostic codes should be used.***

- - ***Provide the date the sample was collected.***

- Testing results will be sent to the Administrator. The turn-around time for receiving test results is approximately 24-48 hours. Test results can be obtained from the TriCore Data Portal. Please ensure you are able to access this portal. **If someone becomes symptomatic during this time frame follow the guidance for isolation precautions and for symptomatic staff.**

- Facilities shall keep a surveillance log of residents and staff tested to include, full names (first, middle and last), date of birth, date tested, date sent to TriCore or another laboratory, date results received and test results. Any positive cases should be immediately reported to DHI.

- By October 1, 2020, each facility must provide DHI with one spreadsheet of all staff members (organized by the first letter of the last name) containing the information listed above for the preprinted forms. By October 1, 2020, each facility must provide DHI with a separate spreadsheet of all residents (organized by the first letter of the last name) containing the information listed above for the preprinted forms.

Facilitating Enrollment in Medicaid Program to Cover Testing Costs for the Uninsured for Residents or Staff who do not have Insurance.

The Medical Assistance Division of the New Mexico Human Services Department, which runs NM's Medicaid Program (MAD), has established a program to cover the cost of COVID-19 diagnostic testing and testing-related services provided to uninsured individuals as authorized through the Families First Coronavirus Response Act (FFCRA). This coverage includes both the administration of testing and testing-related services and the associated medical visit at no cost to the patient. Uninsured individuals include those not otherwise Medicare or Medicaid-eligible and not covered by group or individual private insurance or another federal health program.

The Medical Assistance Division will assist in enrolling any uninsured residents or staff in the program. Each facility must provide a list of uninsured residents and staff to DHI by October 1, 2020 and work with MAD to enroll those individuals in the FFCRA program. Facilities may assist staff and residents to enroll in this program and can find an application here.

Penalties for Noncompliance

Failure to comply with the testing requirements stated in this correspondence may be considered neglect of a patient/client/resident and may be considered grounds for revocation or suspension of a license pursuant to NMAC 7.9.2.18.G. Additionally, a facility found to be in noncompliance may be assessed civil monetary penalties under 7.1.8 NMAC.

TRICORE   505.938.8888   www.TriCore.org   800.245.3296

Client #: _____

_____, ___

Phone: _____
Use for TriCore testing only

111111111 CROSSEY, MICHAEL J   (222222222 LUKE, MATTHEW)

9/16/2020
FORM #: BLANK-COVID

* Your TriCore Client ID #

1 Circle provider's name OR Write the provider's name and include NPI number.

PATIENT INFORMATION (YELLOW AREAS MUST BE FILLED IN)

PATIENT LAST NAME   FIRST NAME   MI   PATIENT ID   DATE OF BIRTH   SEX   FASTING

M F   YES NO

MAILING ADDRESS

ORDERING PHYSICAN (FULL NAME)

CITY   STATE   ZIP   PATIENT PHONE

SOCIAL SECURITY #
PATIENT ONLY

DATE COLLECTED   TIME COLLECTED   AM   PM   COLLECTED BY

MEDICARE ONLY COVERS TESTING THAT IS NECESSARY TO DIAGNOSE OR TREAT, AND IN GENERAL DOES NOT PAY FOR ROUTINE SCREENING

2 Write collection date and time.

* Complete all fields, including all patient and insurance information.

BILL TO   MEDICARE   MEDICAID   PHP   BCBS   OTHER   NMDOH

Information below is required when copy of insurance card is not provided.

Member ID / Policy # _____   Group # _____

Policy holder name _____   Date of Birth _____
(if not the patient)

ICD-10 Diagnosis codes are mandatory. Only order tests that are medically necessary for the diagnosis and treatment of the patient. If a diagnosis has not been determined, please provide ICD-10 codes that describe the patient's signs and symptoms. Insurance billing options must be exhausted before New Mexico Department of Health (NMDOH) can be billed.

3 Include all insurance information for staff/resident to include policy#, group#, and name of the insured member if different from the patient. Please provide a copy of the insurance card, when possible.

REQUIRED PATIENT INFORMATION

1. First test   ☐ Yes ☐ No ☐ Unknown
2. Employed in healthcare   ☐ Yes ☐ No ☐ Unknown
3. Symptomatic as defined by CDC ☐ Yes ☐ No ☐ Unknown
   If yes, date of symptom onset: _____
4. Hospitalized   ☐ Yes ☐ No ☐ Unknown
5. ICU   ☐ Yes ☐ No ☐ Unknown
6. Resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting)   ☐ Yes ☐ No ☐ Unknown
7. Staff in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting)   ☐ Yes ☐ No ☐ Unknown
8. Pregnant   ☐ Yes ☐ No ☐ Unknown

RACE
☐ American Indian   Tribal Affiliation _____
☐ Asian
☐ Black/African American
☐ Native Hawaiian/Pacific Islander
☐ White
☐ Other

ETHNICITY
☐ Hispanic
☐ Non-Hispanic

* Information required by CDC

TESTS

COVID	COVID-19 by PCR	
COVIGG	CORONAVIRUS 2019 Antibody IgG	

COMMON ICD-10 DIAGNOSIS CODES (COVID-19 Diagnosis as of June 2, 2020)

Code	Description	Code	Description
Z20.828	Contact with and susp exposure to oth viral comm dis	J80	ARDS
R05	Cough	O98.513	Oth viral dis comp preg, 1st trim
R06.82	SOB	O98.512	Oth viral dis comp preg, 2nd trim
R50.9	Fever, unspec	O98.513	Oth viral dis comp preg, 3rd trim
U07.1	COVID-19	O98.519	Oth viral dis comp preg, unspec trim
Z03.818	Obs for susp exposure to oth biol agents ruled out	O98.52	Oth viral dis comp childbirth
J12.89	Oth viral pneumonia	O98.53	Oth viral dis comp puerperium
J18.9	Acute bronch itis due to oth spec org		OTHER
J22	Unspec acute lower resp inf		
J98.8	Oth spec respiratory dis		
J40	Bronchitis, not spec as acute or chronic		

LABELS

4 Mark the box by the printed test OR Write the test **COVID**

COVID

5 Write the ICD-10 diagnostic code or provide the staff/residents' signs and symptoms.

6 Clearly label specimens with staff/residents' name, date of birth and collection date.

7 Each specimen and the requisition go in one bag.

SHIPPING/TRANSPORT AND STORAGE		
	Temperature	**Stability**
Stabilities/Storage (*collection to initiation of testing*)	refrigerated	96 hours
	frozen*	2 weeks

*If pickup is more than 48 hours away, place specimen in *Keep Frozen* ziplock bag and freeze.

Keep Frozen ziplock bag

NOTES

For more information regarding diagnosis coding, please visit the CMS website: https://www.cdc.gov/nchs/data/icd/COVID-19-guidelines-final.pdf. Please note that effective 10/1/2020, ICD-10-CM Codes Z11.59 and U07.2 will be invalid. If you have additional questions, contact your representative at the New Mexico Department of Health (NMDOH) or the New Mexico Department of Aging.

Turnaround time (TAT) is impacted by changes in volume and availability of testing resources from manufacturers; this changes daily. Our current TAT is approximately 72 hours **from the time the specimen arrives at our Core Lab in Albuquerque.**

- For hotspots, supplies will be sent within 24 (business day) hours after NMDOH notification.
- Include staff/residents' insurance information. Marking no insurance for everyone is not acceptable. The New Mexico Department Health requires TriCore to bill staff/residents' insurance companies.

For intakes and discharges that cannot wait for courier pickup, please drop off specimens at the closest TriCore patient care center or TriCore's Woodward location (1001 Woodward Place NE, Albuquerque), south entrance. TriCore's patient care center locations and hours can be found at www.tricore.org/locations.

CLIENT ENGAGEMENT
505.938.8888 **|** 800.245.3296

SUPPLIES   (to receive supplies and requisitions automatically)
505.938.8957 **|** supplies@tricore.org

ICD-10-CM Official Guidelines for Coding and Reporting
FY 2021
(October 1, 2020 - September 30, 2021)

The Centers for Medicare and Medicaid Services (CMS) and the National Center for Health Statistics (NCHS), two departments within the U.S. Federal Government's Department of Health and Human Services (DHHS) provide the following guidelines for coding and reporting using the International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM). These guidelines should be used as a companion document to the official version of the ICD-10-CM as published on the NCHS website. The ICD-10-CM is a morbidity classification published by the United States for classifying diagnoses and reason for visits in all health care settings. The ICD-10-CM is based on the ICD-10, the statistical classification of disease published by the World Health Organization (WHO).

1. Chapter 1: Certain Infectious and Parasitic Diseases (A00-B99), U07.1
   g. Coronavirus infections
       1) COVID-19 infection (infection due to SARS-CoV-2)

          (a) Code only confirmed cases
          Code only a confirmed diagnosis of the 2019 novel coronavirus disease (COVID-19) as documented by the provider or documentation of a positive COVID-19 test result. For a confirmed diagnosis, assign code U07.1, COVID-19. This is an exception to the hospital inpatient guideline Section II, H. In this context, "confirmation" does not require documentation of a positive test result for COVID-19; the provider's documentation that the individual has COVID-19 is sufficient.

          If the provider documents "suspected," "possible," "probable," or "inconclusive" COVID-19, do not assign code U07.1. Instead, code the signs and symptoms reported. See guideline I.C.1.g.1.g.

          (b) Sequencing of codes
          When COVID-19 meets the definition of principal diagnosis, code U07.1, COVID-19, should be sequenced first, and followed by the appropriate codes for associated manifestations, except when another guideline requires that certain codes be sequenced first, such as obstetrics, sepsis, or transplant complications.

             • *For a COVID-19 infection that progresses to sepsis, see Section I.C.1.d. Sepsis, Severe Sepsis, and Septic Shock*
             • *See Section I.C.15.s. for COVID-19 infection in pregnancy, childbirth, and the puerperium*
             • *See Section I.C.16.h. for COVID-19 infection in newborn*
             • *For a COVID-19 infection in a lung transplant patient, see Section I.C.19.g.3.a. Transplant complications other than kidney.*

          (c) Acute respiratory manifestations of COVID-19
          When the reason for the encounter/admission is a respiratory manifestation of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the respiratory manifestation(s) as additional diagnoses.

The following conditions are examples of common respiratory manifestations of COVID-19.

(i) Pneumonia

For a patient with pneumonia confirmed as due to COVID-19, assign codes U07.1, COVID-19, and J12.89, Other viral pneumonia.

(ii) Acute bronchitis

For a patient with acute bronchitis confirmed as due to COVID-19, assign codes U07.1.and J20.8, Acute bronchitis due to other specified organisms.

Bronchitis not otherwise specified (NOS) due to COVID-19 should be coded using code U07.1 and J40, Bronchitis, not specified as acute or chronic.

(iii) Lower respiratory infection

If the COVID-19 is documented as being associated with a lower respiratory infection, not specified (NOS), or an acute respiratory infection, NOS, codes U07.1 and J22, Unspecified acute lower respiratory infection, should be assigned.

If the COVID-19 is documented as being associated with a respiratory infection, NOS, codes U07.1 and J98.8, Other specified respiratory disorders, should be assigned.

(iv) Acute respiratory distress syndrome

For acute respiratory distress syndrome (ARDS) due to COVID-19, assign codes U07.1, and J80, Acute respiratory distress syndrome.

(v) Acute respiratory failure

For acute respiratory failure due to COVID-19, assign code U07.1, and code J96.0-, Acute respiratory failure.

(d) Non-respiratory manifestations of COVID-19

When the reason for the encounter/admission is a non-respiratory manifestation (e.g., viral enteritis) of COVID-19, assign code U07.1, COVID-19, as the principal/first-listed diagnosis and assign code(s) for the manifestation(s) as additional diagnoses.

(e) Exposure to COVID-19

For asymptomatic individuals with actual or suspected exposure to COVID-19, assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases.

For symptomatic individuals with actual or suspected exposure to COVID-19 and the infection has been ruled out, or test results are inconclusive or unknown, assign code Z20.828, Contact with and (suspected) exposure to other viral communicable diseases. See guideline I.C.21.c.1, Contact/Exposure, for additional guidance regarding the use of category Z20 codes.

If COVID-19 is confirmed, see guideline I.C.1.g.1.a.

(f) Screening for COVID-19

During the COVID-19 pandemic, a screening code is generally not appropriate. For encounters for COVID-19 testing, including preoperative testing, code as exposure to COVID-19 (guideline I.C.1.g.1.e).

Coding guidance will be updated as new information concerning any changes in the pandemic status becomes available.

(g) Signs and symptoms without definitive diagnosis of COVID-19
For patients presenting with any signs/symptoms associated with COVID-19 (such as fever, etc.) but a definitive diagnosis has not been established, assign the appropriate code(s) for each of the presenting signs and symptoms such as:
- R05 Cough
- R06.02 Shortness of breath
- R50.9 Fever, unspecified

If a patient with signs/symptoms associated with COVID-19 also has an actual or suspected contact with or exposure to COVID-19, assign Z20.828, Contact with and (suspected) exposure to other viral communicable diseases, as an additional code.

(h) Asymptomatic individuals who test positive for COVID-19
For asymptomatic individuals who test positive for COVID-19, see guideline I.C.1.g.1.a. Although the individual is asymptomatic, the individual has tested positive and is considered to have the COVID-19 infection.

(i) Personal history of COVID-19
For patients with a history of COVID-19, assign code Z86.19, Personal history of other infectious and parasitic diseases.

(j) Follow-up visits after COVID-19 infection has resolved
For individuals who previously had COVID-19 and are being seen for follow-up evaluation, and COVID-19 test results are negative, assign codes Z09, Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and Z86.19, Personal history of other infectious and parasitic diseases.

(k) Encounter for antibody testing
For an encounter for antibody testing that is not being performed to confirm a current COVID-19 infection, nor is a follow-up test after resolution of COVID-19, assign Z01.84, Encounter for antibody response examination.

Follow the applicable guidelines above if the individual is being tested to confirm a current COVID-19 infection.

For follow-up testing after a COVID-19 infection, see guideline I.C.1.g.1.j.

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO
DEPARTMENT OF
HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

September 11, 2020

Re: Staff reporting to work with symptoms or sick

All Licensed Long-Term Care Facilities:

All long-term care facilities work with the most vulnerable population to the COVID-19 virus. Governor Michelle Lujan Grisham and Secretary Kathyleen Kunkel have repeatedly told New Mexicans if they are sick or have symptoms do not report to work. This mandate is also included in the COVID Safe Practice for Individuals and Employers issued by the Governor's Office on August 27th. The guide can be found here.

Pursuant to the March 26, 2020 directive all long-term care facilities are required to screen staff prior to entering the facility. Any staff that fail the screening process should not be allowed in the facility and any **staff reporting signs and symptoms of illness cannot report to work**.

Staff that have had exposure to a known positive individual outside of the facility should not report to work.

For staff who are confirmed COVID-19 positive
Maintain isolation at home and do not report to work until:
1. At least 10 days have passed since symptoms first appeared; AND,
2. At least 1 day (24 hours) has passed with no fever; AND
3. Symptoms have improved

For COVID-19 positive staff without symptoms
Maintain isolation at home and do not report to work until:
1. At least 10 days have passed since the date of the first positive test

For staff who had close contact with a COVID-19 positive case
Maintain isolation at home and do not report to work until:
1. You have completed your quarantine period of at least 14 days since the date of the last exposure to the confirmed case.
2. Close contacts are encouraged to get tested. Testing should occur toward then of the quarantine period before returning to work. A negative test does not end the quarantine period, the full 14 days of quarantine must be observed.
3. If close contacts develop symptoms they should be tested as soon as possible
4. If test is positive, follow guidance above.

More information on isolation and quarantine can be found in the New Mexico Department of Health COVID containment policies found here

Having symptomatic or sick staff come to work is a direct violation of the public health orders and DHI has deemed this is an immediate risk to the resident and places them in danger. Reports of LTC's requiring sick or symptomatic staff to report to work will be treated as abuse or neglect of residents and is grounds for sanctions or civil penalties pursuant to NMAC 7.9.2.18(G) and 7.8.2.13(C)(1).

Finally, facilities are required to track and report staff working at multiple facilities to the Aging and Long-Term Services Department. If staff work at multiple facilities and a facility becomes a "hot spot", that employee should only be permitted to work at the hot spot facility and no others.

Facilities should also be aware of their obligations pursuant to the Occupational Safety and Health Administration (OSHA) through the New Mexico Environment Department.
Should you have questions please contact me at 505-252-4494.

Sincerely,

Christopher Burmeister
Division of Health Improvement Director

MICHELLE LUJAN GRISHAM
GOVERNOR

NEW MEXICO
DEPARTMENT OF
HEALTH

KATHYLEEN M. KUNKEL
CABINET SECRETARY

September 18, 2020

Re: Hospice in Long-Term Care Facilities

All Licensed Long-Term Care Facilities:

Per the Public Health Order dated 03/24/20, Home Health/Hospice Care Workers or aides are considered "essential". The Public Health Order dated 03/13/20 restricting visitors for Nursing Homes and the follow-up letter dated 03/26/20 extending the order to Assisted Living Facilities was intended to limit resident's visitors, not their healthcare providers.

Healthcare provider and physician should evaluate which services/care can wait, be done telephonically, or can be completed by facility staff and which services/care are considered essential and cannot wait, with the intention to limit all unnecessary exposure to residents.

Please note that on 06/04/20, the Governor and Secretary Scrase approved the below hospice protocol:

> "Hospice nurse documents in NF record that the end of life is probable within 30'days AND family follows ALL NF guidance related to symptom checking, Temp checking, PPE, etc. "

 Should you have questions please contact me at 505-252-4494.

Sincerely,

Christopher Burmeister
Division of Health Improvement Director

ADMISSIONS GUIDANCE FOR LONG-TERM CARE FACILITIES

September 30, 2020

This guidance is issued pursuant to the Department of Health Guidance issued March 26, 2020.

TESTING REQUIREMENTS FOR ADMISSIONS/READMISSIONS

There <u>are no testing requirements for admissions/readmissions to facilities</u>. Facilities should not require 2 negative tests prior to admission. Facilities should follow the admissions guidance below.

NEW ADMISSIONS

Certain precautions should be taken when admitting new residents to a facility. <u>Facilities should admit any individual that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present</u>. Facilities should dedicate a unit/wing exclusively for new admissions or residents coming from the hospital. This can serve as a step-down unit where they remain in quarantine for 14 days and are monitored for signs or symptoms of illness. (instead of integrating as usual on short-term rehab floor or returning to long-stay to their original room). Residents can be transferred out of the admission quarantine area to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected. Anyone who develops symptoms should be immediately tested and isolated.

READMISSIONS AND RETURNS

<u>A facility should readmit a resident after hospitalization</u>. If the resident was diagnosed with COVID-19, they should be admitted under transmission-based precautions for COVID-19. If a facility is unable to comply with the requirements for transmission-based precautions, readmission must wait until these precautions are discontinued. Facilities are advised to avoid unnecessary discharges and transfers at this time to discourage and limit spread of illness between facilities. To the extent a discharge or transfer of a patient is necessary, facilities must ensure the patient can be discharged in a safe manner.

Resuming Hair Salons in Long-Term Care Facilities

September 30, 2020

Recommendations include those residents who are COVID negative and those, such as dialysis residents, with weekly scheduled appointments that require them to remain in quarantine.

Recommendations exclude residents newly admitted or readmitted (14-day quarantine), and residents suspected or positive for COVID-19. Hair salons can resume providing services to residents with the following precautions in place:

- Services must be provided by a New Mexico licensed hairdresser or barber.

- Salon personnel cannot work at other healthcare facilities and are restricted from engaging in outside employment. Employment with the facility should be their primary employment.

- Salon staff should be screened daily on arrival (symptom/temp check), and sick staff, or those with known exposures should not report to work.

- Appointments should limit one resident and one hairdresser in the salon at a time (shared equipment should be cleaned and disinfected following professional standards and licensing requirements.

- The time between clients 15 minutes to ensure area and equipment is cleaned and disinfected between resident appointments.

- Salon personnel must be tested for COVD-19 as part of standard surveillance testing of facility personnel.

- Residents must wear a mask while in the salon.

- Salon personnel wear a mask, face shield or goggles, and gown when providing services.

- Perform hand hygiene before contact with residents.

- The facility must be identified to have a less than 5% positivity rate (green county) to be eligible for providing salon services.

- The facility must not be identified as having an outbreak (outbreak in long-term care facilities is identified as one or more new positive cases of either staff or resident in the facility).

Compassionate Care and End of Life Visitation Guidance

This document encompasses both end of life care visits and compassionate care visits. New Mexico's positivity rate does not impact a facility's ability to provide compassionate care or end of life visitation.

End of Life Visits: are one-time, with one visitor at a time, and allowed on a limited basis as an exception to visitor restrictions.

Compassionate Care Visits: are one-time, with one visitor, and allowed on a limited basis as an exception to visitor restrictions.

What is a Compassionate Care Visit?
A Compassionate Care Visit refers to any one of the following scenarios:

- A resident whose condition is defined by any or all of the following:
    - When a resident is newly enrolled in a hospice program;
    - When a resident has a change in status to palliative care as determined by an order from the clinician;
    - When a resident is determined to be in the dying process [terminal within 30 days];
    - The emergence of a condition/disease in which a resident is declining in accordance with the care plan/service team and most recent assessment;
    - 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;
    - 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; or
    - 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).
- Failure to thrive manifested by functional parameters to include:
    - The emergence of unplanned weight loss problem;
    - The emergence of a new pressure injury, an unstageable pressure injury, a deep tissue injury, or a worsening in pressure injury status;
    - A fall that resulted in an injury or in which the resident was transferred to the hospital for evaluation;
    - A decrease in function as noted by a decline in Activities of Daily Living (ADL) or physical functioning; or
    - The ability or capacity of a resident's decision-making has worsened.

What is an End of Life Visit?
End of Life Visits refers to the following scenario:

- Visitation with a person who has a terminal condition or dementia-related disorder that has become advanced, progressive, and or incurable. The person is in the active stages of dying (probable within thirty days).

Visitation Area Criteria

Revised 09/22/2020

The visitation area should be established as follows:
- Conducted outdoors if the health of the resident and weather allows:
  - If possible, the outdoor visitation area should be accessible for visitors from the outdoors;
  - Outdoor visitation should occur only on days when there are no weather warnings that would put either visitors or residents at risk;
  - Visitation spaces must provide adequate protection from weather elements (e.g., shaded from the sun);
  - Visitation areas must be sanitized after every visitor.
- If outdoor visitation is not feasible or is not advisable for the health of the resident, visitation should be conducted in a designated room inside of the facility.
  - If possible, the room should be located close to the entrance of the facility, so the visitor has the least amount of contact with the rest of the facility;
- If the resident cannot be moved from their room, a compassionate care or end of life visit can be held in the resident's room.
  - It is preferred that residents receiving compassionate care or end of life visit have a private room. If this is not possible and the resident has a roommate, a partition should be in place between the living areas of the resident and their roommate. If the resident is in the room during the visit, they should also wear a face covering.

Resident Criteria

Before a visit takes place, the facility must document:
- Resident's status related to the need for compassionate care or end of life visit;
- Other interventions employed to improve the resident's status and the outcome;
- The need for a compassionate care visit to improve the resident's status; and
- A physician or designate's order for the compassionate care visit.

The following criteria must be met for a visit:
- The resident has never been COVID-19 positive; or
- The resident was COVID-19 positive, but no longer requires transmission-based precautions as outlined by the CDC;
- Residents must wear a face covering or mask if medically feasible; and
- Residents must practice appropriate hand hygiene before and after the visit.

Facility Criteria

- The compassionate care visit must be scheduled in advance.
- Adequate staff must be present to facilitate the visitation, monitor visitation if necessary, and sanitize visitation areas after each visit.
- Residents and visitors must not go through a COVID-positive or quarantined area to get to the visitation area.
- The facility must screen visitors for signs and symptoms of COVID. (See Visitor Criteria Section)
- Areas, where visitors and residents sit, must be sanitized between visitations using an approved antiviral disinfectant - https://www.cdc.gov/coronavirus/2019-ncov/community/reopen-guidance.html
- There must be adequate PPE to permit residents, if they can comply, to wear a face-covering or mask during visitation.
- Facilities must provide alcohol-based hand sanitizer to visitors and demonstrate how to use it appropriately.

Revised 09/22/2020

- Facilities may establish additional reasonable guidelines as needed to protect patient health and safety.

Visitor Criteria

- Visitors must sign-in the visitors log with complete name, address, and phone number.
- Visitors must pass visitor screening criteria:
  - Must not be COVID-19 positive or have signs or symptoms of COVID-19.
  - If a visitor has had COVID-19, they must provide documentation (e.g., doctor's note) that they no longer meet CDC criteria for transmission-based precautions.
  - Must have their temperatures taken and logged at the facility entrance.
  - Must have no fever (body temperature above 100 degrees Fahrenheit) and no sign of a respiratory infection, including coughing or shortness of breath.
- Visitors must agree to be escorted to and from the visitation area and must agree not to leave the designated visitation area.
- Visitors must wear a face covering or mask during the entire visitation.
- Visitors must perform appropriate hand hygiene immediately before and after the visitation.
- Visitors must meet any other reasonable condition of visitation that the facility deems necessary to protect patient health and safety.
- Visitors must be 18 years of age and older.
- Visitors during and end of life visit must enter individually one at a time.
- Those who cannot meet all the conditions of entry will not be permitted visitation.

Revised 09/22/2020