

**Visitation Guidance: Summary of New CMS Rule Guidance**

**September 18, 2020**

On September 17th CMS released memo QSO-20-39-NH outlining visitation guidance to facilitate in-person visitation in nursing homes in an effort to address the psychosocial needs of residents.

What follows is a high-level summary of these new requirements. LeadingAge Minnesota will continue to analyze the information and its implications for providers, flag questions where we need additional information from CMS and the MN Department of Health (MDH), and identify, where necessary develop operational tools and resources to support members with implementation.

**Effective Date & Duration**

The guidance is effective immediately; however, the states have up to 30-days to communicate with their survey and certification staff, managers and state/CMS locations. We do not yet know when surveyors will evaluate based upon this memo.

**Overview**

Visitation for nursing home residents is currently conducted through multiple different methods including outdoor visits, indoor visits, and compassionate care visits. During visitation, CMS cites the following principles of COVID-19 Infection Prevention.

Core principles of COVID-19 Infection Prevention

* Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions or observations about signs or symptoms), and denial of entry of those with signs or symptoms
* Hand hygiene (use of alcohol-based hand rub is preferred)
* Face covering or mask (covering mouth and nose)
* Social distancing at least six feet between persons
* Instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, infection control precautions, other applicable facility practices (e.g., use of face covering or mask, specified entries, exits and routes to designated areas, hand hygiene)
* 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 COVID-19 care)
* Resident and staff testing conducted as required at 42 CFR 483.80(h) (see QSO-20-38-NH) CMS further reports utilization of physical barriers reduces the risk of transmission. These physical barriers can include items such as Plexiglas dividers or curtains. Emphasized, is the requirement to create a person-centered approach to visits including the ability to have as much privacy as possible for visitations.

It is not required to test visitors; however, CMS is encouraging nursing homes that have a county positivity rate in medium or high counties (5% +) to test visitors if the facility is able to do so. If testing all visitors is not feasible, nursing homes may test visitors that visit regularly and often, for example, weekly; or, they may require visitors to obtain their own tests within 2-3 days of visiting and provide proof of negative test when they come to visit.

Indoor Visitation / Communal Dining & Activities

Facilities may not restrict visitation without a reasonable clinical or safety cause and the memo sites statute 483.10(f)(4)(v). If a nursing home has no COVID-19 cases in the last 14-days; AND, its county positivity rate is low or medium (0-10%), they MUST facilitate in-person visitation consistent with the regulations by applying guidance within the memo (See Guidance in Appendix A). Nursing homes that do not facilitate visitation without a reasonable clinical or safety reason would be reason for a potential violation and the nursing home would receive a citation and be subject to enforcement.

Residents on transmission- based precautions should not receive indoor visits except in the event of a compassionate care situation. However, as soon as precautions are discontinued, the resident should be allowed visitation once again.

Nursing homes may provide communal activities and communal dining as long as infection control principles are followed. While eating in the same room or participating in communal activities, residents should be appropriately physically distanced, practice hand hygiene, and wear a face covering. If a resident is exposed to COVID, tests positive, or is in isolation/quarantine, they should not participate. The nursing home may take into consideration the status of COVID in their building and whether or not to place limitations on congregate dining and/or communal activities.

Health Care Workers / Service Providers / Ombudsman

Nursing homes are required to provide the Ombudsman with access to resident medical, social and administrative records and immediate access to any resident; while in-person visits may be limited because of infection control; we cannot limit in-person access without a good reason to do so. The Ombudsman are expected to follow infection control practices during in-person visits. If in-person visits are not possible, it is the nursing home’s responsibility to facilitate communication with the ombudsman by another means of communication such as by phone or be other technology means.

Healthcare workers who are not employees of the facility must be permitted entrance to the facility as long as they do not have signs and symptoms of COVID-19 when screened or have been exposed to COVID-19. Examples cited in the memo include:

* Emergency Medical Services Workers (EMS)
* Dialysis Technicians
* Laboratory Technicians
* Radiology Technicians
* Social Workers
* Clergy

**CMP Funds – Visitation**

In QSO 20-28-NH, CMP funds were approved to purchase communication aides to assist in more effective resident communication. Facilities are limited to on device per 7-10 residents with a maximum of $3,000 per facility. New additions to the use of CMP funds to facilitate in-person visitation now includes tents and clear dividers to reduce the risk of transmission during in-person visits. Tents and dividers are also limited to a maximum of $3,000 per facility. Of note, the Minnesota Department of Health is working with the Department of Engineering to determine appropriate tents/tent material for outdoor visitations and will be releasing this guidance soon.

**Closing**

At this time, there are still many questions regarding the guidance within this memo. LeadingAge Minnesota is actively working with the Minnesota Department of Health to obtain answers to all questions and to clarify guidance and how it fits with the current Minnesota visitation guidances that are in place

Attachment A: Specific Language for Outdoor and Indoor Visitation Practices

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred and can also be conducted in a manner that reduces the risk of transmission. Outdoor visits pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever practicable. Aside from weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual resident’s health status (e.g., medical condition(s), COVID-19 status), or a facility’s outbreak status, outdoor visitation should be facilitated routinely. 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. When conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing). We also recommend reasonable limits on the number of individuals visiting with any one resident at the same time.

**Indoor Visitation**

Facilities should accommodate and support indoor visitation, including visits for reasons beyond compassionate care situations, based on the following guidelines:

a) There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;

b) Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;

c) Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and

d) Facilities should limit 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. Visits for residents who share a room should not be conducted in the resident’s room.

NOTE: For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

Facilities should use the COVID-19 county positivity rate, found on the COVID-19 Nursing Home Data site as additional information to determine how to facilitate indoor visitation:

• \_Low (<5%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)

• \_Medium (5% – 10%) = Visitation should occur according to the core principles of COVID-19 infection prevention and facility policies (beyond compassionate care visits)

• \_High (>10%) = Visitation should only occur for compassionate care situations according to the core principles of COVID-19 infection prevention and facility policies

Facilities may also monitor other factors to understand the level of COVID-19 risk, such as rates of COVID-19-Like Illness2 visits to the emergency department or the positivity rate of a county adjacent to the county where the nursing home is located. We note that county positivity rate does not need to be considered for outdoor visitation.

We understand that some states or facilities have designated categories of visitors, such as

“essential caregivers,” based on their visit history or resident designation. CMS does not distinguish between these types of visitors and other visitors. Using a person-centered approach when applying this guidance should cover all types of visitors, including those who have been categorized as “essential caregivers.”