STATE OF MICHIGAN

GRETCHEN WHITMER
GOVERNOR

DEPARTMENT OF HEALTH AND HUMAN SERVICES
LANSING

ELIZABETH HERTEL
DIRECTOR

March 2, 2021

Emergency Order under MCL 333.2253 – Requirements for Residential Care Facilities
Rescission of December 8, 2020 Order

Michigan law imposes on the Michigan Department of Health and Human Services (MDHHS) a duty to "continually and diligently endeavor to prevent disease, prolong life, and promote the public health," and gives the Department "general supervision of the interests of the health and life of the people of this state." MCL 333.2221. MDHHS may "[e]xercise authority and promulgate rules to safeguard properly the public health; to prevent the spread of diseases and the existence of sources of contamination; and to implement and carry out the powers and duties vested by law in the department." MCL 333.2226(d).

The novel coronavirus (COVID-19) is a respiratory disease that can result in serious illness or death. It is caused by a new strain of coronavirus not previously identified in humans and easily spread from person to person. COVID-19 spreads through close human contact, even from individuals who may be asymptomatic.

In recognition of the severe, widespread harm caused by epidemics, the Legislature has granted MDHHS specific authority, dating back a century, to address threats to the public health like those posed by COVID-19. MCL 333.2253(1) provides that:

> If the director determines that control of an epidemic is necessary to protect the public health, the director by emergency order may prohibit the gathering of people for any purpose and may establish procedures to be followed during the epidemic to insure continuation of essential public health services and enforcement of health laws. Emergency procedures shall not be limited to this code.

See also In re Certified Questions from the United States District Court, Docket No. 161492 (Viviano, J., concurring in part and dissenting in part, at 20) ("[T]he 1919 law passed in the wake of the influenza epidemic and Governor Sleeper's actions is still the law, albeit in slightly modified form."); *id.* (McCormack, C.J., concurring in part and dissenting in part, at 12). Enforcing Michigan's health laws, including preventing disease, prolonging life, and promoting public health, requires limitations on gatherings and the establishment of procedures to control the spread of COVID-19. This includes limiting the number, location, size, and type of gatherings, and requiring the use of mitigation measures at gatherings as a condition of hosting such gatherings.

As of February 27, the State of Michigan had a seven-day average of 91.2 cases per million people, nearly 88% lower than the case rate in mid-November. While that case rate is similar to the rate in early October, it has plateaued over the past week and remains three times the rate of the summer low point. Test positivity was 3.7% as of February 27, 2021, and has started to plateau as well. While metrics have decreased from all-time highs, further progress has tapered off and there is growing concern of another spike with the presence of more infectious variants in Michigan and the United States as a whole. A high number of cases creates significant pressure on our emergency and hospital systems. Improvements in healthcare capacity have slowed but are near the levels of early October. An average of 102 daily hospital admissions was seen in Michigan in the last week, with individuals under the age of 60 accounting for 40% of all new admissions. As of February 27, nearly 850 Michiganders were hospitalized with COVID-19 and 3.9% of all available inpatient beds were occupied by patients who had COVID-19. The state death

rate was at that time 2.2 deaths per million people and there were approximately 150 weekly deaths in Michigan attributable to COVID-19. This is an 84% decrease from the second peak, which reached 13.7 deaths per million on December 10, 2020.

Yet, new and unexpected challenges continue to arise. In early December 2020, a variant of COVID-19 known as B.1.1.7 was detected in the United Kingdom. This variant is roughly 50 to 70 percent more infectious than the more common strain. On January 16, 2021, this variant was detected in Michigan. It is anticipated that the variant, if widespread in the state, would significantly increase the rate of new cases. Continued progress in controlling the virus necessitates close monitoring of cases and impacts, alongside efforts to increase the rate of vaccination. Therefore, as lower COVID-19 rates permit easing of precautions, we must continue to proceed slowly and carefully.

Even where COVID-19 does not result in death, and where our emergency and hospital systems are not heavily burdened, the disease can cause great harm. Recent estimates suggest that one in ten persons who suffer from COVID-19 will experience long-term symptoms, referred to as "long COVID." These symptoms, including fatigue, shortness of breath, joint pain, depression, and headache, can be disabling. They can last for months, and in some cases, arise unexpectedly in patients who had few or no symptoms of COVID-19 at the time of diagnosis. COVID-19 has also been shown to damage the heart and kidneys. Furthermore, minority groups in Michigan have experienced a higher proportion of "long COVID." The best way to prevent these complications is to prevent transmission of COVID-19.

To date, the Food and Drug Administration has granted emergency use authorization to three vaccines to prevent COVID-19, providing a path to end the pandemic. Indeed, the State of Michigan is part of the largest mass vaccination effort in modern history and is presently working toward vaccinating at least 70% of its residents 16 and older as quickly as possible. Recently, increased access to rapid tests has redefined state and federal landscape of pandemic control. Rapid tests are both efficient and reliable. They assure access to point of care testing and confidence in immediate results.

Considering the above, and upon the advice of scientific and medical experts, I have concluded pursuant to MCL 333.2253 that the COVID-19 pandemic continues to constitute an epidemic in Michigan. I have also, subject to the grant of authority in 2020 PA 238 (signed into law on October 22, 2020), herein defined the symptoms of COVID-19 based on the latest epidemiological evidence. I further conclude that control of the epidemic is necessary to protect the public health and that it is necessary to restrict gatherings and establish procedures to be followed during the epidemic to ensure the continuation of essential public health services and enforcement of health laws. As provided in MCL 333.2253, these emergency procedures are not limited to the Public Health Code.

I therefore order that:

1. Definitions.

   For purposes of this Order, terms are defined as follows:

   (a) "Adult foster care facility" has the meaning as provided by section 3(4) of the Adult Foster Care Facility Licensing Act, 1979 PA 218, as amended, MCL 400.703(4).

   (b) "Appropriate PPE" means, at minimum, the Personal Protective Equipment recommended by MDHHS and the Centers for Disease Control and Prevention (CDC).

   (c) "Assisted living facility" means an unlicensed establishment that offers community-based residential care for at least three unrelated adults who are either over the age of 65 or need assistance with activities of daily living (ADLs), including personal, supportive, and intermittent health-related services available 24-hours a day.

(d) "Communal dining and group activities" means dining areas and group activities involving residents in facilities that house more than six individuals.

(e) "Confirmed COVID-19 positive employee or resident" means a case of COVID-19 originating in the facility, including those involving staff or residents ("facility-onset cases").

(f) "Face mask" means a tightly woven cloth or other multi-layer absorbent material that closely covers an individual's mouth and nose.

(g) "Home for the aged" has the meaning as provided by section 20106(3) of the Public Health Code, MCL 333.20106(3).

(h) "Nursing home" has the meaning as provided by section 20109(1) of the Public Health Code, MCL 333.20109(1).

(i) "Outbreak testing" is the testing of residents and staff that begins after any new case arises in a residential care facility and continues until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result.

(j) "Principal symptoms of COVID-19" are fever, uncontrolled cough, or atypical new onset of shortness of breath or at least 2 of the following not explained by a known physical condition; loss of taste or smell, muscle aches, sore throat, severe headache, diarrhea, vomiting, or abdominal pain.

(k) "Residential care facilities" means a nursing home, home for the aged, adult foster care facility, hospice facility, substance use disorder residential facility, or assisted living facility. It does not include independent living facilities.

(l) "Serious or critical condition or in hospice care" includes residents enrolled in hospice services regardless of whether the resident appears to be in serious or critical condition or at the End of Life; residents receiving End of Life care who are not enrolled in hospice; residents whose wellbeing is at significant risk, based on the clinical judgment of a treating medical professional, where family visits are a potentially effective intervention; and residents who experience a significant adverse change of condition.

(m) "End of Life" is as determined and documented by a qualified medical professional.

2. Resident and Employee Protections.

(a) Residential care facilities (hereafter referred to as "facilities" in this order) shall:

(1) Make efforts to allow communal dining and group activities to occur for those residents who are fully recovered from a COVID-19 infection or are not in isolation, or are otherwise not under observation for symptoms of COVID-19. Dining and group activities must:

(A) Have adequate physical distancing, at least six feet between participants.

(B) Require participating residents to wear masks, if able, when not eating or drinking.

(C) Provide access to hand hygiene; and

(D) Otherwise comply with the Center for Medicare and Medicaid Services guidance included in **QSO-20-39-NH** (issued on September 17, 2020).

(2) Inform employees and residents of the presence of a confirmed COVID-19 positive employee or resident as soon as reasonably possible, but no later than 12 hours after identification.

(3) As soon as reasonably possible, but no later than 24 hours after identification of a confirmed COVID-19 positive employee or resident:

(A) Inform legal guardians or healthcare proxies for all residents within the facility of the presence of a confirmed COVID-19 positive employee or resident;

(B) Post a notice in a visible and obvious place near the main entrance of the facility indicating the presence of a confirmed COVID-19 positive employee or resident. The notice must continue to be displayed until 14 days after the last positive COVID-19 test result for an employee or resident in the facility;

(C) Adopt a protocol to inform prospective residents and staff of the presence of a confirmed COVID-19 positive employee or resident. Such notification must continue until 14 days after the last positive COVID-19 test result for an employee or resident in the facility. The protocol must specify how guardians and health care proxies will be informed of the positive COVID-19 test result;

(D) Contact the local health department in the facility's jurisdiction to report the presence of a confirmed COVID-19 positive employee or resident; and

(E) Support and comply with contact tracing efforts as requested.

(4) Timely notify employees of any changes in CDC recommendations related to COVID-19;

(5) Keep accurate and current data regarding the quantity of each type of Appropriate PPE available onsite, and report such data to EMResource upon MDHHS's request or in a manner consistent with MDHHS guidance; and

(6) Report to MDHHS and the applicable Local Health Department all presumed positive COVID-19 cases in the facility together with any additional data when required under MDHHS guidance.

(b) Independent Living Facilities shall:

(1) Contact the local health department in the facility's jurisdiction to report the presence of a confirmed COVID-19 positive employee or resident; and

(2) Support and comply with contact tracing efforts as requested.

3. Visitation.

(a) In accordance with this Order, facilities must support and accommodate residents receiving visitors. Visitation includes, to the extent practicable, both indoor and outdoor visitation unless otherwise specified. Visitation or visitor does not include an individual entering the facility for the purpose of performing official government functions. Adult foster care homes licensed for 12 or fewer residents, hospice facilities, substance use disorder residential facilities, and assisted living facilities are encouraged to implement visitor and staff testing protocols.

(b) Except as otherwise provided in this Order, visitation may only occur when the facility meets all of the following criteria:

(1) The facility has had no new COVID-19 cases originate in the facility, including those involving residents or staff ("facility-onset cases"), within the prior 14 days and is not currently conducting outbreak testing. Admission of a resident who is known to be COVID-19-positive at the time of admission does not constitute a facility-onset case;

(2) The local health department or MDHHS has not prohibited visitation at the facility.

(3) Nursing homes, homes for the aged, and adult foster care facilities licensed to care for 13 individuals or more must ensure that all visitors over 13 years old participating in indoor visitation are subject to the testing requirements in section 4. Outdoor visitation is not subject to the testing requirements of section 4.

(c) Facilities allowing visitation consistent with this order shall, without exception:

(1) Permit visits by appointment only. Facilities may impose reasonable time limits on visits and must require that visitors log arrival and departure times, provide their contact information, and attest, in writing, that they will notify the facility if they develop symptoms consistent with COVID-19 within 14 days after visiting.

(2) Limit the number of visitors per scheduled visit to two persons or fewer at any given time.

(3) For facilities with a MDHHS-required resident and staff testing regimen, in accordance with section 3(b)(3), require the testing of visitors in accordance with section 4 of this Order.

(4) Exclude visitors who are unwilling or unable to wear a face mask for the duration of their visit or follow hand hygiene requirements, and instead encourage those persons to use video or other forms of remote visitation. Further, require visitors to wear appropriate PPE, and comply with the facility's visitor PPE requirements based on applicable infection control protocols.

(5) Limit visitor entry to designated entrances that allow proper COVID-19 screening.

(6) Perform a health evaluation of all visitors each time the visitor seeks to enter the facility and deny entry to visitors who do not meet the evaluation criteria. Screenings must include tests for fever (≥100.4°F), other symptoms consistent with COVID-19, and known exposure to someone with COVID-19. Facilities must restrict anyone with fever, symptoms, or known COVID-19 exposure from entering the facility.

(7) Post signage at all visitor entrances instructing that visitors must be assessed for symptoms of COVID-19, will, if applicable, be required to test before entry, and instruct persons who have symptoms of COVID-19 to not enter the facility.

(8) Require that visitors follow physical distancing requirements and refrain from any physical contact with residents and employees during indoor and outdoor visits, except that:

(A) Individuals who are providing services requiring physical contact under subsections 3(e)(3), 3(e)(4), and (3)(e)(5) are not required to abide by physical distance requirements between the visitor and the resident while providing such services; provided those service providers are wearing appropriate PPE and the time spent within six feet of a resident is no longer than 15 minutes.

(B) Visitors participating in visits at the End of Life may have physical contact with a resident if that resident is not COVID-19 positive, the visitors are wearing appropriate PPE, and the time spent within 6 feet of the resident is no longer than 15 minutes.

(9) Make hand sanitizer and/or hand washing facilities safely available to visitors and post educational materials on proper hand washing and sanitization.

(10) Ensure availability of adequate staff to assist with the transition of residents, monitoring of visitation, and for cleaning to disinfect surfaces in the visitation areas after each visit.

(11) Educate visitors on additional PPE use requirements for visitors beyond a face mask, if any. The facility must supply the visitor with the additional PPE. Entry may not be denied based on a visitor not having the additional PPE required by the facility.

(12) Disallow visitation during aerosol-generating procedures or during collection of respiratory specimens unless deemed necessary by staff for the care and well-being of the resident.

(13) Restrict visitor movement within the facility to reduce the risk of infection.

(14) Make accommodations to support visitation for residents who share a room with another resident. Visits for residents who share a room shall not be conducted in the resident's room.

(15) Make available an employee or volunteer trained in infection control measures at all times during the visit. This individual is not required to supervise a visit but must be available for questions.

(16) Limit the number of overall visitors at the facility in any given time based upon limited space, infection control capacity, and other necessary factors to reduce the risk of transmission.

(17) Advise residents and visitors to not share food.

(18) Communicate regularly with residents and their families to inform them of updated visitation protocols.

(19) Prohibit visits to residents who are in isolation or are otherwise under observation for symptoms of COVID-19.

(d) Prior to offering outdoor visitation, the facility must assure all of the following:

(1) The outdoor visitation area allows for at least six feet between all persons. Tables are recommended as a barrier to ensure proper physical distancing. Marked areas and signage may be necessary to inform visitors of expectations. Tables and chairs must be disinfected after each use; and

(2) The outdoor visitation area provides adequate protection from weather elements (e.g., in a shaded area).

(e) Facilities should accommodate the following visitation even when visitation would otherwise not be permitted under section 3(b)(1)-(3):

(1) Window visits when a barrier is maintained between the resident and visitor.

Accommodations shall be made for residents without access to ground floor window or a window that does not open to an area accessible to the visitor. Accommodations may include utilizing a visitation room or space with a window or door access to a visitor.

(2) A parent, foster parent, or guardian of a resident who is 21 years of age or under.

(3) Visits that support Activities for Daily Living (ADL) or visits that are necessary to ensure effective communication with individuals with hearing, vision or speech impairments. Facilities with residents that had ADL arrangements prior to March 14, 2020, or residents that have had a change of condition that could be improved with ADL arrangements, must attempt to contact the resident's next of kin or an individual identified by the resident in partnership with the local ombudsman to establish arrangements. Except in circumstances where the visitor tests positive for COVID-19, facilities that deny visitation under this section must provide written notice to the visitor with an explanation of why visitation is being denied. The denial notice must also be sent to MDHHS and the LTC ombudsman.

(4) Visits, including those by clergy, that occur when a resident is in serious or critical condition or in hospice care. Except in circumstances where the visitor tests positive for COVID-19, facilities that deny visitation under this section must provide written notice to the visitor with an explanation of why visitation is being denied. The denial notice must also be sent to MDHHS and the LTC ombudsman.

(5) Medical service providers such as hospice providers, podiatrists, dentists, durable medical equipment providers, social workers and other behavioral health providers, speech pathologists, occupational therapists, physical therapists, and other health care providers, including resident physicians and clinical students. If these services must be provided indoors, the facility must restrict movement within the facility to the greatest extent possible to reduce the risk of infection.

(f) The following visitation may occur even when visitation would otherwise not be allowed under section 3(b)(2)):

(1) Non-medical service providers, such as hairdressers, nail salon technicians, cosmetologists, and providers of religious or spiritual services, when it is determined by a qualified medical professional that there will be an actual or potential negative impact on the resident when the service is not provided, and the resident will not benefit from remote service delivery. These services may be provided to residents who have never been diagnosed with COVID-19, or who are no longer in the infectious period for COVID-19 per CDC guidance. These services must be provided outdoors or in a well-ventilated area whenever possible. If services must be provided indoors, the facility must restrict movement within the facility to the greatest extent possible to reduce the risk of infection.

(2) Volunteers who have been trained in infection control measures and are supporting visitation (e.g. scheduling visits, conducting screening of visitors, escorting visitors or residents to visitation location, and/or monitoring visits for infection control compliance).

4. Testing.

(a) For the purposes of this order, when visitor testing is required, facilities should conduct point of entry testing of visitors whenever possible. When point of entry testing is not available, facilities must require visitors to be tested on their own within 72 hours of coming to the facility and require proof of negative test results upon entry.

(b) Testing shall be required prior to entry for indoor visitation at all facilities, except that:

(1) Testing is not required prior to visits under subsections 3(e)(1) and visits at the End of Life, though such testing is strongly encouraged.

(2) Testing requirements for visitation under subsections 3(e)(5) and 3(f)(1)-(2) must be the same as for similar staff working in the facility.

(3) Testing is not required for visitors 13 years of age or younger.

5. Implementation.

(a) Nothing in this order should be taken to modify, limit, or abridge protections provided by state or federal law for a person with a disability.

(b) Under MCL 333.2235(1), local health departments are authorized to carry out and enforce the terms of this order.

(c) Law enforcement officers, as defined in the Michigan Commission on Law Enforcement Standards Act, 1965 Public Act 203, MCL 28.602(f), are deemed to be "department representatives" for purposes of enforcing this order and are specifically authorized to investigate potential violations of this order. They may coordinate as necessary with the appropriate regulatory entity and enforce this order within their jurisdiction.

(d) Consistent with MCL 333.2261, violation of this order is a misdemeanor punishable by imprisonment for not more than 6 months, or a fine of not more than $200.00, or both.

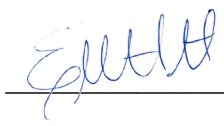
(e) The December 8, 2020 order entitled "Requirements for residential care facilities" is rescinded as of the effective date of this order. Nothing in this order shall be construed to affect any prosecution or enforcement based on conduct that occurred before the effective date of this order.

(f) Consistent with any rule or emergency rule promulgated and adopted in a schedule of monetary civil penalties under MCL 333.2262(1) and applicable to this order, violations of this order are punishable by a civil fine of up to $1,000 for each violation or day that a violation continues.

(g) If any provision of this order is found invalid by a court of competent jurisdiction, whether in whole or in part, such decision will not affect the validity of the remaining part of this order.

This Order is effective immediately.

Date: March 2, 2021



Elizabeth Hertel, Director

Michigan Department of Health and Human Services