Subject: Visitors at Lakeview Terrace Assisted Living Facility

Responsibility: Direct: Director of Nursing and Administrator

Consultative: Executive Director, Security and Designated Management Consultant Staff

Purpose: To establish procedures for visitation at Lakeview Terrace Assisted Living Facility that promotes Resident choice, engagement in activity and well-being.

To ensure Residents choice of visitors, and their right to privacy for family and friends.

Standards: 42CFR 483.10 Resident Rights
CMS Memo QSO-20-39-NH revised 9.23.22
Agency for Health Care Administration Re-Opening of Long-Term Care Facilities Emergency Order 21-001 Questions & Answers, March 29,2021
SB 988, No Patient Left Alone Act
59A-36-007(5) FAC; 429.28 (1-2) FS 429.27

- The facility shall establish procedures and guidelines for visitation at the facility.
- The facility will not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.
- The facility will follow CDC, DOH and Federal and State regulatory guidelines regarding visitation.
- QSO-20-39 revised May 8, 2023
- 59AER23-2, Appropriate Use of Facial Coverings

Definitions:

1. **CDC** - Centers for Disease Control and Prevention

2. **Family** - Family or Family Member. The terms "family" or "family member" solely for this protocol are understood and interpreted to include any person(s) who plays a significant role in an individual's socio-emotional life. This may include a person(s) not legally related to the individual. Members of "family" may include spouses, domestic partners, and both different-sex and same-sex significant others. "Family" may include a minor Resident's parents, regardless of the gender of either parent.

3. **PPE** - Personal Protective Equipment

4. **Resident representative**

   (1) An individual chosen by the Resident to act on behalf of the Resident in order to support

the Resident in decision-making; access medical, social or other personal information of the Resident; manage financial matters; or receive notifications;

(2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the Resident in order to support the Resident in decision-making; access medical, social or other personal information of the Resident; manage financial matters; or receive notifications;

(3) Legal representative, as used in section 712 of the Older Americans Act; or

(4) The court-appointed guardian or conservator of a Resident.

5. **Visitor** - A "visitor" is defined as a guest of the Resident. Family members are considered to be visitors as well.
6. **AHCA** – The Agency for Health Care Administration

Procedures:

1. Administration of the protocol

    a. The Administrator and Director of Nursing are responsible for the oversight of this protocol.
    b. The facility has designated the Unit Manager/Nurse-in-Charge to oversee that daily visitation policies and procedures are followed by staff, residents and visitors.
    c. All staff are responsible for ensuring that visitation policies are followed by residents and visitors.

2. The facility will develop a visitation plan in compliance with local, state, federal and CDC guidelines. This plan will be communicated to staff, residents, family and guardians and all other visitors. The plan will establish a process to allow visitation at all times for all residents under existing regulations, while promoting core principles of infection prevention and privacy.
   https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

3. The facility will follow the recommendations outlined in CMS Memo QSO-20-39-NH revised 05.08.23, the core principles of COVID-19 infection prevention, and other CDC guidance to prevent the transmission of contagious diseases (e.g. education visitors risks, when they may want to defer visiting, source control/wearing a mask, etc.)

4. Visitation may be conducted through different means based on the facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors with adequate environmental control, and for circumstances considered compassionate care situations. Virtual visits will also be supported.

5. Visitations will be person-centered, taking into account resident and family/visitor needs and privacy will be provided. Consensual physical contact between residents and their visitors/loved ones is allowed.

6. Residents have the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and the right to withdraw or deny such consent at any time.

7. Visitations will be person-centered, taking into account resident and family/visitor needs and privacy will be provided.

8. Residents' families and friends are encouraged to visit regularly and maintain contact by letter, telephone or electronic means when visiting is not possible. In these cases staff will ensure, as part of care planning, that where help to respond is necessary, this will be provided in the most appropriate manner, e.g. assisting with telephone calls or letter writing, ensuring birthday cards are sent and facilitating outings with or to relatives and friends, when clinically able.

9. There are no set visiting hours and guests may visit at any time based on Resident choice and the rights and well-being of the Residents.

10. Visitors will be welcomed at all reasonable times, and these may need to take into consideration not only when this is most suitable for the Resident, but also 'unsociable' hours in order to maintain contact. The Resident's wishes must be paramount in these decisions. This is of particular importance during any illness of the Resident and for end of life planning, when families and Residents may wish to be together. Visiting should never unreasonably be prevented.

11. When visitors intrude on other Residents or visit at times that may infringe upon the rights of other Residents, the facility will attempt to accommodate the other Resident, such as finding another place for the visitation to occur.

12. The facility will provide immediate access to a Resident by immediate family, other relatives of the Resident or other guests, subject to the Resident's right to deny or withdraw consent at any time.

13. When the Resident is unable to express consent or express who is family or friend, the Resident representative will be contacted to facilitate consent and safe visitations.

14. The facility will allow in-person visitation in all of the following circumstances, unless the resident objects:

    a. End-of-life situations.

b. A resident, client, or patient who was living with family before being admitted to the provider's care is struggling with the change in environment and lack of in-person family support.
c. A resident is making one or more major medical decisions.
d. A resident is experiencing emotional distress or grieving the loss of a friend or family member who recently died.
e. A resident needs cueing or encouragement to eat or drink which was previously provided by a family member or caregiver.
f. A resident who used to talk and interact with others is seldom speaking.
g. For hospitals, childbirth, including labor and delivery.
h. Pediatric patients.

15. Compassionate Caregivers will be allowed to visit at all times.

16. Access to any Resident will be granted to any representative of the State or advocacy group and the Residents' physician. Persons visiting for purposes relative to State and Federal regulations must have proper identification cards. (Refer to protocol on Resident Rights).

17. Visitors should sign the visitors' book on arrival and departure from the facility.

18. Children under the age of 16 should always be accompanied by an adult other than the Resident.

19. Visitors are encouraged to raise any concerns or questions with the nurse-in charge and to be aware of the Grievance procedure. Visitors are encouraged to make suggestions and participate in family activities, such as consultation meetings and events.

20. At any time, the Resident has the right to refuse to see any visitor, and this right will be respected and upheld by the nurse-in-charge who will, if necessary, inform the visitor of the Resident's wishes. Any such request or refusal of the Resident will be recorded, with reasons, in the Resident's personal file and where necessary, especially in an ongoing refusal, be included in the care plan. All staff and Security will be made aware of such Resident wishes, and ensure that any visitors involved should be tactfully referred to the nurse-in-charge on arrival.

21. Under certain circumstances a particular visitor may be contrary to the well-being of the Resident or the facility in general. The nurse-in-charge will report this fact to the Administrator who may, at his/her discretion, exclude the visitor(s) from the facility, giving the reasons for this decision. Such instances will be recorded in the Resident's personal file, together with the reasons for exclusion.

22. Visitation may be restricted based on reasonable clinical and safety restrictions and the Resident's right to deny consent at any time. Visual guidance may be posted at entrances

informing visitors about recommendation actions to take if they feel they have an infectious disease, or are at risk by being exposed or having symptoms.

a. Visitors with signs and symptoms of a communicable disease or symptoms of an Influenza-like illness will be informed of facility Infection control and prevention policies and recommend that they defer visitation based on CDC guidelines.
b. All visitors will be encouraged to follow hand-hygiene and respiratory etiquette. Additional measures will be instructed to the visitors based on the Resident's specific condition, such as isolation and PPE requirements either due to infectious agents or immunosuppression.
c. Visitors not abiding by facility policies, after re-education may be restricted from visiting. This includes the prohibition of smoking on campus grounds.
d. Visitors found to have been committing criminal acts such as theft or being inebriated or disruptive may be restricted.
e. Visitors may also be denied access or provided with limited and supervised visitation to a resident if the individual is suspected of abusing, exploiting, or coercing a resident, until an investigation into the allegation has been completed or has been found to be abusing, exploiting, or coercing a resident; or having a history of bringing illegal substances in the facility which places residents' health and safety at risk.
f. The Director of Nursing and Medical Director may provide guidance on the clinical reason for visitation restriction. This restriction will be documented in the Resident's record.
g. Once a clinical or safety restriction is no longer a concern, the Director of Nursing or designee will promptly review and remove the visitation restriction, if appropriate.
h. Refer to facility policies on Infection Guidelines.

23. Facial coverings
    a. The facility may choose to require a visitor to wear a facial covering only when the visitor is:
        i. Exhibiting signs or symptoms of or has a diagnosed infectious disease that can be spread through droplet or airborne transmission,
        ii. In sterile areas of the health care setting or an area where sterile procedures are being performed,
        iii. In an in-resident or clinical room with a resident who is exhibiting signs or symptoms of or has a diagnosed infectious disease that can be spread through droplet or airborne transmission, or
        iv. Visiting a resident whose treating health care practitioner has diagnosed the resident with or confirmed a condition affecting the immune system in a manner which is known to increase risk of transmission of an infection from employees without signs or symptoms of infection to a patient and whose treating practitioner has determined that the use of facial coverings is necessary for the resident's safety.
    b. Opt out options will be made available per visitor request if an alternative method of infection control or infectious disease prevention is available.

24. Visitors or family members with prohibitive legal documentation, such as applicable restraining orders, will not be allowed to visit. Security will be notified of such legal restrictions.

25. The facility will not tolerate any form of aggression, violence, harassment, or discrimination. Any visitor violating these areas will be asked to leave the premises and Security will be notified. Any future visit will be the subject of an agreed 'personal contract' between the facility and the visitor, if appropriate.

26. Visitors are encouraged to read the facilities' policies relating to making grievances or suggestions, abuse prevention and response and infection prevention.

27. Family, visitors and guests may park in any designated parking area except near fire hydrants, or in areas designated for handicapped parking without proper disabled parking permit or sticker.

28. Protocol access:
    a. The facility shall provide their visitation policies and procedures to AHCA when applying for initial licensure, licensure renewal, or change of ownership, and the provider will make it available to AHCA for review at any time, upon request
    b. This protocol will be posted in the facility and on the facility's website homepage or as required by regulations.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: QSO-20-39-NH

DATE: **September 17, 2020** ***REVISED 05/08/2023***

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Nursing Home Visitation - COVID-19 *(REVISED)*

Memorandum Summary

- CMS is committed to continuing to take critical steps to ensure America's healthcare facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).
- **Visitation is allowed for all residents at all times.**
- ***Updated guidance to align with the ending of the PHE***

Background

Nursing homes have been severely impacted by COVID-19, with outbreaks causing high rates of infection, morbidity, and mortality. The vulnerable nature of the nursing home population combined with the inherent risks of congregate living in a healthcare setting have required aggressive efforts tolimit COVID-19 exposure and to prevent the spread of COVID-19 within nursing homes.

In March of 2020, CMS issued memorandum QSO 20-14-NH providing guidance to facilities on restricting visitation of all visitors and non-essential healthcare personnel, except for certain compassionate care situations, such as an end-of-life situation.

While CMS guidance has focused on protecting nursing home residents from COVID-19, we recognize that physical separation from family and other loved ones has taken a physical and emotional toll on residents and their loved ones. Residents may feel socially isolated, leading to increased risk for depression, anxiety, and expressions of distress. Residents living with cognitive impairment or other disabilities may find visitor restrictions and other ongoing changes related to COVID-19 confusing or upsetting. CMS understands that nursing home residents derive value from the physical, emotional, and spiritual support they receive through visitation from family and friends. In light of this, CMS is revising the guidance regarding visitation in nursing homes during the COVID-19 PHE. The information contained in this memorandum supersedes and replaces previously issued guidance and recommendations regarding visitation.

Since the release of QSO memorandum 20-39-NH on September 17, 2020, COVID-19 vaccines have received full approval and Emergency Use Authorization from the Food and Drug Administration. Millions of Vaccinations have since been administered to nursing home residents and staff, and these vaccines have been shown to help prevent symptomatic SARS-CoV-2 infection (i.e., COVID-19). In addition, CMS requires nursing homes to educate residents and staff on the risks and benefits of the vaccines, offer to administer the vaccine, and report residentand staff vaccination data to CDC's National Healthcare Safety Network. CMS now posts this information on the CMS COVID-19 Nursing Home Data website along with other COVID-19 data, such as the weekly number of COVID-19 cases and deaths. **Therefore, CMS, in conjunction with the Centers for Disease Control and Prevention (CDC), is updating its visitation guidance accordingly, but emphasizing the importance of maintaining infection prevention practices.**

We note that the reason for visitation restrictions during the COVID-19 PHE were to mitigate the opportunity for visitors to introduce COVID-19 into the nursing home. Per 42 CFR § 483.10(f)(4), a resident has the right to receive visitors of his or her choosing at the time of his or her choosing, and in a manner that does not impose on the rights of another resident, such as a clinical or safety restriction (see 42 CFR § 483.10(f)(4)(v)). In other words, while all residents have a right to visitation, fully open and unrestricted visitation posed a clinical health and safety risk to other residents during this PHE, and therefore, it was reasonable to place limits on visitation. However, current nursing home COVID-19 data shows approximately 87% of residents and *83*% of staff are fully vaccinated as of February 2022.

On November 4, 2021, CMS issued a regulation requiring that all nursing home staff be vaccinated against COVID-19 as a requirement for participating in the Medicare and Medicaid programs. This requirement also applied to nearly all Medicare and Medicaid-certified providers and suppliers. CMS will continue to monitor vaccination and infection rates, including the effects of COVID-19 variants on nursing home residents, which have recently caused the number of cases to slightly increase. However, at this time, continued restrictions on this vital resident's right are no longer necessary.

We acknowledge that there may still be concerns associated with visitation, however, adherence to the core principles of COVID-19 infection prevention mitigates these concerns. Furthermore, we remind stakeholders that, per 42 CFR § 483.10(f)(2), the resident has the right to make choices about aspects of his or her life in the facility that are significant to the resident. We further note that residents may deny or withdraw consent for a visit at any time, per 42 CFR § 483.10(f)(4)(ii) and (iii). Therefore, if a visitor, resident, or their representative is aware of the risks associated with visitation, and the visit occurs in a manner that does not place other residents at risk (e.g., in the resident's room), the resident must be allowed to receive visitors as he/she chooses.

On April 10, 2023, the President signed legislation that ended the COVID-19 national emergency. On May 11, 2023, the COVID-19 public health emergency is expected to expire. While the PHE will end, CMS still expects facilities to adhere to infection prevention and control recommendations in accordance with accepted national standards.

Guidance

Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, and outdoors. Regardless of how visits are conducted, certain core principles and best practices reduce the risk of COVID-19 transmission:

Core Principles of COVID-19 Infection Prevention *and Control (IPC)*

- Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19. Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact if they meet criteria described in CDC healthcare guidance (e.g., cannot wear source control).
- Hand hygiene (use of alcohol-based hand rub is preferred)
- Face covering or mask (covering mouth and nose) in accordance with CDC guidance
- *Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias) These alerts should include instructions about current IPC recommendations (e.g., when to use source control).*Cleaning and disinfecting *of frequently* touched surfaces in the facility often, anddesignated visitation areas after each visit
- Appropriate staff use of Personal Protective Equipment (PPE)
- Effective cohorting of residents (e.g., separate areas dedicated to COVID-19 care)
- Resident and staff testing conducted *following nationally accepted standards, such as CDC recommendations.*

These core principles are consistent with the Centers for Disease Control and Prevention (CDC) guidance for nursing homes, and should be **adhered to at all times**. Additionally, visitation should be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. The risk of transmission can be further reduced through the use of physical barriers (e.g., clear Plexiglass dividers, curtains). Also, nursing homes should enable visits to be conducted with an adequate degree of privacy. Visitors who are unable to adhere to the core principles of infection prevention should not be permitted to visit or should be asked to leave. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance.

Outdoor Visitation

Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. For outdoor visits, facilities should create accessible and safe outdoorspaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident's health status (e.g., medical condition(s), COVID-19 status, quarantine status) may hinder outdoor visits. When conducting outdoor visitation, all appropriate infection control and prevention practices should be followed.

Indoor Visitation

Facilities must allow indoor visitation at all times and for all residents as permitted under the regulations. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.

Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 infection prevention and does not increase risk to other residents. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission.

Face Coverings and Masks during visits

The facility's policies regarding face coverings and masks should be based on recommendations from the CDC, state and local health departments, and individual facility circumstances.

Indoor Visitation during an Outbreak Investigation

An outbreak investigation is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. To swiftly detect cases, we remind facilities to adhere to CMS regulations *at 42 CFR §483.80 Infection Control following accepted national standards, such as CDC recommendations.* If residents or their representative would like to have a visit during an outbreak investigation, *the visit should ideally occur in the resident's room, the resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible) during the visit*. While an outbreak investigation is occurring, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area

Visitor Testing and Vaccination

While not required, we encourage facilities to offer testing to visitors, if feasible.

CMS strongly encourages all visitors to *stay up to date with their COVID-19 vaccinations* and facilities should educate and also encourage visitors to become vaccinated. Visitor testing and vaccination can help prevent the spread of COVID-19. **Visitors are not required to be tested or vaccinated** (or show proof of such) as a condition of visitation.

Required Visitation

Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f)(4)(v). In previous nursing home visitation guidance during the PHE, CMS outlined some scenarios related to COVID-19 that would constitute a clinical or safety reason for limited visitation. However, there are no longer scenarios related to COVID-19 where visitation should be limited, except for certain situations when the visit is limited to being conducted in the resident's room. Therefore, a nursing home **must** facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, per 42 CFR § 483.10(f)(4), which states "The resident has a right to receive

visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose onthe rights of another resident," would constitute a potential violation and the facility would be subject to citation and enforcement actions.

As stated above, we acknowledge that there are still risks associated with visitation and COVID-19. However, the risks are reduced by adhering to the core principles of COVID-19 infection prevention. Furthermore, we remind facilities and all stakeholders that, per 42 CFR § 483.10(f)(2), residents have the right to make choices about aspects of his or her life in the facility that are significant to the resident. Visitors, residents, or their representative should be made aware of the potential risk of visiting and necessary precautions related to COVID-19 in order to visit the resident. However, if a visitor, resident, or their representative is aware of the risks associated with visitation, and the visit occurs in a manner that does not place other residents at risk (e.g., in the resident's room), the resident must be allowed to receive visitors as he/she chooses.

Access to the Long-Term Care Ombudsman

Regulations at 42 CFR § 483.10(f)(4)(i)(C) require that a Medicare and Medicaid-certified nursing home provide representatives of the Office of the State Long-Term Care Ombudsman with immediate access to any resident. If an ombudsman is planning to visit a resident who is in TBP or quarantine the resident and ombudsman should be made aware of the potential risk of visiting, and the visit should take place in the resident's room. We note that representatives of the Office of the Ombudsman should adhere to the core principles of COVID- 19 infection prevention as described above. If the resident or the Ombudsman program requests alternative communication in lieu of an in-person visit, facilities must, at a minimum, facilitate alternative resident communication with the Ombudsman program, such as by phone or through the use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident's medical, social, and administrative records as otherwiseauthorized by State law.

Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs

42 CFR § 483.10(f)(4)(i)(E) and (F) requires the facility to allow immediate access to a resident by any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act), and of the agency responsible for the protection and advocacy system for individuals with a mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000). P&A programs authorized under the DD Act protect the rights of individuals with developmental and other disabilities and are authorized to "investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported to the system orif there is probable cause to believe the incidents occurred." 42 U.S.C. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A programs are permitted access to all facility residents, which includes "the opportunity to meet and communicate privately with such individuals regularly, both formally and informally, by telephone, mail and in person." 42 CFR § 51.42(c); 45 CFR § 1326.27.

If the P&A is planning to visit a resident who is in TBP or quarantine in a county where the level of community transmission is high in the past 7days, the resident and P&A representative should be made aware of the potential risk of visiting and the visit should take place in the resident's room.

Additionally, each facility must comply with federal disability rights laws such as Section 504 of

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the Rehabilitation Act of 1973, 29 U.S.C. § 794 (Section 504) and the Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101 et seq. (ADA).

For example, if communicating with individuals who are deaf or hard of hearing, it is recommended to use a clear mask or mask with a clear panel. Face coverings should not be placed on anyone who has trouble breathing or is unable to wear a mask due to a disability, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

In addition, if a resident requires assistance to ensure effective communication (e.g., a qualified interpreter or someone to facilitate communication) and the assistance is not available by onsite staff or effective communication cannot be provided without such entry (e.g., video remote interpreting), the facility must allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude nursing homes from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the core principles of COVID-19 infection prevention. Any questions about or issues related to enforcement or oversight of the non-CMS requirements and citations referenced above under this section subject heading should be referred to the HHS Office for Civil Rights (Toll-free: 800-368-1019) (TDD toll-free: 800-537-7697), the Administration for Community Living (202-401-4634),or other appropriate oversight agency.

Entry of Healthcare Workers and Other Providers of Services

All healthcare workers must be permitted to come into the facility as long as they are not subject to a *work exclusion*. In addition to health care workers, personnel educating and assisting in resident transitions to the community should be permitted entry consistent with this guidance. We note that EMS personnel do not need to be screened, so they can attend to an emergency without delay. We remind facilities that all staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of COVID-19 infection prevention.

Communal Activities, Dining and Resident Outings

While adhering to the core principles of COVID-19 infection prevention, communal activities and dining may occur. Facilities must permit residents to leave the facility as they choose. Should a resident choose to leave, the facility should remind the resident and any individual accompanying the resident to follow all recommended infection prevention practices, especially for those at high risk for severe illness.

Upon the resident's return, nursing homes should screen residents upon return for signs or symptoms of COVID-19:

- If the resident or family member reports possible close contact to an individual with COVID-19 while outside of the nursing home, see the CDC's guidance for residents who have had close contact for next steps regarding testing and quarantine.
- If the resident develops signs or symptoms of COVID-19 after the outing, see the CDC's *guidance* for residents with symptoms of COVID-19.

In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) except in certain situations, described in the CDC's *empiric transmission-based precautions* guidance.

Residents who leave the facility for 24 hours or longer should generally be managed as a new

admission, as recommended by the CDC in the *Managing admissions and residents who leave the facility* section.

Survey Considerations

State survey agencies and CMS are ultimately responsible for ensuring that surveyors are compliant with the applicable expectations. Therefore, LTC facilities are not permitted to restrict access to surveyors. If facilities have questions about the process a state is using to ensure surveyors can enter a facility safely, those questions should be addressed to the State Survey Agency. Surveyors should not enter a facility if they have a positive viral test for COVID-19, signs or symptoms of COVID-19, or currently meet the criteria for quarantine. Surveyors should also adhere to the core principles of COVID-19 infection prevention and adhere to any COVID-19 infection prevention requirements set by federal and state agencies (including Executive Orders).

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance at 42 CFR § 483.10(b), F550.
- For concerns related to a facility limiting visitors, surveyors should investigate for non-compliance at 42 CFR § 483.10(f)(4), F563.
- For concerns related to ombudsman access to the resident and the resident's medical record, surveyors should investigate for non-compliance at 42 CFR §§ 483.10(f)(4)(i)(C), F562 and 483.10(h)(3)(ii), F583.
- For concerns related to lack of adherence to infection control practices, surveyors should investigate for non-compliance at 42 CFR § 483.80(a), F880.

Contact: Questions related to this memorandum may be submitted to: DNH_TriageTeam@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey andcertification staff, their managers, and the State/CMS Locations within 30 days of this memorandum.

/s/
David R. Wright

cc: Survey Operations Group

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May 8, 2023

Nursing Home Visitation
Frequently Asked Questions (FAQs)

CMS is providing clarification to recent guidance for visitation (see CMS memorandum QSO-20-39- NH REVISED). While CMS cannot address every aspect of visitation that may occur, we provide additional details about certain scenarios below. However, the bottom line is visitation must be permitted at all times with very limited and rare exceptions, in accordance with residents' rights. In short, nursing homes should enable visitation following these three key points:

- Adhere to the core principles of infection prevention, especially wearing a mask and performing hand hygiene;
- Encourage physical distancing during large gatherings; and
- Work with your state or local health department when an outbreak occurs.

States may instruct nursing homes to take additional measures to make visitation safer, while ensuring visitation can still occur. This includes recommending that, during visits, residents and visitors wear masks in accordance with CDC recommendations. Masks should be well-fitting, and preferably those with better protection, such as surgical masks or KN95. States should work with CMS on specific actions related to additional measures they are considering.

1. **What is the best way for residents, visitors, and staff to protect themselves from *COVID-19*?**

   A: The most effective tool to protect anyone from COVID-19 is to be up-to-date with all recommended COVID-19 vaccine doses. Also, we urge all residents, staff, and visitors to follow the guidelines for preventing COVID-19 from spreading.

2. **Can visits occur in a resident's room if they have a roommate?**

   A: Yes.

3. **Can a visitor share a meal with or feed the resident they are visiting?**

   A: *Yes.*

4. **How should nursing homes work with their state or local health department when there is a COVID-19 outbreak?**

   A: Prior to the COVID-19 Public Health Emergency (PHE), there were occasions when a local or state health department advised a nursing home to pause visitation and new admissions due to a large outbreak of an infectious disease. Consultation with state health departments on how to address outbreaks should still occur. In fact, we remind nursing homes that they are still expected to contact their health department when responding to COVID-19 transmission within the facility.

   While residents have the right to receive visitors at all times and make choices about aspects of their life in the facility that are significant to them, there may be times when the scope and severity of an outbreak warrants the health department to intervene with the facility's

operations. We expect these situations to be extremely rare and only occur after the facility has been working with the health department to manage and prevent escalation of the outbreak. We also expect that if the outbreak is severe enough to warrant pausing visitation, it would also warrant a pause on accepting new admissions (as long as there is adequate alternative access to care for hospital discharges). For example, in a nursing homes where, despite collaborating with the health department over several days, there continues to be uncontrolled transmission impacting a large number of residents (e.g., more than 30% of residents became infected*), and the health department advised the facility to pause visitation and new admissions temporarily. In this situation, the nursing home would not be out of compliance with CMS' requirements.

*CMS does not define a specific threshold for what constitutes a large outbreak and this could vary based on facility size or structure. However, we emphasize that any visitation limits should be rare and applied when there are many cases in multiple areas of the facility.

Nursing facilities should continue to consult with their state and local health departments when outbreaks occur to determine when modifications to visitation policy would be appropriate. Facilities should document their discussions with the health department, and the actions they took to attempt to control the transmission of COVID-19.

5. **Should the facility pause communal activities and dining during an outbreak investigation?**

   A: No. Communal activities and dining do not have to be paused during an outbreak, unless directed by the state or local health department. Residents who are on TBP (i.e. isolation or quarantine) should not participate in communal activities and dining until the criteria to discontinue TBP has been met.

6. **Is a resident (not on transmission-based precautions or quarantine) who is unable or unwilling to wear a mask, when expected based on CDC recommendations, allowed to attend communal dining and activities?**

   A: A resident who is unable to wear a mask due to a disability or medical condition may attend communal activities, however they should physically distance from others during large gatherings. If possible, facilities should educate the resident on the core principles of infection prevention, such as hand hygiene, physical distancing, cough etiquette, etc. and staff should provide frequent reminders to adhere to infection prevention principles.

   A resident who is unable to wear a mask and whom staff cannot prevent having close contact with others should not attend large gatherings. To help residents prevent having close contact, such as in the case of a memory care unit, the staff should limit the size of group activities. They should also encourage frequent hand hygiene, assist with maintaining physical distancing as much as possible, and frequently cleaning high-touch surfaces.

   If a resident refuses to wear a mask and physically distance from others during large gatherings, the facility should educate the resident on the importance of masking and physical distancing, document the education in the resident's medical record, and the resident should not participate in large gatherings.

7. **How can a long-term care provider coordinate an onsite clinic to provide COVID-19 vaccine and boosters for staff and residents?**

A: Many LTC providers have already identified strategies and partnerships to obtain and administer COVID-19 vaccines for residents and staff, including: working with established LTC partners and retail pharmacy partners or coordinating with state and local health departments. You may request vaccination support from a pharmacy partner enrolled in the Federal Retail Pharmacy Program. If you are having difficulties arranging COVID-19 vaccination for your residents and staff, contact your state or local health department's immunization program for assistance. If the state or jurisdictional immunization program is unable to connect your LTC setting with a vaccine provider, CDC is available as a safety net support (Contact CDC INFO at 800-232-4636 for additional support).

8. **Why can a resident choose to have a visit *if* COVID-19 cases are increasing?**

A: It is important to note that federal regulations explicitly state that residents have the right to make choices about significant aspects of their life in the facility and the right to receive visitors, as long as it doesn't infringe on the rights of other residents (42 CFR 483.10(f)(2) and (4), respectively). In this case, as long as a visit doesn't increase the risk of COVID-19 for other residents (i.e., by using the guidance for conducting safe visits), the resident still has the right to choose to have a visitor. Therefore, if the resident is aware of the risks of the visit, and the visit is conducted in a manner that doesn't increase the risk of COVID-19 transmission for other residents,the visit must still be permitted in accordance with the requirements.

9. **Are there any suggestions for how to conduct visits that reduce the risk of COVID-19 transmission?**

A: There are ways facilities can and should take extra precautions, such as hosting the visit outdoors, if possible; creating dedicated visitation space indoors; permitting in-room visits when the resident's roommate is not present; and the resident and visitor should wear a well-fitting mask (preferably those with better protection, such as surgical masks or KN95), in accordance with CDC recommendations, *and* perform frequent hand-hygiene. Some other recommendations include:

- Offering visitors *face coverings or masks*.
- Limiting the visitor's movement in the facility, during an outbreak, to only the location of the visit.
- Increasing air-flow and improving ventilation and air quality.
- Cleaning and sanitizing the visitation area after each visit.
- *Post visual alerts (e.g., signs, posters) that include instructions about current IPC recommendations (e.g., when to use source control).*

10. **Are there best practices for improving air quality to reduce risks during visitation?**

A: Yes, a facility may consider a number of options related to air quality such as:

- Adding ultraviolet germicidal irradiation (UVGI) to the heating ventilation and air

conditioning system (HVAC),

- Adding portable room air cleaners with high-efficiency particulate air (HEPA, H-13 or -14) filters to communal areas.
- Ensure proper maintenance of HVAC system to ensure maximum outdoor air intake.

For additional information on air cleaning and disinfecting, see CDC's Ventilation FAQs or the American Society of Heating, Refrigerating and Air-Conditioning Engineers site on Filtration and Disinfection.

11. What are ways a facility can improve and or manage air flow during visitation?

A: A facility may consider implementing the following:

- The use of a portable fan placed close to an open window could enable ventilation. A portable fan facing towards the window (i.e. facing outside) serves to pull the room and exhaust air to the outside; a fan facing towards the interior of the room (i.e. facing inside) serves to pull in the outdoor air and push it inside the room. Direct the fan discharge towards an unoccupied corner and wall spaces or up above the occupied zone.
- The use of ceiling fans at low velocity and potentially in the reverse-flow direction (so that air is pulled up toward the ceiling), especially when windows are closed.
- Avoid the use of the high-speed settings for any fan.
- Keeping doors to resident rooms or visitation areas closed during visits to control air flow and reducing spread of infection.

For additional information on improving air quality, optimizing air flow and use of barriers, see the Centers for Disease Control and Prevention (CDC) site on Ventilation in Buildings.

12. Is there funding available for environmental changes which reduce transmission of COVID-19?

A: Yes, a facility may request the use of Civil Money Penalty (CMP) Reinvestment funds to purchase portable fans and portable room air cleaners with high-efficiency particulate air (HEPA, H-13 or -14) to increase or improve air quality. A maximum use of $3,000 per facility including shipping costs may be requested.

13. Can a state require facilities to test visitors as a condition of entering the facility?

A: States can require visitors to be tested prior to entry if the facility is able to provide a rapid antigen test (i.e., the visitor is not responsible for obtaining a test). If the facility cannot provide the rapid antigen test, then the visit must occur without a test being performed if the visitor(s) has not had a positive viral test, does not report COVID-19 symptoms or meet the criteria for quarantine.