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April 21, 2022

TO: Matthew V. Barrett, JD, MPA, President and CEO,
Connecticut Association of Health Care Facilities, Inc.

FROM: Heather O. Berchem, Esq. and Madiha M. Malik, Esq.

RE: Update on Status of Key Connecticut DPH and Federal CMS Mandates

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This memo covers important updates related to the expiration of certain state and federal mandates that were implemented in response to the COVID-19 pandemic. The purpose of this memo is to highlight key updates; however this is not an exhaustive list of all updates that may be relevant to skilled nursing facilities.

CT Long-Term Care Worker COVID-19 Vaccination Mandate Expired April 15, 2022 While CMS Vaccine Mandate Remains in Effect

Connecticut Executive Order 14B, which is the State mandate that required covered long-term care workers to be fully vaccinated, with both primary and booster vaccines, expired last Friday, April 15, 2022. However, the CMS vaccine mandate, codified at 42 CFR §483.80, continues to require skilled nursing facilities to develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19.

As a reminder, the CMS vaccine mandate applies to "staff" who are defined as individuals who provide any care, treatment, or other services for the facility and/or its residents, including employees; licensed practitioners; adult students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangements. Staff are considered "fully vaccinated" if it has been two weeks or more since the staff member completed a primary vaccination series of COVID-19 (two doses of a multi-dose vaccine series or one dose of a single-dose vaccine series). The federal definition of "fully vaccinated" does not currently include the requirement to receive a booster vaccination, however the CMS vaccine mandate requires that facilities track and maintain documentation of any staff who have obtained booster doses. Facilities should ensure that the required policies and procedures are in place and should familiarize themselves with the CMS vaccine mandate guidance documents (QSO-22-07-ALL and Attachment A - Long-Term Care and Skilled Nursing Facility) and the attached Checklist (previously provided in CAHCF Memo issues January 26, 2022 and revised January 27, 2022) DPH Surveyors will be using to track compliance with the CMS vaccine mandate.

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CT Temporary Suspension of Out-of-State Practitioners Expires April 15, 2022

The DPH Order, which temporarily suspended licensure, certification, and registration requirements to allow certain out-of-state providers (e.g. physicians, licensed nurses, respiratory therapists, social workers) to temporarily work in Connecticut, expired on April 15, 2022. This Order has not been extended. As such, after last Friday, any out-of-state providers identified in the Order who are not appropriately credentialed to work in Connecticut under either statute or regulation, are not permitted to provide services.

CMS Blanket Waiver of CNA Training and Certification Ending June 6, 2022 and CT Temporary Nurse Aide Program Ending June 30, 2022

On April 7, 2022, CMS announced (QSO-22-15-NH & NLTC & LSC) the expected termination of certain emergency blanket waivers for SNFs, including the blanket waiver of 42 CFR §483.35(d) waiving the training and certification requirements for CNAs, which is set to expire on June 6, 2022. However, providers will be able to continue to employ Temporary Nurse Aides under Executive Order 13E, which was recently extended (S.B. No. 493), allowing the Temporary Nurse Aide (TNA) program to remain in effect until June 30, 2022.

Under the TNA program, detailed in DPH Order dated September 20, 2021, facilities are permitted to employ individuals who complete an 8-hour online course for a TNA, register with DPH as a TNA, and complete onsite training at the facility. After June 30th, providers will only be able to employ Temporary Nurse Aides if they have either (1) enrolled in an approved training program or (2) completed an approved nurse aide training program and are working within the allowed 120 days after hire, within which time they must successfully complete the Nurse Aide exam in order to continue employment beyond 120 days.

Given the impending termination of the TNA program on June 30th, we strongly recommend providers start taking steps now that are necessary to transition presently employed TNAs to Certified Nurse Aides (CNAs), by using the process outlined in DPH's Blast Fax 2021-20.

Licensure Renewal Extension Expiring August 15, 2022

DPH Order dated March 30, 2022 previously suspended the need for licensure renewals or payment of renewal fees until six months after the end of the public health emergency. Given that the public health emergency ended on February 15, 2022, licenses that were due for renewal during the public health emergency will expire on August 15, 2022. Facilities that are due for license renewals prior to August 15th are advised to submit renewal applications as soon as possible in anticipation of the high volume of renewal applications that are likely to be filed with DPH.

Other CMS Blanket Waivers Expiring May 7, 2022

Other CMS blanket waivers ending May 7, 2022 include:

- Restricting in-person resident groups - 42 CFR §483.10(f)(5)
- Physician delegation of tasks to other clinical positions - 42 CFR §483.30(e)(4)
- Physician telehealth visits and physician visits by other clinical positions 42 CFR §483.30
- Suspension of QAPI efforts – 42 CFR §483.75(b)–(d) and (e)(3)
- Waiving utilization of certain resources to help residents choose post-acute care provider - 42 CFR §483.21(c)(1)(viii)
- Requirement to provide residents a copy of their record within two working days - 42 CFR §483.10(g)(2)(ii)

For any questions, please contact Heather O. Berchem at hberchem@murthalaw.com or Madiha M. Malik at mmalik@murthalaw.com.

	FLIS WORKSHEET, NOT AN OFFICIAL DOCUMENT	

Facility Name & Address **Surveyor(s)** **Survey Date(s)**

FLIS COVID-19 Vaccination Facility Staff Checklist

Survey Process

Compliance will be assessed through observation, interview, and record review as part of the survey process.

1. Entrance Conference

- ☐ Surveyors will ask the facility to provide vaccination policies and procedures. At a minimum, the policy and procedures must provide:
- ☐ A process for ensuring all required staff have received, at a minimum, the first dose of a multi-dose COVID-19 vaccine, or a one-dose COVID-19 vaccine, before staff provide any care, treatment, or other services for the facility and/or its patients/residents;
- ☐ A process for ensuring that all required staff are fully vaccinated;
- ☐ A process for ensuring that the facility continues to follow all standards of infection prevention and control practice, for reducing the transmission and spread of COVID-19 in the facility, especially by those staff who are unvaccinated or who are not yet fully vaccinated;
- ☐ A process for tracking and securely documenting the COVID-19 vaccination status for all required staff;
- ☐ A process for ensuring all staff obtain any recommended booster doses, and any recommended additional doses for individuals who are immunocompromised, in accordance with the recommended timing of such doses;
- ☐ A process by which staff may request a vaccine exemption from the COVID-19 vaccination requirements based on recognized clinical contraindications or applicable Federal laws, such as religious beliefs or other accommodations;
- ☐ A process for tracking and securely documenting information confirming recognized clinical contraindications to COVID-19 vaccines provided by those staff who have requested and have been granted a medical exemption to vaccination;
- ☐ A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable State and local laws, and for further ensuring that such documentation contains:
- ☐ all information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and
- ☐ a statement by the authenticating practitioner recommending that the staff member be exempted from the hospital's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications;

1. Entrance Conference (*cont.*)

- ☐ A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, or individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and

- ☐ Contingency plans for staff that are not yet vaccinated for COVID-19 (and without an exemption for medical contraindications or without a temporary delay in vaccination due to clinical considerations as recommended by the CDC and as specified in paragraph (g)(3)(x)), including deadlines for staff to be vaccinated.

The facility will provide a list of all staff and their vaccine status:

- ☐ Including the percentage of unvaccinated staff, excluding those staff that have approved exemptions

- ☐ If any concerns are identified with the staff vaccine status list, surveyors should verify the percentage of vaccinated staff.

- ☐ The provider or supplier must identify any staff member remaining unvaccinated because it's medically contraindicated or has a religious exemption.

- ☐ The facility must also identify newly hired staff (hired in the last 60 days).

- ☐ The facility must indicate the position or role of each staff member

2. **Record Review, interview, and observations:**

Surveyors will review the policy and procedure to ensure all components are present.

- ☐ Surveyors will review any contingency plan developed to mitigate the spread of COVID-19 infections by the facility that may include:

- ☐ Requiring unvaccinated staff to follow additional, CDC-recommended precautions, such as adhering to universal source control and physical distancing measures in areas that are restricted from patient access (e.g., staff meeting rooms, kitchen), even if the facility or service site is located in a county with low to moderate community transmission.

- ☐ Reassigning unvaccinated staff to non-patient care areas, to duties that can be performed remotely (i.e., telework), or to duties which limit exposure to those most at risk (e.g., assign to patients who are not immunocompromised, unvaccinated);

- ☐ Requiring at least weekly testing for unvaccinated staff, regardless of whether the facility or service site is located in a county with low to moderate community transmission

☐ Requiring unvaccinated staff to use a NIOSH-approved N95 or equivalent or higher-level respirator for source control, regardless of whether they are providing direct care to or otherwise interacting with patients.

Surveyors will select a sample of staff based on current staff sample selection guidelines. Surveyors should also examine the documentation of each staff identified as unvaccinated due to medical contraindications. The sample should include (as applicable):

Direct care staff (vaccinated and unvaccinated) ☐

Contracted staff ☐

Direct care staff with an exemption ☐

For each individual identified by the facility as vaccinated, surveyors will:

1. Review facility records to verify vaccination status. Examples of acceptable forms of proof of vaccination include:
    a. CDC COVID-19 vaccination record card (or a legible photo of the card)
    b. Documentation of vaccination from a health care provider or electronic health record
    c. State immunization information system record
2. Conduct follow-up interviews with staff and administration if any discrepancies are identified. If applicable, determine if any additional doses were provided. ☐

For each individual identified by the facility as unvaccinated, surveyors will:

1. Review facility records ☐
2. Determine, if they have been educated and offered vaccination ☐
3. Interview staff and ask if they plan to get vaccinated, if they have declined to get vaccinated and if they have a medical contraindication or religious exemption. ☐
    a. Request and review documentation of the medical contraindication ☐
    b. request to see employee record of the staff education on the facility policy and procedure regarding unvaccinated individuals ☐
    c. Observe staff providing care to determine compliance with current standards of practice with infection control and prevention. ☐

For each individual identified by the facility as unvaccinated due to a medical contraindication:

1. Review and verify that all required documentation is:
    a. Signed and dated by a physician or advanced practice provider ☐
    b. States the specific vaccine that is contraindicated and the recognized clinical reason for the contraindication with a statement recommending exemption. ☐

Surveyor Notes