



**Center for Clinical Standards and Quality/Quality, Safety & Oversight Group**

**Ref: QSO-21-14-ICF/IID & PRTF**

**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 (ICF/IIDs) and Psychiatric Residential Treatment Facilities (PRTFs) - Coronavirus Disease-2019 (COVID-19)

**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 ICF/IIDs and PRTFs during the COVID-19 PHE. 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 ICF/IIDs 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 ICF/IIDs and PRTFs to help control and prevent the spread of the virus.

**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. In light of this, CMS is providing guidance regarding visitation in ICF/IIDs and PRTFs during the COVID-19 PHE.

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:

- 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. We recommend facilities follow the most current CDC guidance.
- Establish a process to ensure everyone (e.g., patients, healthcare personnel, and visitors) entering the facility is screened for signs and symptoms of COVID-19 and for a history of close contact with someone with suspected or confirmed COVID-19 infection within 14 days prior to the visitation.
- Restrict anyone with fever, symptoms, or known exposure from entering the facility. Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility. Visitors should be assessed to determine risks to their health. 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 a cloth face covering 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). 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 cloth face covering or facemask (if tolerated) during a visit and whenever leaving their room. Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. In addition to the categories described above, cloth face coverings should not be placed on children under 2. Reference: Guidance for Wearing Mask | 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 visit 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 and procedures and CDC guidance. Reference: [Guidance for COVID-9 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. 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. Additionally, 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. Have 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 and can be conducted in a manner that reduces the risk of contracting COVID-19. Outdoor visits 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), 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 must 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.

### **Indoor Visitation**

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

- a) No new confirmed [SAR-CoV-2 infections](#) or suspected COVID-19 cases (staff or clients/residents) have occurred during the previous 14 days while daily monitoring is conducted, and the facility is not currently conducting voluntary outbreak testing.
- b) Visitors should be willing to adhere to the recommended principles of infection prevention and staff should provide monitoring for persons who may have difficulty adhering to recommended principles, such as children.
- c) Facilities should reasonably limit the number of simultaneous visitors per client/resident and limit the total number of visitors in the facility simultaneously, based on the size of the building and physical space and staffing capabilities. Facilities may consider scheduling visits for a specified length of time to help ensure all clients/residents are able to receive visitors. Physical distancing of at least 6 feet between persons is recommended, whenever possible.
- d) Facilities should limit visitor movement in the facility. For example, visitors should not walk around the halls of the facility. Rather, they should go directly to the client's/resident's room or designated visitation area. Visits for clients/residents who share a room should not be conducted in the client's/resident's room. Dedicated bathrooms solely for visitors should be clearly designated and communicated by staff to visitors, and exhaust fans should run continuously.
- e) When permissible, facilities should "consider ventilation system upgrades or improvements and other steps to increase the delivery of clean air and dilute potential contaminants." Reference: [Guidance on Ventilation | CDC](#)

NOTE: For situations where there is a roommate and the health status of the client/resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the recommended 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 [United States COVID-19 Cases and Deaths by State | CDC](#). 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.”

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

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](#)

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**

While testing is not required, facilities are encouraged to screen visitors for their current status and exposure for COVID-19. 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).

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.

At all times, visits should be conducted using physical distancing; however, if during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following all appropriate CDC infection prevention guidance (e.g., visitor is wearing face covering/mask and exercising proper hand hygiene) and for a limited amount of time. 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 individuals to visit for the following purposes: (1) compassionate care visits; (2) visits by P&As; (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**

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. However, 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.”).

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.

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 face piece 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.

**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, 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. 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 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, there should be additional limitations considered and how the following guidance should be applied in a specific care setting. While adhering to the recommended principles of COVID-19 prevention, communal activities and dining



may occur. Clients/Residents may eat in the same room with physical distancing and face covering/mask (e.g., limited number of people at each table and with at least six feet between each person). Additionally, group activities may also be facilitated (for clients/residents who have fully recovered from COVID-19, and for those **not in isolation** or **quarantine** for observation, or with suspected or confirmed COVID-19 status) with physical distancing among clients/residents, appropriate hand hygiene, and use of face coverings. Facilities may be able to offer a variety of social and skill building 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. Some facilities may be able to establish or have already established “bubbles” of clients/residents who do not test positive for COVID-19 infection, or who have successfully recovered from COVID-19, to facilitate regular social and other interaction.

### **Survey Considerations**

- 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 , tagcontrol.”), tag W454 for ICF-IIDs.

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

### **CDC Resources:**

- [Guidance for Group Homes for Individuals with Disabilities | CDC](#)
- [Listing of All State Health Agencies | CDC](#)
- [Guidance on Outdoor and Indoor Gatherings to Avoid COVID-19 | CDC](#)
- [Guidance on Personal and Social Gatherings | CDC](#)
- [Guidance for Infection Control | CDC](#)
- [Preparing for COVID-19 in Nursing Homes | CDC](#)
- [Guidance for Nursing Home and Longterm Care COVID-19 | CDC](#)
- [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic | CDC](#)

- [Guidance for Nursing Homes and Long-Term Care Facilities | CDC](#)
- [Guidance to prevent getting sick-How COVID Spreads | CDC](#)
- [Frequently Asked Questions about COVID-19 Vaccination | CDC](#)

**CMS Resources:**

- [CMS Nursing Home Visitation Guidance](#)
- [CMS ICF/IID Appendix J](#)
- [CMS PRTF Appendix N](#)

**Advocacy Resources:**

- [Self-advocacy-Plain Language Information-on-Coronavirus.pdf](#)
- [Self-advocacy Spanish Plain Language Information-on-Coronavirus.pdf](#)

**Contact:** Email [QSOG\\_EmergencyPrep@cms.hhs.gov](mailto: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