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/Quality, Safety & Oversight Group

Ref: QSO-21-14-ICF/IID & PRTF
REVISED 06/03/2021

DATE: **February 10, 2021**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Visitation at Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) and Psychiatric Residential Treatment Facilities (PRTFs) - Coronavirus Disease -2019 (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 Guidance:** CMS is issuing new guidance for visitation in ICFs/IID and PRTFs during the COVID-19 PHE *to include the impact of COVID-19 vaccination*. The guidance below provides ways an ICF/IID and PRTF can more safely facilitate in-person visitation and address the psychosocial needs of clients/residents.
- **Coordination with the Centers for Disease Control and Prevention (CDC) and public health departments -** We encourage all ICFs/IID and PRTFs to monitor the CDC website for information and resources and contact their health department when needed (CDC Resources for Health Care Facilities: Management of Visitors to Healthcare Facilities in the Context of COVID-19: Non-US Healthcare Settings | CDC)

Background

CMS is responsible for ensuring the health and safety of ICF/IID clients and PRTF residents by enforcing the standards required to help each client/resident attain or maintain their highest level of functioning. In light of the continued spread of COVID-19, we are providing additional guidance to ICFs/IID and PRTFs to help control and prevent the spread of the disease.

Prior to and since the release of QSO memorandum 21-14- ICF/IID & PRTF on February 10, 2021, COVID-19 vaccines have received Emergency Use Authorization from the Food and Drug Administration. Millions of vaccinations have been administered to clients/residents and staff in

long-term care facilities, as well as to ICFs/IID and PRTFs clients/residents and staff, and these vaccines have been shown to limit the incidence of symptomatic infection from SARS-CoV-2, the virus that causes COVID-19. ***Therefore, CMS is updating its visitation guidance accordingly. CMS continues to emphasize the importance of maintaining infection prevention practices given the continued risk of COVID-19 transmission while simultaneously supporting safe visitation that vaccination permits for clients/residents commensurate with the CDC and public health best practices. This guidance applies to individuals 12 years of age and older, who per the CDC are now eligible to get a COVID-19 vaccination (refer to vaccination manufacturer, requirements and directions). This vaccine guidance will not apply to those individuals whowho may not be eligible to receive the vaccine under the EUA.***

Guidance

While CMS has focused on helping to protect ICF/IID and PRTF clients/residents from the risk of contracting COVID-19, we also recognize that physical separation from family, caregivers, friends, and others has taken and continues to take a physical, emotional, and psychological toll on clients/residents. Clients/residents may feel socially isolated, leading to increased risk for depression, anxiety, and other expressions of distress. Clients/residents living with an intellectual disability and/or a severe mental illness may find visitor restrictions and other ongoing changes related to COVID-19 confusing or upsetting. CMS understands that clients/residents value physical and emotional support they receive through visitation. *Additionally, in some cases, individuals with disabilities (or other protected classes under the law), is critical in facilitating communication and other activities necessary to the exercise of their federally protected civil rights (see discussion below).* In light of this, CMS is providing guidance regarding visitation in ICF/IIDs and PRTFs during the COVID-19 PHE *to include the impact of COVID-19 vaccinations*.

Visitation can be conducted through different means based on a facility's structure and clients/residents' needs, such as in resident rooms, dedicated visitation spaces, and outdoors. Facilities should transparently communicate through various means (e.g., website, phone, text, and posted notices) all infection prevention and control (IPC) requirements to visitors as far as possible in advance of any visits. Each facility will need to determine what visitation policies and procedures to implement based on local community prevalence of COVID-19 and federal, state and local requirements and guidance. Prior to introducing visitors to the facility, it is important for staff and visitors to understand how COVID-19 spreads. Regardless of how visits are conducted, the following are certain guidelines and/or recommendations that reduce the risk of COVID-19 transmission, even for those who have received COVID-19 vaccinations:

- We recommend facilities follow the most current CDC guidance. Screen and triage all visitors who enter the facility for signs and symptoms of COVID-19 and deny entry of those with signs or symptoms *(regardless of their vaccination status).* Visitors who are at high risk for severe illness from COVID-19, such as older adults and those with underlying medical conditions, should be strongly discouraged from entering the facility.
- Regular hand hygiene is critical and should consist of washing hands with soap and water for at least 20 seconds. When hand washing is not possible, use an alcohol-based hand sanitizer (ABHS) with at least 60% to 95% alcohol. Remind all visitors to keep their hands away from their face.
- Visitors should wear face coverings while in the facility or visiting the resident/patient outdoors. Use commercial or homemade face coverings/mask that have at least two layers of finely woven cloth that fit snugly around edges (covering mouth and nose *or a disposable mask with multiple layers of non-woven material and a nose wire that fits snugly around edges (covering mouth and nose)*. If communicating with individuals who are deaf or hard of

hearing, it is recommended to use a clear mask or cloth mask with a clear panel. Residents should wear a face covering or facemask (if tolerated) during a visit and whenever leaving their room. 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 to the categories described above, face coverings should not be placed on children under two years of age. Reference: Guidance for Wearing Masks | CDC.

- Social distancing (also called "physical distancing") of at least six feet between persons (approximately 2 arm-lengths between persons) for visitors or individuals who do not live together within the care facility. Physical distancing should be utilized in combination with face coverings/facemasks and regular hand hygiene. Facilities should have a process to limit both the number of visitors and the number of visits (maximum visitors occurring simultaneously to support safe infection prevention actions (e.g., maintaining social physical distancing).
- The use of physical barriers during visits (e.g., clear Plexiglass/plastic dividers, curtains) can further reduce the spread of infection.
- Posting instructional signage throughout the facility and proper visitor education on COVID-19 signs and symptoms, IPC precautions, other applicable facility practices (e.g., use of face covering or mask; specified entries, exits, and routes to designated areas; hand hygiene).
- Routine cleaning and disinfecting frequently touched surfaces in the facility and designated visitation areas after each visit. Reference: Guidance for Disinfection | CDC
- Appropriate staff use of Personal Protective Equipment (PPE).
- Effective cohorting of clients/residents who require outpatient or post-acute care level of services. Those needing more intensive-care needs should be appropriately triaged to a higher level of care (e.g., separate areas and staff dedicated to COVID-19 care).
- Movement of visitors in these facilities should be restricted. Visitors should limit their movement to see only the client/resident they are visiting and should not go to other locations in the facility.
- Resident and staff testing should be conducted in accordance with applicable state, local, and facility policies, procedures, and CDC guidance. Reference: Guidance for COVID-19 Testing | CDC
- Limiting and monitoring points of entry to the facility.

These recommendations of COVID-19 IPC are consistent with the current CDC guidance for nursing homes and congregate settings, such as ICF/IID and PRTFs, and should be followed except where they prevent a necessary accommodation. Where accommodations to meet the specific needs of a client/resident prevent implementation of a protective measure, additional levels of protection should be addressed in a person-centered manner. For example, touch-based communication may be necessary for clients/residents with combined hearing and vision impairment, but increased use of touch-based communication may necessitate higher levels of hand hygiene, respiratory protection and/or other protections that may be appropriate in such situations. *Likewise, physical touch may be necessary in compassionate care visits, such as when clients/residents participate in certain religious practices, including in end-of-life situations.* Also, ICF/IIDs and PRTFs should enable visits to be conducted with an adequate degree of privacy. Visitors who are unwilling to adhere to the recommended principles of COVID-19 infection prevention should not be permitted to visit in person or should be asked to leave. *All* visitation should be person-centered, supportive of quality of life, and considerate of clients /residents' physical, mental, and psychosocial well-being. By following a person-centered approach and adhering to these recommended principles, visitation can occur more safely based on this guidance. *This document can be used to help facilities develop a*

plan for when the facility will implement additional restrictions, ranging from limiting the number of visitors and allowing visitation only during select hours or in select locations to restricting all visitors, except for compassionate care reasons.

Outdoor Visitation

While taking a person-centered approach and adhering to the recommended principles of COVID-19 infection prevention, outdoor visitation is preferred *even when the client/resident is fully vaccinated* against COVID-19,* and can be conducted in a manner that reduces the risk of contracting COVID-19. Outdoor visits *generally* pose a lower risk of transmission because of increased space and airflow; therefore, visits should be held outdoors whenever practicable. To ensure the highest level of protection for clients/residents, however, wearing of a face covering/mask is recommended and maintaining social distancing is recommended for all visitors and patients/residents, even during outdoor visits. Outdoor visitation should be facilitated routinely unless weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual's health status (e.g., medical condition(s), COVID-19 status, *quarantine status*), or a facility's outbreak status make these options untenable. Facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, and parking lots, including the use of well-ventilated and/or open tents, if available. When outdoor visitation is deemed appropriate and necessary to protect clients/residents, visitors should not enter the facility during their visit (not even to use restrooms). When conducting outdoor visitation, facilities should set the time duration for each visit and should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining physical distancing). We also recommend each facility limit the number of individuals visiting per client/resident at the same time as predicated on the size of the outdoor space.

**The CDC defines* "Fully Vaccinated" *as a person who has received the required dose or doses of a COVID-19 vaccine and that individual has reached the post-vaccine period where the vaccine is at maximum effectiveness, at least 14 days after the second dose in a two-dose series or 14 days after one dose of a single-dose vaccine.*

Indoor Visitation

See the current CDC guidance at Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination | CDC for information on indoor visitation.

Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), with certain exceptions as noted below due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times; see examples in compassionate care section below). Indoor visitation should be limited under the following scenarios:

- *Unvaccinated clients/residents if the COVID-19 county positivity rate is >10% **and** <70% of clients/residents in the facility are fully vaccinated https://covid.cdc.gov/covid-data-tracker/#county-map;*
- *Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated, until they have met the criteria to discontinue Transmission-Based Precautions; and*
- *Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine. Refer to the CDC quarantine guidance: COVID-19: When to Quarantine | CDC*

Facilities should consider how the number of visitors per client/resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention. If necessary, facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors. During indoor visitation, 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. Visits for residents who share a room should not be conducted in the resident's room, if possible. 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 their county's COVID-19 test positivity rate, found on the CDC site at COVID-19 Data Tracker-County Map | CDC and the National Health Care Safety Network Tool | CDC as additional information to determine how to facilitate indoor visitation:

• Low county or jurisdiction test positivity rate (<5%): Visitation should occur according to the recommended principles of COVID-19 infection prevention and facility policies (beyond/in addition to compassionate care visits).
• Medium county or jurisdiction test positivity rate (5% – 10%): Visitation should occur according to the recommended principles of COVID-19 infection prevention and facility policies (beyond/in addition to compassionate care visits).
• High county or jurisdiction test positivity rate (>10%): Visitation should only occur for compassionate care situations, according to the recommended principles of COVID-19 infection prevention and facility policies.

The CDC COVID Data Tracker is another tool to determine trends locally. It provides COVID-19 cases and deaths by state. Facilities may also monitor other factors to understand the level of COVID-19 risk, such as rates of COVID-19-like illness, visits to the emergency department, or the test positivity rate of a county adjacent to the county where the ICF/IID or PRTF is located. We note that county positivity rate may need to be taken into consideration to determine what or if an additional outdoor visitation protocol should be instituted. For information on COVID- 19-like illness, reference: COVID-19-Like Illness | CDC

We understand that some states or facilities have designated categories of visitors, such as "essential caregivers," based on their visit history or client/resident designation. If essential caregivers are visiting, the most stringent requirements (Federal, State, local or facility) should be followed. Essential caregivers, for example, could be parents/guardians or other legally responsible individuals that provide some of the day-to-day care for minor clients/residents, and their visits may be included as an essential support in the IPP. 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 received a special categorization like "essential caregivers."

Note: CMS and CDC continue to recommend that facilities, residents, and families adhere to the core principles of COVID-19 infection prevention, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either residents or visitors has not been fully vaccinated. However, we acknowledge the toll that separation and isolation has taken. We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, if the client/resident is fully vaccinated, they can choose to have close contact (including touch) with their visitors in accordance with CDC guidelines, Updated Healthcare Infection Prevention and Control

Recommendations in Response to COVID-19 Vaccination | CDC. Visitors should physically distance from other residents and staff in the facility.

Indoor Visitation during an Outbreak

For States and local governments that have ICF/IID and PRTF outbreak testing requirements, this guidance is intended to describe how visitation may still occur when there is evidence that the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility. An outbreak exists when a new ICF/IID or PRTF onset of COVID-19 occurs (i.e., a new COVID-19 case among clients/residents or staff). While outbreaks increase the risk of COVID-19 transmission, a facility may not need to restrict visitation for all clients/residents for an extended period of time when there is an outbreak. To detect cases swiftly, we remind facilities to adhere to CDC guidance for COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing. Refer to CDC guidance for Group Homes for Individuals with Disabilities: Guidance for Group Homes for Individuals with Disabilities | CDC

When a new case of COVID-19 among clients/residents or staff is identified, a facility should immediately begin outbreak testing, and suspend all indoor visitation (except that required under federal civil rights law, including disability rights law), until at least one round of facility-wide testing is completed. Visitation may resume based on the following criteria:

- *If the first round of outbreak testing reveals **no additional COVID-19 cases in other areas (e.g., units) of the facility**, then visitation may resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing.*
    - *For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, visitation may resume for residents in areas/units with no COVID-19 cases.*
- *If the first round of outbreak testing **reveals one or more additional COVID-19 cases in other areas/units of the facility** (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated) until the facility meets the criteria to discontinue outbreak testing.*

Note: While these scenarios describe how visitation can continue after one round of outbreak testing, facilities should continue all necessary rounds of outbreak testing. In other words, this guidance provides information on how visitation may occur during an outbreak but testing guidelines remain the same.

Also, in all cases, visitors should be notified about the potential for COVID-19 exposure in the facility if they are permitted to visit (i.e., appropriate signage regarding current outbreaks, etc.).

*We note that compassionate care visits should be **allowed at all times** for any resident (vaccinated or unvaccinated), regardless of the above scenarios. Also, facilities and visitors should continue all infection prevention and control practices, including effective hand hygiene, using face-coverings, and social distancing. Lastly, facilities should continue to consult with their state or local health departments when an outbreak is identified, to ensure adherence to infection control precautions, and for recommendations to reduce the risk of COVID-19 transmission.*

COVID-19 Testing of ICF/IID and PRTF Staff and Clients/Residents *and Vaccination*

To enhance efforts to keep COVID-19 from entering and spreading through ICF/IIDs and PRTFs, facilities are strongly encouraged to test clients/residents and staff based on general parameters and a

frequency recommended by the CDC, State and local authorities, and a facility's policies and procedures. Routine testing is essential to maintaining the health and safety of residents/clients, staff, and visitors. Facilities without the ability to conduct COVID-19 Point-of-Care (POC) testing should have arrangements to take clients/residents to a community test site and/or utilize self-administered tests, if conducted by staff. These are now available at some pharmacies. Reference: COVID-19 Point-of-Care Testing | CDC

Similarly, CMS encourages all clients/residents and staff to become vaccinated when they have the opportunity. See link for recent Interim Final Rule requiring the offering of vaccination to staff and clients as well as COVID-19 vaccination education in ICFs/IID: IFC-COVID-19 Vaccine Requirements for LTC and ICFs/IID Residents, Clients, and Staff.

The facility should continue to assess symptoms of all staff (in each shift), each client or resident (daily), and all persons entering the facility, such as vendors, volunteers, and visitors, for signs and symptoms of COVID-19. When prioritizing individuals to be tested, facilities should prioritize individuals with signs and symptoms of COVID-19 first and then perform screening tests in response to an outbreak (as recommended below).

Visitor COVID-19 Testing *and Vaccination*

Facilities are encouraged to screen visitors for their current status and exposure for COVID-19. *While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation; this guidance can also be found in the CMS QSO-20-39-NH-Revised. Facilities should also screen representatives of the Protection and Advocacy (P&A) systems, long-term ombudsmen, auxiliary aids and services for the provision of effective communication (such as sign language interpreters), and support persons or other reasonable accommodation providers as required by CMS and federal civil rights law, including disability rights law, as described below.* Reference: Guidance for Quarantine | CDC

Compassionate Care Visits

While end-of-life situations have been used as examples of compassionate care situations, the term "compassionate care situations" does not exclusively refer to end-of-life situations, reference: Nursing Home Visitation-COVID-19. Examples of other types of compassionate care situations that are applicable to ICF/IIDs and PRTFs may include, but are not limited to, the following:

- A client/resident who was living with their family before recently being admitted to an ICF/IID or PRTF, and is struggling with the change in environment and lack of physical family support.
- A client/resident who needs cueing and encouragement with daily care needs such as eating, drinking, or hygiene previously provided by family and/or caregiver(s). This may be especially significant for minors.
- A client/resident, who is used to talking and interacting with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the client/resident had rarely cried in the past) *may benefit from communication with a mental health service provider.*

Allowing a visit in these situations would be consistent with the intent of "compassionate care situations." In addition to family members and caregivers, any individual that can meet the client/resident's needs, such as clergy or laypersons offering religious or spiritual support, can conduct compassionate care visits. Furthermore, the above is not an exhaustive list as there may be

other compassionate care situations not included therein. *Compassionate care visits should be allowed at all times, regardless of a client's/resident's vaccination status, the county's COVID-19 positivity rate, or an outbreak.*

At all times, visits should be conducted using physical distancing*, though physical touch may be necessary in compassionate care visits, such as when clients/residents participate in certain religious practices*. However, as noted above, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting facemask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility. Through a person-centered approach, facilities should work with clients/residents, families, caregivers, client/resident representatives, and Protection and Advocacy Agency (P&A) representatives to identify the need for compassionate care visits.

Facilities should make every effort to permit visitation for all purposes, but particularly for the following purposes: (1) compassionate care visits; (2) visits by P&A's; (3) in-person supports necessary for equal access to care and effective communication under disability rights laws; and (4) outside healthcare and service providers, including providers assisting with transition. Even if the facility is otherwise limiting in-person visitation, unless the visitor has COVID-19 symptoms or refuses to comply with the facility's infection control practices, visitation should proceed.

Required Visitation

ICF/IID facilities should promote and may not restrict visitation without a reasonable clinical or safety cause, consistent with requirements at 42 CFR 483.420(a) ("Standard: Protection of clients' rights.") and 42 CFR 483.420(c) ("Standard: Communication with clients, parents, and guardians.") We believe the guidance above represents numerous ways an ICF/IID or PRTF can facilitate in-person visitation. Except for ongoing use of virtual visits, facilities may still restrict visitation due to their county's COVID-19 test positivity rate, the facility's COVID-19 status, a client's/resident's COVID-19 status, visitor symptoms, lack of adherence to proper infection control practices, or other relevant factor related to the COVID-19 PHE.

Residents who are on transmission-based precautions for COVID-19 should only receive visits that are virtual, through windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. However, this restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines, and other visits may be conducted as described above.

Facilities should actively assess and restrict visitation by all visitors, including healthcare personnel (HCP) who are employees and those that are not employees but provide direct care to clients/residents, such as contract therapists, clergy, etc., who meet the following criteria:

1. Any staff who has known or suspected signs of COVID-19 while on-the-job. If so, these steps should be taken:
    a. Inform the facility's leadership (e.g., Administrator Supervisor, IPC Manager, etc.) and include information on individuals, equipment, and locations the person has come into contact with within the 48 hours before symptom onset, put on a facemask, self-isolate outside of the facility; and
    b. For next steps, contact and follow the state health department recommendations (e.g., quarantine, testing).
2. Has new signs or symptoms of a respiratory infection, such as a fever, cough, or difficulty

breathing.

3. Had close contact with someone who is positive for COVID-19 infection, someone who is considered a person under investigation (PUI) for COVID-19, or someone with respiratory illness, even if not experiencing symptoms.

We note that EMS personnel who are responding to an emergency at the facility do not need to be assessed (they should follow all recommended principles and exercise caution as required by individual EMS providers) but should have face coverings/masks to ensure they can attend to an emergency immediately. We remind facilities that all staff, including individuals providing services under arrangement, as well as volunteers, should adhere to the recommended principles of COVID-19 infection prevention.

For those individuals who do not meet the three criteria above, facilities may allow entry but should require visitors to wear a face covering/mask. Outside HCPs may be allowed entry, with the appropriate use of PPE, such as a surgical mask and/or an N95 filtering facepiece respirator (based on the activity) and including eye protection (e.g., face shield or goggles).

For those clients/residents that are not able to have visitors or outside HCP visits because of their high-risk medical status, or for those clients/residents that test positive for COVID-19 infection, facilities should implement one or more of the following options:

a) Offering alternative means of communication for people who would otherwise visit, such as virtual communications (phone, video-communication, etc.).
b) Creating/increasing listserv communication and website notifications to update families and caregivers, or outside HCPs, such as advising them not to visit when circumstances require.
c) Assigning dedicated staff as primary contacts to families and caregivers for inbound calls and conduct regular outbound calls to keep families and caregivers up to date.
d) Offering a phone line with a voice recording updated at set times (e.g., daily) with the facility's general operating status, COVID-19 infection status, and when it will be safe to resume visits.
e) Facilitating physically distant and/or outdoor visits (see above) using appropriate protection with only fully vaccinated visitors

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

P&A systems authorized under the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. §§ 15041–15045) protect the rights of individuals with developmental and other disabilities. P&As have a number of authorities, including the authority to "investigate incidents of abuse and neglect of individuals with developmental disabilities if the incidents are reported or if there is probable cause to believe the incidents occurred." 42 U.S.C.A. § 15043(a)(2)(B). Under its federal authorities, representatives of P&A systems are permitted immediate and unrestricted 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(d) ("Access to facilities and residents."); 45 CFR § 1326.27(d) ("Access to service providers and individuals with developmental disabilities.").

Additionally, each facility must comply with federal disability rights laws such as Section 504 of the Rehabilitation Act, Section 1557 of the Patient Protection and Affordable Care Act (ACA), and the Americans with Disabilities Act, as applicable. Under these laws, facilities may be obligated to permit in-person visits for individuals with disabilities in certain circumstances. For example, facilities may

be required to permit entry of a designated support person to meet an individual's disability-related needs, including, as may be appropriate in some cases, supporting an individual's transition from an institutional setting into the community. Reference: OCR Resolves Complaints After State CT Private Hospital Safeguards the Rights of Persons | HHS; see also, COVID-19 Considerations Strategies and Resources for Crisis Standards of Care in PALTC Facilities | HHS .

Where ICF/IID's are licensed as nursing facilities and are certified under section 1919 of the Social Security Act, the ICF/IID must allow visitation by the long-term care Ombudsman program, consistent with 42 CFR 483.10(f)(4)(i)(C). Reference: visitation guidance for Nursing Homes: QSO-20-39-NH memo.

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 entry into the facility of a person to interpret or facilitate as stated in 42 CFR 483.420(a)(1) and (2) for ICF/IIDs and 42 CFR 483.356(c)(2) for PRTFs. *Federal disability rights law also requires effective communication for individuals with disabilities:* ADA Requirements: Effective Communication. These obligations do not preclude facilities from imposing legitimate safety measures that are necessary for safe operations, such as requiring such individuals to adhere to the recommended 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, the Administration for Community Living, or other appropriate oversight agency.

Communal Activities and Dining

Based on the status of COVID-19 infections in a facility, *the facility* should consider whether additional limitations on the following guidance should be applied in a specific care setting. While adhering to the recommended principles of COVID-19 infection prevention, facilities may permit communal activities and communal dining may occur. *The CDC has provided additional guidance on group activities and group dining based on client/resident and staff vaccination status. For example, clients/residents who are fully vaccinated may dine and participate in activities together without face coverings or social distancing if all participating clients/residents are fully vaccinated; if unvaccinated clients/residents are present during communal dining or activities, then all clients/residents should use face coverings when not eating and unvaccinated clients/residents should physically distance from others. See the current CDC guidance* Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination | CDC *for information on communal activities and dining.*

Survey Considerations

Federal and state surveyors must be permitted entry into facilities unless the surveyors show signs or symptoms of COVID-19 are present. Surveyors must also adhere to the recommended principles of COVID-19 infection prevention.

- For concerns related to resident communication with and access to persons and services inside and outside the facility, surveyors should investigate for non-compliance with 42 CFR 483.420(a) ("Standard: Protection of clients' rights."), tag W122 for ICF-IIDs.
- For concerns related to involvement of parents, guardians or representatives in developing a plan of care and treatment decisions, surveyors should investigate for non-compliance with 42 CFR

441.155(b)(2) ("Individual plan of care.") for PRTFs, 42 CFR 483.440(c)(2) ("Appropriate facility staff must participate in interdisciplinary team meetings") for ICF-IIDs, and 42 CFR 482.13(b)(1) ("Standard: Exercise of rights.") for hospitals, as applicable.
- For concerns related to an ICF/IID limiting visitors (such as family, legal guardian, or client advocates) without a reasonable clinical and safety cause, surveyors should investigate for non-compliance with 42 CFR 483.420(c)(3) ("Standard: Communication with clients, parents, and guardians.").
- For concerns related to an ICF/IID failing to provide proper notice of visitation rights, surveyors should investigate for non-compliance with 42 CFR 483.420(a)(1) ("Standard: Protection of clients' rights.").
- For concerns related to lack of adherence to infection control practices, surveyors should investigate for non-compliance with 42 CFR 483.470(l) ("Standard: Infection control."), tag W454 for ICF-IIDs.

Guidance: CMS urges providers to take advantage of several resources that are listed below:

CDC Resources:
- Interim Public Health Recommendations for Fully Vaccinated People | CDC
- Frequently Asked Questions about COVID-19 Vaccination | CDC
- Guidance for Vaccine Considerations for People with Disabilities | CDC

CMS Resources:
- CMS ICF/IID Appendix J
- CMS PRTF Appendix N

Contact: Email QSOG_EmergencyPrep@cms.hhs.gov

NOTE: The situation regarding COVID-19 is still evolving nationwide and worldwide and can change rapidly. Stakeholders should be prepared for guidance from CMS and other agencies (e.g., CDC) to change. Please monitor the relevant sources regularly for updates.

Effective Date: Immediately. This policy should be communicated to all survey and certification staff, their managers and the State/Regional Office training coordinators immediately.

/s/
David R. Wright

cc: Survey and Operations Group Management