**Visitation During COVID-19**

**Implementation Checklist**

**Implementation Checklist: Visitation include but not limited to:**

| **Regulation** | **Suggested Actions** |
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| **Centers for Medicare & Medicaid Services (CMS)**  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, outdoors, and for circumstances beyond compassionate care situations. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of COVID-19 transmission:  **Core Principles of COVID-19 Infection Prevention**  • 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  • Instructional signage throughout the facility and proper visitor education on COVID19 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)  • Cleaning and disinfecting high-frequency touched surfaces in the facility often, and designated 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 as required at 42 CFR § 483.80(h) (see QSO-20-38-N) 1  **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 outdoor spaces 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. During peak times of visitation and large gatherings (e.g., parties, events) facilities should encourage physical distancing. 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  If the nursing home’s county COVID-19 community transmission is high, everyone in a healthcare setting should wear face coverings or masks.  If the nursing home’s county COVID-19 community transmission is not high, the safest practice is for residents and visitors to wear face coverings or masks, however, the facility could choose not to require visitors wear face coverings or masks while in the facility, except during an outbreak. 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.  Regardless of the community transmission level, residents and their visitors when alone in the resident’s room or in a designated visitation area, may choose not to wear face coverings or masks and may choose to have close contact (including touch). Residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit. If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.  Additional information on levels of community transmission is available on the CDC’s COVID-19 Integrated County View webpage.  NOTE: CDC states that Community Transmission is the metric currently recommended to guide select practices in healthcare settings to allow for earlier intervention, before there is strain on the healthcare system, including its workforce, and better protect the vulnerable individuals seeking care in these settings. The Community Transmission metric is different than the COVID-19 Community Level metric used for non-healthcare settings.  Nursing homes should use the Community Transmission Level metric not the Community Level metric.  While not recommended, residents who are on transmission-based precautions (TBP) or quarantine can still receive visitors. In these cases, visits should occur in the resident’s room and the resident should wear a well-fitting facemask (if tolerated). Before visiting residents who are on TBP or quarantine, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to the core principles of infection prevention. Facilities may offer well-fitting facemasks or other appropriate PPE, if available; however, facilities are not required to provide PPE for visitors.”1  **Indoor Visitation during an Outbreak**  “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 and guidance for COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing.  When a new case of COVID-19 among residents or staff is identified, a facility should immediately (but not earlier than 24 hours after the exposure, if known) begin outbreak testing in accordance with CMS QSO 20-38-NH REVISED and CDC guidelines.  While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits and visits should ideally occur in the resident’s room. 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. Also, visitors should physically distance themselves from other residents and staff, when possible. 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 during an outbreak investigation.”1  **Visitor Testing and Vaccination**  While not required, we encourage facilities in counties with high levels of community transmission to offer testing to visitors, if feasible. If facilities do not offer testing, they should encourage visitors to be tested on their own before coming to the facility (e.g., within 2–3 days). CMS strongly encourages all visitors to become vaccinated and facilities should educate and also encourage visitors to become vaccinated. Visitor testing and vaccination can help prevent the spread of COVID-19 and facilities may ask about a visitors’ vaccination status, however, visitors are not required to be tested or vaccinated (or show proof of such) as a condition of visitation. If the visitor declines to disclose their vaccination status, the visitor should wear a face covering or mask at all times. This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems”1  **Compassionate Care Visits**  “Compassionate care visits are allowed at all times. Previously during the PHE, there were some scenarios where residents should only have compassionate care visits. However, visitation is now allowed at all times for all residents, in accordance with CMS regulations. Therefore, we believe there are few scenarios when visitation should be limited only to compassionate care visits. In the event a scenario arises that would limit visitation for a resident (e.g., a resident is severely immunocompromised and the number of visitors the resident is exposed to needs to be kept to a minimum), compassionate care visits would still be allowed at all times. CMS expects these scenarios to be rare events.”1  **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 or the rare event that visitation is limited to compassionate care. Therefore, a nursing home must facilitate in-person visitation consistent with the applicable CMS regulations”1  **Access to the Long-Term Care Ombudsman**  **“**As stated in previous CMS guidance QSO-20-28-NH (revised), 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 in a nursing home in a county where the level of community transmission is high in the past 7 days, 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 otherwise authorized by State law.”1  **Federal Disability Rights Laws and Protection & Advocacy (P&A) Programs**  “2 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 or if 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 7 days, 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 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.”1 | * It is recommended that the Interdisciplinary team meet and develop an updated visitation plan to include indoor and outdoor visitation based upon current guidance to include:   + Space identified for outdoor visits   + Process for visitation for all residents at all times   + Visitation policies and procedures   + Screening procedures   + Resident, employee, and visitor education on adherence to the Core Principles of COVID-19 Infection Prevention and Control   + Hand Hygiene   + Source Control   + PPE   + Physical distancing with large gatherings and during outbreak investigation   + Cleaning and Disinfection * Determine who will identify the county COVID-19 community transmission:   + If high     - Everyone in a healthcare setting should wear face coverings or masks   + If not high     - It is the safest practice for residents and visitors to wear source control     - Facility can choose not to require visitors to wear source control in the facility except during an outbreak (based upon current State, CDC and local health department recommendations as well as facility circumstances   + If the resident and their visitor(s) are alone in the resident room or designated visitation area, they may choose not to wear face coverings or masks and choose to have close contact     - Resident and visitors should be advised of the risks of physical contact before the visit     - If roommate is present, it is safest for the visitor to wear a face covering or mask   + Face coverings or masks should be on when around staff or other residents * It is recommended that the Interdisciplinary Team meet to develop a plan for indoor visitation including screening, education and adherence to the Core Principles of Infection Prevention and Control * It is recommended that the Interdisciplinary Team identify the process to notify visitors about the potential for COVID-19 exposure in the facility, risk and adherence to the core principles of COVID-19 infection prevention and control * It is not recommended, however, residents on transmission-based precautions or quarantine can still have visitors in the resident’s room   + Resident should wear a well-fitting facemask if tolerated   + Visitor(s) must be made aware of the risks and precautions necessary for the visit to occur   + The facility is not required to provide PPE for visitors * Determine a process to ensure that physical distancing can still be maintained * Determine a process to communicate source control and physical distancing for large gatherings   + The facility may ask visitors to schedule visits at staggered timeslots throughout the day to allow for physical distancing   + Unless there is a high volume of visitors where physical distancing cannot be maintained, there should be no limit on:     - The number of visitors a resident can have     - The frequency of visits     - Length of visits (unless physical distancing cannot be maintained or if the visit infringes on the rights and safety of others) * Visitation is recommended to be conducted in the roommate is not present. If there is not another option, the visitors can be asked to limit the number of visitors in the room at one time and the visitor should wear a face covering or mask and adhere to the principles of infection control. * Residents will be able to eat with visitors if the resident, resident representative, and the visitor are all aware of the risks and continue to adhere to the core principles of infection prevention.   + A separate dining area is recommended     - If a separate dining area is not feasible, visitor should wear a mask or face covering when not eating and/or drinking * It is recommended that the facility collaborate with the local health department with outbreaks * It is recommended that the interdisciplinary team develop a process to identify whether visitors are fully vaccinated.   + Visitors are not required to be tested or vaccinated but should be encouraged to be tested on their own prior to coming to the facility   + If visitor declines to disclose vaccination status, visitor should wear a face covering or mask at all times * It is recommended that the interdisciplinary team educate visitors on COVID-19 vaccination * Review and revise as necessary, facility policy and procedure on required visitation, education to residents and resident representatives, and system implementation * Develop a process for communication with the Long-Term Care Ombudsman on communicating the county level of community transmission in the past 7 days as well as potential risk of visitation   + If remote visit occurs, develop system to assist for visit * Conduct education to social services and nursing * Review and revise, if necessary, facility policy to allow immediate access to a resident by any representative of the protection and advocacy systems * Conduct education to social services and nursing |
| **F563: Right to Receive/Deny Visitors**  “§483.10(f)(4) 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 on the rights of another resident.  (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident’s right to deny or withdraw consent at any time;  (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident’s right to deny or withdraw consent at any time;  (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident’s right to deny or withdraw consent at any time; and  (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.  **GUIDANCE §483.10(f)(4)(ii)-(v)**  “**Reasonable clinical and safety restrictions”** include a facility’s policies, procedures or practices that protect the health and security of all residents and staff. These may include, but are not be limited to:  • Restrictions placed to prevent community-associated infection or communicable disease transmission to one or more residents. A resident’s risk factors for infection (e.g., immunocompromised condition) or current health state (e.g., end-of-life care) should be considered when restricting visitors.  • In general, visitors with signs and symptoms of a transmissible infection (e.g., a visitor is febrile and exhibiting signs and symptoms of an influenza-like illness) should defer visitation until he or she is no longer potentially infectious (e.g., 24 hours after resolution of fever without antipyretic medication), or according to CDC guidelines, and/or local health department recommendations.  • Keeping the facility locked or secured at night with a system in place for allowing visitors approved by the resident;  • Denying access or providing limited and supervised access to an individual if that 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;  • Denying access to individuals who have been found to have been committing criminal acts such as theft;  • Denying access to individuals who are inebriated or disruptive; or  • Denying access or providing supervised visitation to individuals who have a history of bringing illegal substances into the facility which places residents’ health and safety at risk.  **Visitation Considerations During a Communicable Disease Outbreak**  Facilities may need to modify their visitation practices when there are infectious outbreaks or pandemics to align with current CMS guidance and CDC guidelines that enables maximum visitation, such as by:  • Offering options for outdoor or virtual visitation, or indoor designated visitation areas  • Providing adequate signage with instructions for infection prevention, i.e. hand hygiene, cough etiquette, etc.  • Ensuring access to hand hygiene supplies  • Taking other actions that would allow visitation to continue to occur safely in spite of the presence of a contagious infection  • Contacting their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of communicable disease transmission during an outbreak  During an infectious disease outbreak, while not recommended, residents who are on transmission-based precautions (TBP) can still receive visitors. In these cases, before visiting residents who are on TBP, visitors should be made aware of the potential risk of visiting and precautions necessary in order to visit the resident. Visitors should adhere to principles of infection prevention.  For purposes of this regulation, immediate family is not restricted to individuals united by blood, adoptive, or marital ties, or a State’s common law equivalent. It is important to understand that there are many types of families, each of which being equally viable as a supportive, caring unit. Advanced Copy  For example, it might also include a foster family where one or more adult serves as a temporary guardian for one or more children to whom they may or may not be biologically related. Residents have the right to define their family. During the  admissions process, facility staff should discuss this issue with the resident. If the resident is unable to express or communicate whom they identify as family, facility staff should discuss this with the resident’s representative.  Resident’s family members are not subject to visiting hour limitations or other restrictions not imposed by the resident, with the exception of reasonable clinical and safety restrictions, consistent with §483.10(f)(4)(v), placed by the facility based on recommendations of CMS, CDC, or the local health department. With the consent of the resident, facilities must provide 24-hour access to other non-relative visitors, subject to reasonable clinical and safety restrictions. Visitation should be person-centered, consider the residents’ physical, mental, and psychosocial well-being, and support their quality of life.  If these familial visitation rights infringe upon the rights of other residents, facility staff must find a location other than a resident’s room for visits. For example, if a resident’s family visits in the late evening when the resident’s roommate is asleep, then the visit should take place somewhere other than their shared room so that the roommate is not disturbed.  Individuals who provide health, social, legal, or other services to the resident have the right of reasonable access to the resident. Facility staff must provide space and privacy for such visits.”2 | * Develop plans for resident face to face visitation with guests within COVID-19 prevention guidelines * Inform residents, families, and staff of visitation protocols and requirements * Opportunities for residents/guests to visit. Develop a system to educate visitors on the Core Elements of COVID-19 Infection Prevention and adherence to facility protocols * Include sanitization protocols prior and following individual resident/guest visits |
| **F564 Resident Right to Visitors**  **“§483.10(f)(4)(vi) The facility is required to:**  (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of 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 his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.2 | * Review and revise as necessary, the facility written visitation policy and procedure to include:   + Visitation 24-hours/day   + Subject to resident’s choice   + Visitation considerations during a communicable disease outbreak   + Visitation and illegal substance use   + Reasonable restrictions for clinical or safety concerns     - Communicable disease outbreak modifications     - Referral to local law enforcement if facility determines illegal substance are brought into the facility by a visitor     - Facility staff may not search resident’s personal belongs unless resident or resident representative agrees to search     - Additional monitoring and supervision as indicated * Conduct training for all staff related to visitation policy and procedure * Conduct training for residents and resident representatives on the visitation policy and procedure |
| **F564 Inform of Visitation Rights/Equal Visitation Privileges**  §483.10(f)(4)(vi) A facility must meet the following requirements:  (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section.  (B) Inform each resident of 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 his or her right to withdraw or deny such consent at any time.  (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.  (D) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.”2 | * Review and revise as necessary facility visitation policy and procedure regarding visitation limitations and restrictions * Conduct training to all staff on the facility policy and procedure for visitation to include the right to consent to receive or deny visitors he/she designates and any clinical or safety restriction to include residents’ rights consistent with resident preference, ensuring resident’s visitation rights to include:   + Visits from spouse or domestic partner including same-sex spouse or partner   + Informing resident, family, or resident representative of their rights   + A system to prevent denying or restricting a resident’s visitation privileges when there are no clinical or safety reasons to do so * Conduct audits for compliance |
| **F583: Personal Privacy**  **“§483.10(h) Privacy and Confidentiality.**  The resident has a right to personal privacy and confidentiality of his or her personal and medical records.  §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.  §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70  (i)(2) or other applicable federal or state laws.  (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law.”1  ““**Right to personal privacy**” includes the resident’s right to meet or communicate with whomever they want without being watched or overheard. Private space may be created flexibly and need not be dedicated solely for visitation purposes.”1  “Privacy for visitation or meetings might be arranged by using a dining area between meals, a vacant chapel, office or room; or an activities area when activities are not in progress. Arrangements for private space could be accomplished through cooperation between the facility’s administration and resident or family groups so that private space is provided for those requesting it without infringement on the rights of other residents.”2 | * Review and Revise, if necessary, facility policy and procedure on visitation and provision of privacy with visitation * Conduct education to all staff on the resident’s right to meet and communicate with visitors without being watched or overheard |
| **F562 Immediate Access to Resident**  “§483.10(f)(4)(i) The facility must provide immediate access to any resident by:  (A) Any representative of the Secretary,  (B) Any representative of the State,  (C) Any representative of the Office of the State long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.),  (D) The resident’s individual physician,  (E) 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 (42 U.S.C. 15001 et seq),  (F) Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and  (G) The resident representative.  **GUIDANCE §483.10(f)(4)(i)**  The facility must provide immediate access to the resident by the resident’s physician, representative, and various state and federal officials and organizations as outlined in the regulation, which would include state and federal surveyors.  Surveyors are considered representatives of the Secretary and/or the State. Facility staff cannot prohibit surveyors from talking to residents, family members, and resident representatives.  **NOTE**: If facility staff attempt to interfere with the survey process and restrict a surveyor’s ability to gather necessary information to determine compliance with requirements, surveyors should consult with the CMS Regional Office.”2 | * Review and revise, if necessary, facility policy and procedure regarding immediate access to any resident by:   + A representative of the Secretary   + A representative of the State   + Ombudsman   + Resident’s physician   + A representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill or Rights Act of 2000   + A representative of the agency responsible for protection and advocacy system for individuals with mental disorder(s) and   + The Resident Representative * Conduct education for all staff on immediate access to the resident |
| **F745 Medically Related Social Services**  **“**§483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.”1  An example of medically related social services includes:  “Assisting residents in voicing and obtaining resolution to grievances about treatment, living conditions, visitation rights and accommodation of needs.”2 | * Review and revise process for social services in assisting residents in voicing and obtaining resolution to grievances about visitation rights |
| **F841 Medical Director**  **“**§483.70(h)(1) The facility must designate a physician to serve as medical director.  §483.70(h)(2) The medical director is responsible for—   1. Implementation of resident care policies; and   The coordination of medical care in the facility.”2 | * Review and revise as necessary the role of the medical director in reviewing/revising and implementation of the facility visitation policy and procedure |
| **F865 Quality assurance and performance improvement (QAPI) program.**  “Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life.”2 | * Review and revise as necessary the facility QAPI program, as it relates to the process to improve safety and quality   + Facility visitation policy and procedure compliance |
| **F880 Infection Control**  “§483.80 Infection Control: The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.  §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements  §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;  §483.80(a)(2)Written standards, policies, and procedures for the program, which must include, but are not limited to:   1. A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; 2. When and to whom possible incidents of communicable disease or infections should be reported; 3. Standard and transmission-based precautions to be followed to prevent spread of infections; 4. When and how isolation should be used for a resident; including but not limited to:   (A)The type and duration of the isolation, depending upon the infectious agent or organism involved, and  (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.   1. The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and 2. The hand hygiene procedures to be followed by staff involved in direct resident contact.”2 | * Review for comprehensive and updated Infection Prevention and Control policies including COVID-19 guidelines and staff performance requirements * Complete COVID-19 resident, Representative, and staff testing and screening as required and report results to the appropriate agency (F885, F886) * Complete timely reporting of COVID-19 facility results to the National Health Safety Network as required (F884) Review requirements for and develop plan for maintenance of resident cloth re-useable facial coverings * Educate staff regarding policies for infection prevention, hand hygiene and face mask use on an ongoing basis * Audit employee training and in-service records for IPCP education and competency of infection prevention practices * Educate staff and residents regarding the importance for residents to wear cloth facial coverings when not in their room when Community Transmission is high * Monitor employee performance at varied times to observe proper face mask use and maintenance and for assistance provided to residents in proper facial covering use * Monitor resident and family compliance with Core Prevention Practices and facility policies during visitation * Interact with residents to determine understanding of the need to wear a cloth facial mask and maintain social distance in large gatherings * Complete record review to determine that residents are assessed for ability to apply and remove masks and receive assistance as needed when source control is indicated * Monitor infection rates and trends. Follow national and state specific reporting guidelines * Evaluate staff adherence to universal source control measures and COVID-19 community transmission * Present findings to QAPI Committee for discussion and follow up |
| **F882 Infection Preventionist**  “§483.80(b)(c) The facility must designate one or more individuals to function as the Infection Preventionist(s) (IP)(s) who are responsible for the facility Infection Prevention and Control (IPCP) Program. The IP must:  483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;  482.80(b)(2) Be qualified by education, training, experience, or certification;  482.80(b)(3) Work at least part-time at the facility; and  482.80(b)(4) Have completed specialized training in infection prevention and control” | * Develop policies for Infection Prevention and Control which adhere to infection control practice guidelines and current COVID-19 recommendations by Federal, State, and Local Officials, * Ensure that COVID-19 required reporting is completed to proper agencies and maintains COVID-19 testing, screening, and community transmission validation records * Evaluate environment, infection control practices, and adherence to prevention practices to ensure resident and staff safety * Develop and implement COVID-19 Prevention Program and provide education to staff, residents, and others as required * Ensure that the professional assigned responsibility as the Infection Preventionist meets all qualifications for the role and is a member of the QAPI/QAA committee * Is a member of the health center COVID-19 task force to plan and implement actions to prevent and mitigate spread * Review IPCP program at least annually and as needed and make revisions necessary * Observe staff performance in proper application, removal of PPE and source control * Monitor staff performance of application, removal and disposal of PPE, proper and timely hand hygiene * Complete tracking of COVID-19 cases within the facility and collaborate with health officials in assessing and evaluating of community case levels for risk * Complete reporting to local, state, and Federal officials as required * Maintain accurate and complete records of all infections within the health center and actions being taken to address potential issues * Conducts education for staff, residents and visitors * Present findings and improvement plans to QAPI/QAA Committee for discussion and follow up |
| **F884, F885, F886:** Required Reporting of facility COVID-19 status to the National Health Safety Network | * Complete timely reporting of resident, representative, and staff positivity numbers and results of COVID-19 testing of Residents and Staff to the appropriate local, state, and national agency as required |
| **F940 Training Requirements – General**  “A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles”2 | * Review and revise, as necessary the facility general orientation and ongoing education for all staff related to the visitation policy and procedure * Conduct all staff training related to visitation |

This listing is not all encompassing however should serve as a resource for leaders as they update their internal policies, procedures and operational processes.

Cross Reference: (additional areas for review)

* CMS Regulations:
  + F563: Right to Receive/Deny Visitors
  + F564: Inform of Visitation Rights/Equal Visitation Privileges
  + F583: Privacy and Confidentiality
  + F880: Infection Prevention and Control
  + F841: Responsibilities of the Medical Director
  + F865: QAPI Program
  + F868: QAA Committee
  + F880: Infection Prevention and Control
  + F940: Training Requirements - General

**References**

1Centers for Medicare & Medicaid Services. QSO-20-39-NH, September 17, 2020, Revised 09/23/2022: Nursing Home Visitation – COVID-19 (Revised): <https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf>

2Centers for Medicare & Medicaid Services State Operations Manual, Appendix PP – Guidance to Surveyors for Long Term Care Facilities (Rev. 173, 11-22-17) Advance Copy 6/29/22: <https://www.cms.gov/files/document/appendix-pp-guidance-surveyor-long-term-care-facilities.pdf>

Centers for Medicare & Medicaid Services. Long Term Care Critical Element Pathways, Infection Prevention, Control & Immunizations, CMS 20054, 10/2022: <https://www.cms.gov/files/zip/ce-pathways.zip>