July 12, 2021

GENERAL VISITATION GUIDANCE FOR NURSING HOMES:
A. Core Principles of Infection Control

1. Visitation can be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces and outdoors. Regardless of how visits are conducted, there are certain core principles and best practices that reduce the risk of *COVID-19* transmission including, but not limited to:

- Screening of all who enter the facility for signs and symptoms of *COVID-19* (e.g., questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with *COVID-19* infection in the prior 14 days (regardless of the visitor's vaccination status);
- Hand hygiene (use of alcohol-based hand rub is preferred);
- The use of face coverings or masks (covering mouth and nose) in accordance with CDC guidance;
- Social distancing at least six feet between persons, in accordance with CDC guidance;
- 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 to *COVID-19* care);
- Resident and staff testing conducted as required at 42 CFR § 483.80(h) (see QSO-20-38-NH).

2. These core principles are consistent with CDC guidelines for nursing homes and will be **adhered to at all times**. Additionally, visitation will be person-centered and will consider the residents' physical, mental, and psychosocial well-being, and support their quality of life.

3. **Visitors who are unable to adhere to the core principles of *COVID-19* infection prevention will not be permitted to visit or will be asked to leave**. By following a person-centered approach and adhering to these core principles, visitation can occur safely based on the below guidance.

B. Outdoor Visitation

1. While taking a person-centered approach and adhering to the core principles of *COVID-19* infection prevention, **outdoor visitation is preferred whenever practicable even when the resident and visitor are fully vaccinated* against *COVID-19***. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow.

2. Weather considerations or an individual resident's health status (e.g., medical condition(s), *COVID-19* status and quarantine status) may hinder outdoor visits. For outdoor visits, the facility will 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, all appropriate infection control and prevention practices will be adhered to.

NOTE: Fully vaccinated refers to a person who is ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons.

C. Indoor Visitation

1. See the current CDC guidance, "Updated Healthcare Infection Prevention and Control Recommendations in Response to *COVID-19* Vaccination," available at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html, for information on indoor visitation.
2. In accordance with CDC and CMS guidance, facilities will allow indoor visitation at all times and for all residents (regardless of vaccination status), **except** for a few circumstances when visitation is limited to compassionate care situations due to high risk of *COVID-19* transmission. These scenarios include limiting indoor visitation for:

- Unvaccinated residents if the nursing home's *COVID-19* county positivity rate is >10% **AND** <70% of residents in the facility are fully vaccinated;
- Residents with confirmed *COVID-19* infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; **OR**
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

Note: For county positivity rates go to: https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg

D. Scheduling Visits and Other Facility Visitation

1. Facilities will consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time may affect the ability to maintain the core principles of infection prevention. In addition, the facility will:

- Schedule visits for a specified length of time to help ensure all residents are able to receive visitors; provided scheduling will not limit access to required visitors detailed below. Any visitation schedule will allow residents to receive visitors for their desired length of time, to the extent possible in consideration of the Core Principles of infection control and as necessary to respect the privacy of other residents in the event a resident shares a room.
- Limit visitor movement in the facility; the Long Term Care Ombudsman is permitted to move within the facility and is not subject to scheduling visits.
- If possible, for residents who share a room, visits should not be conducted in the resident's room.
- For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities will attempt to enable in- room visitation while adhering to the core principles of *COVID-19* infection prevention.
- If the resident is fully vaccinated, they can choose to have close contact (including touch) with an unvaccinated visitor while both are wearing a well-fitting face mask and performing hand-hygiene before and after.

- If both the resident and their visitor(s) are fully vaccinated, and the resident and visitor(s) are alone in the resident room or designated visitation room, the resident and visitor may choose to have close contact (including touch) without a mask or face covering.
- Regardless, visitors should physically distance from other residents and staff in the facility.

E. Indoor Visitation During an Outbreak

1. An outbreak exists when a new nursing home onset of *COVID-19* occurs (i.e., a new *COVID-19* case among residents or staff). With the appropriate safeguards, visitation can still occur when there is an outbreak, but there is evidence that the transmission of *COVID-19* is contained to a single area (e.g., unit) of the facility.
2. To swiftly detect cases, the facility will adhere to CMS regulations and guidance for *COVID-19* testing including routine staff testing, testing of individuals with symptoms, and outbreak testing, including but not limed to 42 CFR 483.80(h) and QSO-20-38-NH. The facility will also comply with regulations and applicable Department guidance governing testing.
3. When a new case of *COVID-19* among residents or staff is identified, the facility will immediately begin outbreak testing every 3-7 days and suspend all visitation (except required visitation as detailed further in this guidance), until at least one round of facility-wide testing is completed. Visitation can 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 indoor visitation will resume for residents in areas/units with no *COVID-19* cases. However, the facility will 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, but not in other units, visitation can 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 will suspend indoor visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.
4. While the above scenarios describe how visitation can continue after one round of outbreak testing, facilities will continue all necessary rounds of outbreak testing as required by CMS. In other words, this guidance provides information on how visitation can occur during an outbreak but, does not change any expectations for testing and adherence to infection prevention and control practices.
5. If subsequent rounds of outbreak testing identify **one or more additional *COVID-19* cases in other areas/units of the facility**, then facilities will suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.
6. Compassionate care visits and visits required under federal disability rights law will be allowed at all times, for any resident (vaccinated or unvaccinated) regardless of the above scenarios.

***NOTE**: In all cases, visitors will be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face coverings.*

F. Visitor Testing and Vaccination

1. Testing will be offered to visitors.
2. The facility will prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities will also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days).
3. Visitors will be encouraged to become vaccinated. While visitor testing and vaccination can help prevent the spread of *COVID-19*, **visitors will not be required to be tested or vaccinated (or show proof of such) as a condition of visitation**. **This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems, as described in the Required Visitation section of this guidance.**

REQUIRED VISITATION

A. Limited Restrictions Permitted for General Visitation

1. Consistent with 42 CFR 483.10(f)(4)(v), the facility will not restrict visitation without a reasonable clinical or safety cause. The facility will facilitate in-person visitation consistent with the applicable CMS regulations, which can be done by applying the guidance stated above. Failure to facilitate visitation, without adequate reason related to clinical necessity or resident safety, would constitute a potential violation of 42 CFR 483.10(f)(4), and the facility would be subject to citation and enforcement actions.

2. Residents who are on transmission-based precautions for confirmed or suspected *COVID-19* or an exposure to *COVID-19* as defined by the CDC will only receive visits that are virtual, through windows, or in-person for compassionate care situations, with adherence to transmission-based precautions. This restriction should be lifted once transmission-based precautions are no longer required per CDC guidelines.

B. Access to the Long-Term Care Ombudsman

1. 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.

2. In-person access may be limited to virtual visitation due to infection control concerns and/or concerns relating to the transmission of *COVID-19*, such as the scenarios stated above for limiting indoor visitation or where the representative of the Long-Term Care Ombudsman Program screens positive for signs or symptoms of *COVID-19*; however, in-person access may not be limited without reasonable cause.

3. CMS requires representatives of the Office of the Ombudsman to adhere to the core principles of *COVID-19* infection prevention as described above. If in-person access is deemed inadvisable (e.g., the Ombudsman has signs or symptoms of *COVID-19*), facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology.

4. The facility is 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.

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

1. 42 CFR 483.10(f)(4)(i)(E) and (F) require 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).

2. Protection and Advocacy 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 USC § 15043(a)(2)(B).

3. Under its federal authorities, representatives of Protection and Advocacy 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.

4. Additionally, each facility must comply with federal disability rights laws, such as **Section 504 of the Rehabilitation Act and the Americans with Disabilities Act (ADA).** For example, 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 will allow the individual entry into the nursing home to interpret or facilitate, with some exceptions. This would not preclude the facility 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.

5. Any questions about or issues related to enforcement or oversight of the non-CMS requirements and citations referenced above under this section subject heading will be referred to the HHS Office for Civil Rights, the Administration for Community Living, or other appropriate oversight agencies.

D. Personal Caregiving Visitors

1. The personal caregiving visitation regulations for NHs, which implement the Essential Caregiver Act, remain law, and therefore facilities must have policies and procedures in place regarding personal caregiving visitors, including those who provide compassionate caregiving. However, facilities need only implement these policies and procedures when there is a declared State or local public health emergency. **At this time, there is no Statewide public health emergency.** Please refer to 10 NYCRR 415.3(d) for the specific details for those regulations and any exceptions thereof.

E. Compassionate Caregiving Visitors

1. Consistent with existing State and Federal requirements, and contained at 10 NYCRR 415.3(d)(4), the facility will permit compassionate care visits at all times, regardless of any general visitation restrictions or personal caregiving restrictions and will include the following safeguards:

• Screening for signs and symptoms of *COVID-19* and exposure to *COVID-19* prior to entering the facility,

• Considerations for appropriate infection control and prevention measures if physical contact is necessary (i.e. contact would be beneficial for the resident's mental or psychosocial wellbeing), including appropriate use of personal protective equipment and adherence to hand hygiene protocols; and

• Method(s) to determine the compassionate caregiver's appropriate donning of PPE and compliance with acceptable infection control and prevention measures.

2. Examples of compassionate care visits include, but are not limited to:

- End of life
- A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.

- A resident who is grieving after a friend or family member recently passed away.
- A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
- A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

3. Additional compassionate care situations may be considered by the facility on a resident-specific individualized basis.

4. Compassionate care visits and visits required under federal disability rights law, will be allowed at all times, regardless of a resident's vaccination status, the county's *COVID-19* positivity rate or an outbreak.

F. Healthcare Workers and Other Providers of Services

1. Health care workers who are not employees of the facility **but provide direct care** to the facility's residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy, etc., will be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to *COVID-19* or showing signs or symptoms of *COVID-19* after being screened.

2. EMS personnel do not need to be screened, so they can attend to an emergency without delay. Staff, including individuals providing services under arrangement as well as volunteers, should adhere to the core principles of *COVID-19* infection prevention and must comply with *COVID-19* testing requirements.

G. State and Federal Surveyors

1. Federal and State surveyors **are not required** to be vaccinated and must be permitted entry into facilities unless they exhibit signs or symptoms of *COVID-19* upon screening. Surveyors should also adhere to the core principles of *COVID-19* infection prevention and adhere to any *COVID-19* infection prevention requirements set by State law.

ADDITIONAL GUIDANCE

A. Communal Dining and Activities

1. Consistent with CMS and CDC guidance, communal dining and activities may occur while adhering to the core principles of *COVID-19* infection prevention. Communal dining may occur without out the use of face coverings or physical distancing, if all residents are fully vaccinated. If there are unvaccinated residents also dining in the communal dining area, all residents must wear face coverings when not eating and unvaccinated residents should physically distance from others.

2. Group activities may also be facilitated (for residents who have fully recovered from *COVID-19*, and for those not in isolation for observation, or with suspected or confirmed *COVID- 19* status) with social distancing among residents, appropriate hand hygiene, and use of a face covering (except while eating).

3. Group activities may occur without the use of face coverings or social distancing if all residents are participating are fully vaccinated. If any residents that are not fully vaccinated are participating, all residents must wear a face covering and unvaccinated residents should physically distance from others.

4. The facility may offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.