Infection prevention

What your skilled nursing facility needs to do NOW

SimpleLTC™
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About our speaker

Mary Madison , RN, RAC-CT, CDP, is a registered nurse with over 46 years of healthcare experience, including 45+ years in long-term care. She has held positions of Director of Nursing in a 330-bed SNF, DON in two 60-bed SNFs, Reviewer with Telligen (Iowa QIO), Director of Continuing Education, Manager of Clinical Software Support, Clinical Software Implementer and Clinical Educator. Mary has conducted numerous MDS training and other educational sessions across the country in the past two+ decades. Mary joined Briggs Healthcare as their LTC/Senior Care Clinical Consultant in July 2014.

Madison.Mary@BriggsCorp.com
https://Briggshealthcare.blog
https://www.briggshealthcare.com/

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What You'll Learn

- CMS COVID-19 reporting requirements and timelines for compliance
- Penalties for non-compliance with infection control requirements
- How to audit your existing Infection Prevention and Control Program to identify areas for improvement

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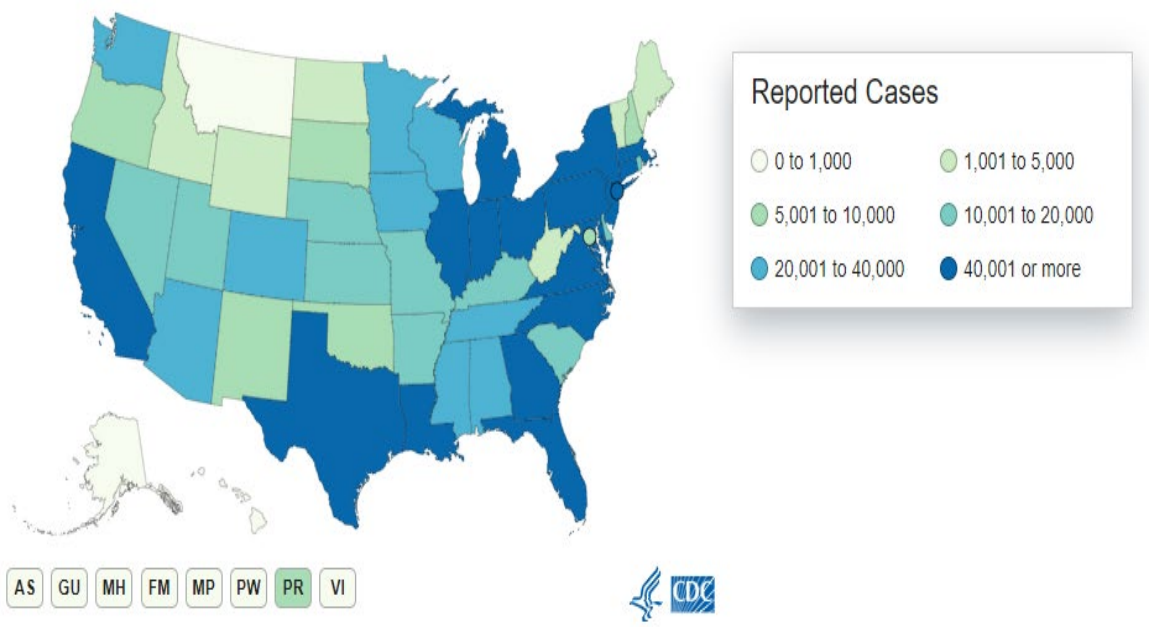
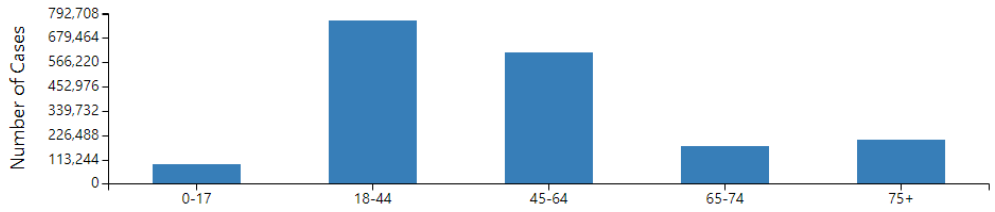
THANK YOU!!

You have provided extraordinary care
for LTC residents during this pandemic.
You are our heroes!

Another View – June 17, 2020



- Total Cases = 2,132,321
- Total Deaths = 116,862
- Cases Among HCP = 78,609 (21.1% of Total Cases) *HCP=Healthcare Professionals*
- Deaths Among HCP = 422 (63.5%)



	0-17	18-44	45-64	65-74	75+
Number of Cases	90,976	759,292	612,608	177,765	207,308

https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html

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JUST THE FACTS: WHAT CAUSED COVID-19 OUTBREAK IN NURSING HOMES

LOCATION OF A NURSING HOME WAS THE DETERMINING FACTOR IN OUTBREAKS ACCORDING TO INDEPENDENT ANALYSIS BY LEADING ACADEMIC AND HEALTH CARE EXPERTS; ASYMPTOMIC SPREAD AND LACK OF TESTING ALSO A KEY FACTOR.

KEY FINDINGS	HARVARD MEDICAL SCHOOL **DAVID GRABOWSKI, PHD** ***Professor Of Health Care Policy***	BROWN Public Health **VINCENT MOR, PHD** ***Professor, Health Services And Policy***	THE UNIVERSITY OF CHICAGO **R. TAMARA KONETZKA, PHD** ***Professor Of Health Services Research***
LOCATION OF FACILITY DETERMINED OUTBREAKS	"According to preliminary research presented, larger facilities located in urban areas with large populations, particularly in counties with a higher prevalence of COVID-19 cases, were more likely to have reported cases." [1]	Mor: "If you're in an environment where there are a lot of people in the community who have COVID, the patients in the building are more likely to have COVID." [1]	"Outbreaks of COVID-19 in nursing homes are often a signal of the communities into which the virus is spreading." [4]
ASYMPTOMIC SPREAD AND LACK OF TESTING WAS A KEY FACTOR	Grawbowski: "It is spreading via asymptomatic and pre-symptomatic cases...We're not going to get a handle on COVID-19 until we get a systematic testing and surveillance system." [1]	"COVID-19's ability to hide in plain sight will continue to crush expectations of halting its spread unless more and quicker testing at nursing homes sweeps the country, said a top U.S. researcher (Mor)." [3]	"Given asymptomatic spread and inadequate testing, staff often do not know which residents are infected. With policymakers and the public initially focused on the spread of infection within hospital settings, nursing homes often lost that competition." [4]
QUALITY RATING OF FACILITY WAS NOT A FACTOR IN OUTBREAKS	"COVID-19 cases in nursing homes are related to facility location and size and not traditional quality metrics such as star rating and prior infection control citations." [2]	"He (Mor) added that counter to some assertions, regression analyses show that infection rates are unrelated to quality rankings..." [3]	"We found no meaningful relationship between nursing home quality and the probability of at least one COVID-19 case or death...Indeed, the first death reported was from a nursing home in Washington State that had a 5-star rating." [4]
NO SIGNIFICANT DIFFERENCE BETWEEN FOR- OR NOT-FOR-PROFITS IN OUTBREAKS	"Characteristics that were not associated with a facility having a COVID case included... whether it was for-profit, part of a chain... These factors had no correlation with whether the facility had cases of COVID-19." [1]	N/A	"We found no significant differences in the probability of COVID-19 cases by profit status, with for-profit nursing homes and not-for-profit nursing homes being equally likely to have cases." [4]
	[1] *Provider Magazine, 5/11/20* [2] *"Characteristics of U.S. Nursing Homes with COVID-19 Cases", 6/2/2020*	[1] *Provider Magazine, 5/11/20* [3] *McKnight's Long Term Care News, 5/11/20*	[4] *Testimony to United States Senate Special Committee on Aging, 5/21/20*

https://www.ahcancal.org/research_data/centerforHPE/Documents/NHSN_COVID_Report_FINAL.pdf
https://www.ahcancal.org/News/news_releases/Documents/Analysis-COVID-Outbreaks-in-Nursing-Homes.pdf

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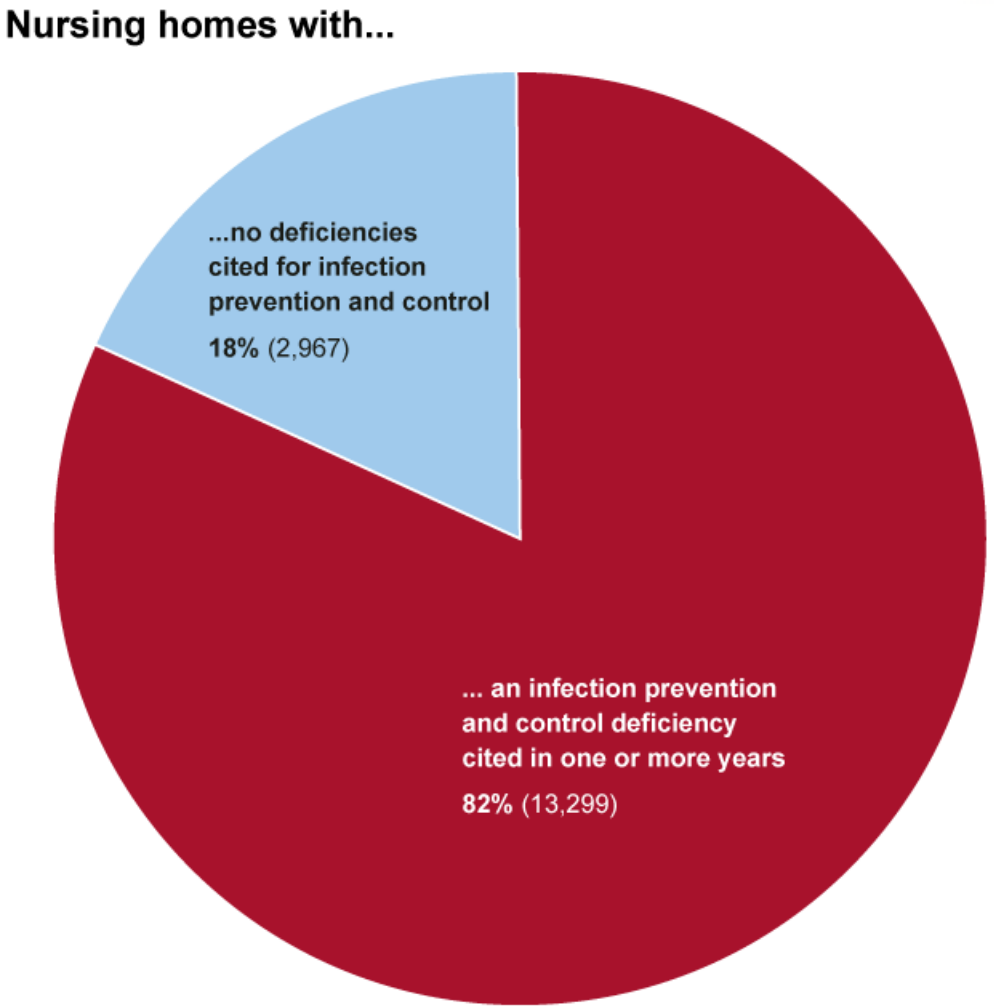
GAO Report … May 20, 2020



- Infection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with most nursing homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017 (13,299 nursing homes, or 82% of all surveyed homes).
- About 40% of surveyed nursing homes had infection prevention and control deficiencies, and this continued in 2018 and 2019.
- About half—6,427 of 13,299 (48%)—of the nursing homes with an infection prevention and control deficiency had this deficiency cited in multiple consecutive years from 2013 through 2017.
- In each year from 2013 through 2017, nearly all infection prevention and control deficiencies (about 99% in each year) were classified by surveyors as not severe, meaning the surveyor determined that residents were not harmed.
- Implemented enforcement actions for these deficiencies were typically rare: from 2013 through 2017, CMS implemented enforcement actions for 1% of these infection prevention and control deficiencies classified as not severe.

GAO-20-576R ... 20 May 2020

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CMS Administrator Verma …

June 15, 2020

* Reported by McKnight's Long-Term Care News

Centers for Medicare & Medicaid Services Administrator Seema Verma noted that about 80% of the nation's nursing homes have "actually done pretty well" managing the coronavirus and haven't reported any cases or deaths. The agency is focused on the other 20%.

"We've been working with governors, asking them to test nursing home residents and their staff and to do that routinely so we can ensure that our nursing home residents are safe," Verma said.

"And we're encouraging governors to go out to these nursing homes and perform inspections — boots on the ground — so that we can ensure that those nursing homes are taking the proper precautions," she added.

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QSO-20-31-ALL … Expanded Survey Activities

Finally, to transition States to more routine oversight and survey activities, once a state has entered Phase 3 of the Nursing Homes Re-opening guidance (https://www.cms.gov/files/document/nursinghome-reopening-recommendations-state-and-local-officials.pdf), or earlier, at the state's discretion, States are authorized to expand beyond the current survey prioritization (Immediate Jeopardy, Focused Infection Control, and Initial Certification surveys) to perform (**for all provider and supplier types**):

- Complaint investigations that are triaged as Non-Immediate Jeopardy-High
- Revisit surveys of any facility with removed Immediate Jeopardy (but still out of compliance),
- Special Focus Facility and Special Focus Facility Candidate recertification surveys, and
- Nursing home and Intermediate Care Facility for individuals with Intellectual Disability (ICF/IID) recertification surveys that are greater than 15 months.

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QSO-20-31-ALL … Enhanced Enforcement for Infection Control Deficiencies

Non-compliance for an Infection Control deficiency when ***none have been cited in the last year (or on the last standard survey):***

- Nursing homes cited for current non-compliance that is not widespread (Level D & E) - *Directed Plan of Correction*
- Nursing homes cited for current non-compliance with infection control requirements that is widespread (Level F) - *Directed Plan of Correction, Discretionary Denial of Payment for New Admissions with **45**-days to demonstrate compliance with Infection Control deficiencies.*

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And…

Non-compliance for Infection Control Deficiencies cited once in the last year (or last standard survey):

- Nursing Homes cited for current non-compliance with infection control requirements that is not widespread (Level D & E) - *Directed Plan of Correction, Discretionary Denial of Payment for New Admissions with 45-days to demonstrate compliance with Infection Control deficiencies, Per Instance Civil Monetary Penalty (CMP) up to $5000 (at State/CMS discretion)*
- Nursing Homes cited for current non-compliance with infection control requirements that is widespread (Level F) - *Directed Plan of Correction, Discretionary Denial of Payment for New Admissions with 45-days to demonstrate compliance with Infection Control deficiencies, $10,000 Per Instance CMP.*

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And…

Non-compliance that has been cited for Infection Control Deficiencies twice or more in the last two years (or twice since second to last standard survey)

- Nursing homes cited for current non-compliance with Infection Control requirements that is not widespread (Level D & E) - *Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, 30-days to demonstrate compliance with Infection Control deficiencies, $15,000 Per Instance CMP (or per day CMP may be imposed, as long as the total amount exceeds $15,000)*
- Nursing homes cited for current non-compliance with Infection Control requirements that is widespread (Level F) - *Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, 30-days to demonstrate compliance with Infection Control deficiencies, $20,000 Per Instance CMP (or per day CMP may be imposed, as long as the total amount exceeds $20,000).*

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And…

Nursing Homes cited for current non-compliance with Infection Control Deficiencies at the Harm Level (Level G, H, I), regardless of past history - *Directed Plan of Correction, Discretionary Denial of Payment for New Admissions with 30 days to demonstrate compliance with Infection Control deficiencies* Enforcement imposed by CMS Location per current policy, but CMP imposed at highest amount option within the appropriate (non-Immediate Jeopardy) range in the CMP analytic tool.

Nursing Homes cited for current non-compliance with Infection Control Deficiencies at the Immediate Jeopardy Level (Level J, K, L) regardless of past history – In addition to the mandatory remedies of Temporary Manager or Termination, *imposition of Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, 15-days to demonstrate compliance with Infection Control deficiencies* Enforcement imposed by CMS Location per current policy, but CMP imposed at highest amount option within the appropriate (IJ) range in the CMP analytic tool.

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Scope & Severity

LEVEL 4	Immediate Jeopardy To Resident Health Or Safety	ISOLATED J	PATTERN K	WIDESPREAD L
LEVEL 3	Actual Harm That Is Not Immediate Jeopardy	ISOLATED G	PATTERN H	WIDESPREAD I
LEVEL 2	No Actual Harm With Potential For More Than Minimal Harm That Is Not Immediate Jeopardy	ISOLATED D	PATTERN E	WIDESPREAD F
LEVEL 1	No Actual Harm With Potential For Minimal Harm	ISOLATED A	PATTERN B	WIDESPREAD C

Guidance on Severity Levels
There are four severity levels. Level 1, no actual harm with potential for minimal harm; Level 2, no actual harm with potential for more than minimal harm that is not immediate jeopardy; Level 3, actual harm that is not immediate jeopardy; Level 4, immediate jeopardy to resident health or safety. These four levels are defined accordingly:

Level 1 - No actual harm with potential for minimal harm: A deficiency that has the potential for causing no more than a minor negative impact on the resident(s) or employees.

Level 2 - No actual harm with a potential for more than minimal harm that is not immediate jeopardy: Noncompliance with the requirements of the life safety code that results in the potential for no more than minimal physical, mental, and/or psychosocial harm to the resident or employee and/or that result in minimal discomfort to the residents or employees of the facility, but has the potential to result in more than minimal harm that is not immediate jeopardy.

Level 3 - Actual harm that is not immediate jeopardy: Noncompliance with the requirements of the life safety code that results in actual harm to residents or employees that is not immediate jeopardy.

Level 4 - Immediate jeopardy to resident health or safety: Noncompliance with the requirements of the life safety code that results in immediate jeopardy to resident or employee health or safety in which immediate corrective action is necessary because the provider's noncompliance with one or more of those life safety code requirements has caused, or is likely to cause, serious injury, harm, impairment or death to a resident receiving care in a facility or an employee of the facility.

Guidance on Scope Levels
Scope has three levels: isolated; pattern; and widespread. The scope levels are defined accordingly:

Isolated - Scope is isolated when one or a very limited number of residents or employees is/are affected and/or a very limited area or number of locations within the facility are affected.

Pattern - Scope is a pattern when more than a very limited number of residents or employees are affected, and/or the situation has occurred in more than a limited number of locations but the locations are not dispersed throughout the facility.

Widespread - Scope is widespread when the problems causing the deficiency are pervasive (affect many locations) throughout the facility and/or represent a systemic failure that affected, or has the potential to affect, a large portion or all of the residents or employees.

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Quality Improvement Organization Support

- All nursing homes across the country can take advantage of weekly National Infection Control Training that focuses on all aspects of infection control, prevention and management to help nursing homes prevent the transmission of COVID-19 in facilities and keep residents safe.
- QIOs are being deployed to provide technical assistance to nursing homes, which includes a targeted focus on approximately 3,000 low performing nursing homes who have a history of infection control challenges.
- Further, States may request QIO technical assistance specifically targeted to nursing homes that have experienced an outbreak.

Nursing homes can locate the QIO responsible for their state here:
http://www.qioprogram.org/locate-your-qio

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Federal Requirement as of May 8, 2020

In addition, at § 483.80(g)(2), facilities are required to provide the information specified above at a frequency specified by the Secretary, but no less than weekly to the Center for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) (OMB Control Number 0920-1290). Furthermore, we note that the information reported will be shared with CMS and we will retain and publicly report this information to support protecting the health and safety of residents, personnel, and the general public, in accordance with sections 1819(d)(3)(B) and 1919(d)(3) of the Act.

CMS-5531-IFC ... 8 May 2020

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New F-Tags

483.80	Infection Control
F880	Infection Prevention & Control
F881	Antibiotic Stewardship Program
F882	{PHASE-3} Infection Preventionist Qualifications/Role
F883	*Influenza and Pneumococcal Immunizations
F884	**Reporting – National Health Safety Network
F885	Reporting – Residents, Representatives & Families

8. Reporting to the Centers for Disease Control and Prevention (CDC) – Performed Offsite by CMS. For consideration by CMS Federal Surveyors only.

☐ Review CDC data files provided to CMS to determine if the facility is reporting at least once a week.
☐ Review data files to determine if all data elements required in the National Healthcare Safety Network (NHSN) COVID-19 Module are completed.

8. Did the facility report at least once a week to CDC on all of the data elements required in the NHSN COVID-19 Module?
☐ Yes ☐ **No F884**

7. Reporting to Residents, Representatives, and Families

Identify the mechanism(s) the facility is using to inform residents, their representatives, and families (e.g., newsletter, email, website, recorded voice message)

☐ Did the facility inform all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other?

☐ Did the information include mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., restrictions to visitation or group activities)?
☐ Did the information include personally identifiable information?
☐ Is the facility providing cumulative updates to residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either: each time a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other?
☐ Interview a resident and a resident representative or family member to determine whether they are receiving timely notifications.

7. Did the facility inform residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility along with mitigating actions in a timely manner? ☐ Yes ☐ **No F885**

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F884

COVID-19 Reporting to CDC as required at §483.80(g)(1)-(2)

Review for F884 will be conducted offsite by CMS Federal surveyors (state surveyors should not cite this F-tag). Following an initial reporting grace period granted to facilities, CMS will receive the CDC NHSN COVID-19 reported data and review for timely and complete reporting of all data elements. Facilities identified as not reporting will receive a deficiency citation at F884 on the CMS-2567 with a scope and severity level at an F (no actual harm with a potential for more than minimal harm that is not an Immediate Jeopardy [IJ] and that is widespread; this is a systemic failure with the potential to affect a large portion or all of the residents or employees), and be subject to an enforcement remedy imposed as described below.

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F885

COVID-19 Reporting to Residents, their Representatives, and Families as required at §483.80(g)(3)(i)-(iii)

Review for F885 is included in the "COVID-19 Focused Survey Protocol" and will occur onsite by State and/or Federal surveyors. If the survey finds noncompliance with this requirement, a deficiency citation at this tag will be recorded on the CMS-2567 and enforcement actions will follow the memo QSO-20-20-All. We note that there are a variety of ways that facilities can meet this requirement, such as informing families and representatives through email listservs, website postings, paper notification, and/or recorded telephone messages. We do not expect facilities to make individual telephone calls to each resident's family or responsible party to inform them that a resident in the facility has laboratory-confirmed COVID-19. However, we expect facilities to take reasonable efforts to make it easy for residents, their representatives, and families to obtain the information facilities are required to provide.

In addition, when the State Survey Agency is planning to conduct these surveys, the COVID-19 Focused Survey should be coded in the Automated Survey Process Environment (ASPEN) under "Survey Type" as U=COVID-19. If the survey is taking place with an IJ complaint investigation, the survey should be coded in ASPEN under "Survey Type" as A=complaint and U=COVID-19. This will help ensure consistent, accurate reporting.

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Requirements/Enforcement Action

- SNFs must submit COVID-19 data for their facility back to May 1, 2020 no later than May 17, 2020
- Facilities that fail to begin reporting by May 31st will receive a warning letter from CMS reminding them to report to CDC
  - Check your CASPER inbox for a letter if you have not submitted. No letter is good news! You're in compliance. Continue to check that inbox every week though in case you forgot to submit your COVID-19 data. Such submission is required at least every 7 days.
- **Facilities that fail to report by June 7, 2020 will be subject to a CMP of $1,000 per day for each failure to report**
- Continued noncompliance will result in additional per day CMPs imposed at an amount increased by $500 per week for a total of $4,500 imposed CMPs

QSO-20-29-NH ... 6 May 2020

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Reporting Frequency

Preferred

Daily reporting:

Selected calendar date must reflect the date in which the responses are being reported in the NHSN LTCF COVID-19 Module.

Non-daily reporting:

Selected calendar date must reflect the date in which responses are being reported in the NHSN LTCF COVID-19 Module.

Counts must include only **new** counts for the specific question since the last time counts were entered in the Module.

Required (Minimum)

Weekly reporting:

Selected calendar date must reflect the date in which responses are being reported in the NHSN LTCF COVID-19 Module.

Include only **new** counts for the specific question since the last time counts were entered in the Module.

Report on the same day of the week every week.

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COVID-19 Module for LTCF: Pathways

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Nursing Home COVID-19 Data

State	Nursing Home COVID-19 Data								State Survey Data		
	Total Nursing Home Resident Cases	Nursing Home Resident COVID-19 Cases per 1,000 NH Residents	Total Nursing Home Resident COVID-19 Deaths	Nursing Home Resident COVID-19 Deaths per 1,000 NH Residents	Total Nursing Home Staff Cases	Total Nursing Home Staff Cases per 1,000 NH Residents	Total Nursing Home Staff Deaths	Total Nursing Home Staff Deaths per 1,000 NH Residents	Total Nursing Homes	Total Nursing Home Surveys	Percentage of Nursing Homes Surveyed
National	**60439**	**62.0**	**25923**	**27.5**	**34442**	**39.5**	**449**	**0.5**	**15412**	**8332**	**54.10%**
Alabama	789	58.2	294	18.4	619	48.0	7	0.4	228	53	23.2
Alaska	1	4.4	0	0.0	1	4.4	0	0.0	19	7	36.8
Arizona	227	55.4	88	18.8	372	135.6	1	0.1	143	69	48.3
Arkansas	237	23.8	67	6.0	151	13.9	0	0.0	227	128	56.4
California	2725	51.0	1169	23.0	1879	37.7	15	0.2	1194	1131	94.7
Colorado	770	86.3	384	28.1	552	50.4	3	0.2	227	227	100.0
Connecticut	3459	236.1	1495	125.0	1369	103.8	5	0.3	215	212	98.6
Delaware	522	155.8	125	37.4	168	53.8	2	1.0	46	41	89.1
District of Columbia	179	255.4	53	131.2	129	206.2	2	0.8	18	4	22.2
Florida	2040	39.8	847	17.9	1161	27.5	9	0.2	698	535	76.6
Georgia	2444	94.9	431	18.6	1023	41.5	11	0.4	358	64	17.9
Hawaii	0	0.0	0	0.0	0	0.0	0	0.0	44	16	36.4
Idaho	54	20.9	32	12.7	41	17.0	4	2.4	82	11	13.4
Illinois	4689	100.7	1913	42.9	3379	90.0	44	1.2	722	313	43.4
Indiana	1841	79.2	1141	41.0	838	36.2	8	0.3	534	270	50.6
Iowa	507	29.7	154	8.8	315	21.1	9	0.6	434	67	15.4
Kansas	133	7.9	189	14.1	107	7.2	1	0.1	331	148	44.7
Kentucky	490	33.8	150	11.8	263	20.7	3	0.2	285	242	84.9
Louisiana	1489	81.5	620	35.4	859	52.2	9	0.5	278	205	73.7
Maine	100	23.0	22	5.0	101	23.6	8	0.6	93	23	24.7
Maryland	2075	118.1	537	33.8	993	61.4	4	0.3	226	37	16.4
Massachusetts	5281	244.4	2261	117.5	3259	160.2	82	5.9	376	86	22.9
Michigan	2864	118.7	1654	63.6	1159	45.1	12	0.5	442	368	83.3
Minnesota	900	39.9	297	12.7	538	25.9	15	0.4	368	246	66.8
Mississippi	546	59.0	247	28.0	369	37.0	6	0.6	204	49	24.0
Missouri	726	24.0	309	10.2	260	9.1	2	0.0	522	287	55.0
Montana	5	0.0	2	0.0	6	0.6	0	0.0	71	44	62.0
Nebraska	232	28.4	66	7.8	187	20.9	1	0.1	201	49	24.4
Nevada	147	34.0	126	6.9	125	101.1	1	13.9	66	66	100.0
New Hampshire	242	39.8	77	18.2	154	23.8	0	0.0	74	19	25.7
New Jersey	5179	206.7	3191	145.5	2731	127.4	63	2.7	363	120	33.1
New Mexico	51	20.5	12	6.7	114	49.5	1	0.4	71	26	36.6
New York	6546	98.5	2948	42.2	3981	61.6	39	0.6	619	231	37.3
North Carolina	789	30.0	216	9.3	448	17.2	2	0.1	428	250	58.4
North Dakota	95	12.1	33	4.5	170	30.1	0	0.0	80	80	100.0
Ohio	1830	46.1	831	18.7	913	25.1	3	0.1	953	293	30.7
Oklahoma	318	27.3	85	7.0	228	16.7	9	0.8	298	164	55.0
Oregon	44	7.0	55	12.4	42	9.8	8	1.3	130	128	98.5
Pennsylvania	4776	94.1	2193	44.2	2361	48.3	30	0.4	695	113	16.3
Rhode Island	681	137.2	282	29.5	337	64.5	2	0.3	80	35	43.8
South Carolina	765	67.1	141	14.9	395	39.9	4	0.5	190	59	31.1
South Dakota	70	6.5	25	2.1	81	8.6	0	0.0	104	77	74.0
Tennessee	167	8.0	56	3.1	158	8.8	9	0.4	316	156	49.4
Texas	1356	23.9	228	4.5	940	18.0	2	0.0	1218	1140	93.6
Utah	39	9.7	9	2.9	66	27.3	0	0.0	99	22	22.2
Vermont	59	0.0	19	0.0	30	0.4	1	0.4	35	18	51.4
Virginia	847	48.9	307	19.9	419	29.7	9	0.0	287	43	15.0
Washington	512	47.4	378	53.7	254	22.8	0	0.0	205	204	99.5
West Virginia	182	27.5	90	14.5	126	19.3	0	0.0	123	14	11.4
Wisconsin	413	26.2	72	4.7	265	16.4	3	0.1	355	105	29.6
Wyoming	6	3.8	1	0.8	6	3.4	0	0.0	37	37	100.0

Nursing Home COVID-19 Data Source: CDC National Healthcare Safety Network (NHSN). This data reflects data entered into the NHSN system by nursing homes as of May 24.

State Survey Data Source: CMS Automated Survey Process Environment System (ASPEN)

Additional background: This data reflects reconciled survey information entered into the ASPEN system by State Survey Agencies. It represents complete surveys and those where a surveyor has logged onsite hours, but not yet completed the survey, as of May 29. There is a lag of between 10-21 days until the findings from these surveys are generated.

Limitations on Data Reporting: As with any new reporting program, some facilities will struggle with their first submissions, and therefore, some of the data from their early submissions may be inaccurate.

As facilities begin reporting in the early weeks, the increase in certain metrics (e.g., number of cases) is a reflection of an increase in reporting, rather than an increase in the actual number of cases.

Facilities may opt to report cumulative data retrospectively back to January 1, 2020. Therefore, some facilities may be reporting higher numbers of cases/deaths compared to other facilities, due to their retrospective reporting. Also, these cumulative reports are included in facilities' first weekly submission to the system. Therefore, the numbers in a facility's first weekly report may be artificially higher because it reflects information that occurred over a longer period of time (e.g., from Jan 1, 2020), rather than the last seven days.

The availability of testing may impact the number of confirmed COVID-19 cases facilities report. Facilities that did not have the ability to test all residents a few weeks ago would not be able to report all residents with confirmed cases. Similarly, access to testing can vary by state, region, or facility. Data may be inconsistent with state data, particularly state death data.

https://www.cms.gov/files/document/6120-nursing-home-covid-19-data.pdf

Summary of the COVID-19 Focused Survey for Nursing Homes

This is a summary of the COVID-19 Focused Survey for Nursing Homes and the Survey Protocol. Surveyors should review the Survey Protocol for more detailed information as well as the Focused Survey. Facilities can review the Focused Survey to determine CMS's expectations for an infection prevention and control program during the COVID-19 pandemic.

Offsite Survey Activity	Onsite Survey Activity	Facility Self-Assessment
• For facilities with an active COVID-19 case, the survey team should contact their State Survey Agency (SSA), the state health department, and CMS Regional Location to coordinate activities for these facilities. • Ensure surveyors are medically cleared, and have personal protective equipment (PPE) that could be required onsite. • Conduct offsite planning to limit interruptions to care while onsite. Obtain information on: o Facility-reported information; o CDC, state/local public health reports; o Available hospital information regarding patients transferred to the hospital; and/or o Complaint allegations. • Identify survey activities that will be conducted offsite, such as: o Medical record review o Telephonic interviews, such as: ▪ Surveillance policies ▪ First onset of symptoms ▪ Communication to facility leaders and health officials ▪ Resident, representatives and families (if feasible, otherwise conduct onsite) o Policy/Procedure Review ▪ Infect. Control/Prev. Plan ▪ Emerg. Prep. Plan, including contingency strategies (e.g., staffing) o Review communication(s) to residents, representatives and families (e.g., newsletter, etc) • Conduct survey exit discussion telephonically and draft the CMS-2567 offsite.	• Limit the onsite team to one to two surveyors. • Identify and prioritize onsite assignments for activities, such as: Resident Care Observations: o Hand hygiene practices o Proper use/discarding of PPE o Cleansing medical equipment o Effective Transmission-Based Precautions Environmental observations: o Signage at entrances and resident rooms o Screening (staff at shift change, entrances, limiting nonessential staff) o Hand hygiene stations Interviews with relevant staff: o Policy/Procedure knowledge o Surveillance for sign/symptoms o Notifying local health officials o Information provided to residents, their representatives, and families concerning COVID-19 activity in the facility • Adhere to all CDC guidance for infection prevention and control related to COVID-19. • Provide the facility with the COVID-19 Entrance Conference worksheet and utilize this to request necessary information. • Identify and arrange for interviews that can be done telephonically. • Be alert of other immediate jeopardy (IJ) situations that may be present, and investigate appropriately.	Facilities should utilize the COVID-19 Focused Survey for Nursing Homes as a self- assessment tool. Priority areas for self- assessment include all of the following: 1. Standard Precautions; a. Hand hygiene b. Use of PPE c. Transmission-Based Precautions 2. Resident care (including resident placement); 3. Infection prevention and control standards, policies and procedures; 4. Infection surveillance; 5. Visitor entry (i.e., screening, restriction, and education); 6. Education, monitoring, and screening of staff; 7. Reporting to residents, representatives, and families on COVID-19 activity in the facility and mitigating actions taken; 8. Reporting to CDC's National Healthcare Safety Network COVID-19 Module; and 9. Emergency preparedness – staffing in emergencies

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Facility:_____ **COVID-19 FOCUSED SURVEY FOR NURSING HOMES** Date:_____

INFECTION CONTROL

This survey tool must be used to investigate compliance at F880, F884 (CMS Federal surveyors only), F885, and E0024. Surveyors must determine whether the facility is implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19 and other communicable diseases and infections. Entry and screening procedures as well as resident care guidance has varied over the progression of COVID-19 transmission in facilities. Facilities are expected to be in compliance with CMS requirements and surveyors will use guidance that is in effect at the time of the survey. Refer to QSO memos released at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions.

This survey tool provides a focused review of the critical elements associated with the transmission of COVID-19, will help surveyors to prioritize survey activities while onsite, and identify those survey activities which can be accomplished offsite. These efficiencies will decrease the potential for transmission of COVID-19, as well as lessen disruptions to the facility and minimize exposure of the surveyor. Surveyors should be mindful to ensure their activities do not interfere with the active treatment or prevention of transmission of COVID-19.

If citing for noncompliance related to COVID-19, the surveyor(s) must include the following language at the beginning of the Deficient Practice Statement or other place determined appropriate on the Form CMS-2567: "Based on [observations/interviews/record review], the facility failed to [properly prevent and/or contain – or other appropriate statement] **COVID-19**."

If surveyors see concerns related to compliance with other requirements, they should investigate them in accordance with the existing guidance in Appendix PP of the State Operations Manual and related survey instructions. Surveyors may also need to consider investigating concerns related to Emergency Preparedness in accordance with the guidance in Appendix Z of the State Operations Manual (e.g., for emergency staffing).

For the purpose of this survey tool, "staff" includes employees, consultants, contractors, volunteers, and others who provide care and services to residents on behalf of the facility. The Infection Prevention and Control Program (IPCP) must be facility-wide and include all departments and contracted services.

Critical Element #8 is only for consideration by CMS Federal Survey staff. Information to determine the facility's compliance at F884 is only reported to each of the 10 CMS locations.

Surveyor(s) reviews for:

- The overall effectiveness of the Infection Prevention and Control Program (IPCP) including IPCP policies and procedures;
- Standard and Transmission-Based Precautions;
- Quality of resident care practices, including those with COVID-19 (laboratory-positive case), if applicable;
- The surveillance plan;
- Visitor entry and facility screening practices;
- Education, monitoring, and screening practices of staff;
- Facility policies and procedures to address staffing issues during emergencies, such as transmission of COVID-19; and
- How the facility informs residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility.

1. STANDARD AND TRANSMISSION-BASED PRECAUTIONS (TBPs)

CMS is aware that there is a scarcity of some supplies in certain areas of the country. State and Federal surveyors should not cite facilities for not having certain supplies (e.g., PPE such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control. However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate steps to obtain the necessary supplies as soon as possible. For example, if there is a shortage of PPE (e.g., due to supplier(s) shortage which may be a regional or national issue), the facility should contact their health department or healthcare coalition for assistance (https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx), follow national and/or local guidelines for optimizing their current supply or identify the next best option to care for residents. Among other practices, optimizing their current supply may mean prioritizing use of gowns based on risk of exposure to infectious organisms, blood or body fluids, splashes or sprays, high contact procedures, or aerosol generating procedures (AGPs), as well as possibly extending use of PPE (follow national and/or local guidelines). Current CDC guidance for healthcare professionals is located at: https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html and healthcare facilities is located at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/index.html. Guidance on strategies for optimizing PPE supply is located at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. If a surveyor believes a facility should be cited for not having or providing the necessary supplies, the State Agency should contact the CMS Regional Location.

COVID-19 Focused Survey for Nursing Homes_Briggs Healthcare

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GENERAL STANDARD PRECAUTIONS

- ❑ Are staff performing the following appropriately:
  - Respiratory hygiene/cough etiquette,
  - Environmental cleaning and disinfection, and
  - Reprocessing of reusable resident medical equipment (e.g., cleaning and disinfection of glucometers per device and disinfectant manufacturer's instructions for use)?

HAND HYGIENE

- ❑ Are staff performing hand hygiene when indicated?
- ❑ If alcohol-based hand rub (ABHR) is available, is it readily accessible and preferentially used by staff for hand hygiene?
- ❑ If there are shortages of ABHR, are staff performing hand hygiene using soap and water instead?
- ❑ Are staff washing hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids)?
- ❑ Do staff perform hand hygiene (even if gloves are used) in the following situations:
  - Before and after contact with the resident;
  - After contact with blood, body fluids, or visibly contaminated surfaces;
  - After contact with objects and surfaces in the resident's environment;
  - After removing personal protective equipment (e.g., gloves, gown, facemask); and
  - Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, and/or dressing care)?
- ❑ When being assisted by staff, is resident hand hygiene performed after toileting and before meals?
- ❑ Interview appropriate staff to determine if hand hygiene supplies (e.g., ABHR, soap, paper towels) are readily available and who they contact for replacement supplies.

PERSONAL PROTECTIVE EQUIPMENT (PPE)

- ❑ Determine if staff appropriately use PPE including, but not limited to, the following:
  - Gloves are worn if potential contact with blood or body fluid, mucous membranes, or non-intact skin;
  - Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin;
  - Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care; and
  - An isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions.
- ❑ Is PPE appropriately removed and discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national/local recommendations), followed by hand hygiene?
- ❑ If PPE use is extended/reused, is it done according to national and/or local guidelines? If it is reused, is it cleaned/decontaminated/maintained after and/or between uses?
- ❑ Interview appropriate staff to determine if PPE is available, accessible and used by staff.
  - Are there sufficient PPE supplies available to follow infection prevention and control guidelines? In the event of PPE shortages, what procedures is the facility taking to address this issue?
  - Do staff know how to obtain PPE supplies before providing care?
  - Do they know who to contact for replacement supplies?

TRANSMISSION-BASED PRECAUTIONS (NOTE: PPE use is based on availability and latest CDC guidance. See note on Page 1)

❑ Determine if appropriate Transmission-Based Precautions are implemented:

- For a resident on Contact Precautions: staff don gloves and isolation gown before contact with the resident and/or his/her environment;
- For a resident on Droplet Precautions: staff don a facemask within six feet of a resident;
- For a resident on Airborne Precautions: staff don an N95 or higher level respirator prior to room entry of a resident;
- For a resident with an undiagnosed respiratory infection: staff follow Standard, Contact, and Droplet Precautions (e.g., facemask, gloves, isolation gown) with eye protection when caring for a resident unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis);
- For a resident with known or suspected COVID-19: staff wear gloves, isolation gown, eye protection and an N95 or higher-level respirator if available. A facemask is an acceptable alternative if a respirator is not available. Additionally, if there are COVID-19 cases in the facility or sustained community transmission, staff implement universal use of facemasks while in the facility (based on availability). When COVID-19 is identified in the facility, staff wear all recommended PPE (e.g., gloves, gown, eye protection and respirator or facemask) for the care of all residents on the unit (or facility-wide based on the location of affected residents), regardless of symptoms (based on availability).
  - Some procedures performed on residents with known or suspected COVID-19 could generate infectious aerosols (e.g., aerosol-generating procedures (AGPs)). In particular, procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously. If performed, the following should occur:
    - Staff in the room should wear an N95 or higher-level respirator, eye protection, gloves, and an isolation gown.
    - The number of staff present during the procedure should be limited to only those essential for resident care and procedure support.
    - AGPs should ideally take place in an airborne infection isolation room (AIIR). If an AIIR is not available and the procedure is medically necessary, then it should take place in a private room with the door closed.
    - Clean and disinfect the room surfaces promptly and with appropriate disinfectant. Use disinfectants on List N of the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-COV-2 or other national recommendations;
- Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) is used, or if not available, then equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare setting prior to use on another resident;
- Objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare setting (effective against the organism identified if known) at least daily and when visibly soiled; and
- Is signage on the use of specific PPE (for staff) posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide)?

❑ Interview appropriate staff to determine if they are aware of processes/protocols for Transmission-Based Precautions and how staff is monitored for compliance.

❑ If concerns are identified, expand the sample to include more residents on Transmission-Based Precautions.

1. Did staff implement appropriate Standard (e.g., hand hygiene, appropriate use of PPE, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment) and Transmission-Based Precautions (if applicable)? ❍ Yes ❍ **No F880**

2. Resident Care

❑ If there is sustained community transmission or case(s) of COVID-19 in the facility, is the facility restricting residents (to the extent possible) to their rooms except for medically necessary purposes? If there is a case in the facility, and residents have to leave their room, are they wearing a facemask, performing hand hygiene, limiting their movement in the facility, and performing social distancing (efforts are made to keep them at least 6 feet away from others). If PPE shortage is an issue, facemasks should be limited to residents diagnosed with or having signs/symptoms of respiratory illness or COVID-19.

❑ Has the facility cancelled group outings, group activities, and communal dining?

❑ Has the facility isolated residents with known or suspected COVID-19 in a private room (if available), or taken other actions based on national (e.g., CDC), state, or local public health authority recommendations?

- ❑ For the resident who develops severe symptoms of illness and requires transfer to a hospital for a higher level of care, did the facility alert emergency medical services and the receiving facility of the resident's diagnosis (suspected or confirmed COVID-19) and precautions to be taken by transferring and receiving staff as well as place a facemask on the resident during transfer (as supply allows)?
- ❑ For residents who need to leave the facility for care (e.g., dialysis, etc.), did the facility notify the transportation and receiving health care team of the resident's suspected or confirmed COVID-19 status?
- ❑ Does the facility have residents who must leave the facility regularly for medically necessary purposes (e.g., residents receiving hemodialysis and chemotherapy) wear a facemask (if available) whenever they leave their room, including for procedures outside of the facility?

2. Did staff provide appropriate resident care? ❍ Yes ❍ **No F880**

3. IPCP Standards, Policies and Procedures

- ❑ Did the facility establish a facility-wide IPCP including standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19?
- ❑ Does the facility's policies or procedures include when to notify local/state public health officials if there are clusters of respiratory illness or cases of COVID-19 that are identified or suspected?
- ❑ Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.

3. Does the facility have a facility-wide IPCP including standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19? ❍ Yes ❍ **No F880**

4. Infection Surveillance

- ❑ How many residents and staff in the facility have fever, respiratory signs/symptoms, or other signs/symptoms related to COVID-19?
- ❑ How many residents and staff have been diagnosed with COVID-19 and when was the first case confirmed?
- ❑ How many residents and staff have been tested for COVID-19? What is the protocol for determining when residents and staff should be tested?
- ❑ Has the facility established/implemented a surveillance plan, based on a facility assessment, for identifying (e.g., screening), tracking, monitoring and/or reporting of fever (at a minimum, vital signs are taken per shift), respiratory illness, and/or other signs/symptoms of COVID-19 and immediately isolate anyone who is symptomatic?
- ❑ Does the plan include early detection, management of a potentially infectious, symptomatic resident that may require laboratory testing and/or Transmission-Based Precautions/PPE (the plan may include tracking this information in an infectious disease log)?
- ❑ Does the facility have a process for communicating the diagnosis, treatment, and laboratory test results when transferring a resident to an acute care hospital or other healthcare provider; and obtaining pertinent notes such as discharge summary, lab results, current diagnoses, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals?
- ❑ Can appropriate staff (e.g., nursing and unit managers) identify/describe the communication protocol with local/state public health officials?
- ❑ Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.

4. Did the facility provide appropriate infection surveillance? ❍ Yes ❍ **No F880**

5. Visitor Entry

- ❑ Review for compliance of:
  - Screening processes and criteria (e.g., screening questions and assessment of illness);
  - Restriction criteria; and
  - Signage posted at facility entrances for screening and restrictions as well as a communication plan to alert visitors of new procedures/restrictions.
- ❑ For those permitted entry, are they instructed to frequently perform hand hygiene; limit their interactions with others in the facility and surfaces touched; restrict their visit to the resident's room or other location designated by the facility; and offered PPE (e.g., facemask) as supply allows?
  What is the facility's process for communicating this information?
- ❑ For those permitted entry, are they advised to monitor for signs and symptoms of COVID-19 and appropriate actions to take if signs and/or symptoms occur?

5. Did the facility perform appropriate screening, restriction, and education of visitors? ❍ Yes ❍ **No F880**

6. Education, Monitoring, and Screening of Staff

- ❑ Is there evidence the facility has provided education to staff on COVID-19 (e.g., symptoms, how it is transmitted, screening criteria, work exclusions)?
- ❑ How does the facility convey updates on COVID-19 to all staff?
- ❑ Is the facility screening all staff at the beginning of their shift for fever and signs/symptoms of illness? Is the facility actively taking their temperature and documenting absence of illness (or signs/symptoms of COVID-19 as more information becomes available)?
- ❑ If staff develop symptoms at work (as stated above), does the facility:
  - Place them in a facemask and have them return home;
  - Inform the facility's infection preventionist and include information on individuals, equipment, and locations the person came in contact with; and
  - Follow current guidance about returning to work (e.g., local health department, CDC: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html).

6. Did the facility provide appropriate education, monitoring, and screening of staff? ❍ Yes ❍ **No F880**

7. Reporting to Residents, Representatives, and Families

Identify the mechanism(s) the facility is using to inform residents, their representatives, and families (e.g., newsletter, email, website, recorded voice message)

- ❑ Did the facility inform all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other?
- ❑ Did the information include mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., restrictions to visitation or group activities)?
- ❑ Did the information include personally identifiable information?
- ❑ Is the facility providing cumulative updates to residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either: each time a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other?
- ❑ Interview a resident and a resident representative or family member to determine whether they are receiving timely notifications.

7. Did the facility inform residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility along with mitigating actions in a timely manner? ❍ Yes ❍ **No F885**

8. Reporting to the Centers for Disease Control and Prevention (CDC) – Performed Offsite by CMS. For consideration by CMS Federal Surveyors only.

❑ Review CDC data files provided to CMS to determine if the facility is reporting at least once a week.

❑ Review data files to determine if all data elements required in the National Healthcare Safety Network (NHSN) COVID-19 Module are completed.

8. Did the facility report at least once a week to CDC on all of the data elements required in the NHSN COVID-19 Module?
❍ Yes ❍ **No F884**

9. Emergency Preparedness – Staffing in Emergencies

❑ Policy development: Does the facility have a policy and procedure for ensuring staffing to meet the needs of the residents when needed during an emergency, such as COVID-19 outbreak?

❑ Policy implementation: In an emergency, did the facility implement its planned strategy for ensuring staffing to meet the needs of the residents? (N/A if an emergency staff was not needed).

9. Did the facility develop and implement policies and procedures for staffing strategies during an emergency?
❍ Yes ❍ **No E0024** ❍ N/A

Section 3087 of the 21st Century Cures Act, signed into law in December 2016, added subsection (f) to section 319 of the Public Health Service Act. This new subsection gives the HHS Secretary the authority to waive Paperwork Reduction Act (PRA) (44 USC 3501 et seq.) requirements with respect to voluntary collection of information during a public health emergency (PHE), as declared by the Secretary, or when a disease or disorder is significantly likely to become a public health emergency (SLPHE). Under this new authority, the HHS Secretary may waive PRA requirements for the voluntary collection of information if the Secretary determines that: (1) a PHE exists according to section 319(a) of the PHS Act or determines that a disease or disorder, including a novel and emerging public health threat, is a SLPHE under section 319(f) of the PHS Act; and (2) the PHE/SLPHE, including the specific preparation for and response to it, necessitates a waiver of the PRA requirements. The Office of the Assistant Secretary for Planning and Evaluation (ASPE) has been designated as the office that will coordinate the process for the Secretary to approve or reject each request.

The information collection requirements contained in this information collection request have been submitted and approved under a PRA Waiver granted by the Secretary of Health and Human Services. The waiver can be viewed at https://aspe.hhs.gov/public-health-emergency-declaration-pra-waivers.

Survey Entrance Information Needed

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

INFORMATION NEEDED FROM THE FACILITY IMMEDIATELY UPON ENTRANCE*
❑ 1. Census number
❑ 2. An alphabetical list of all residents and room numbers (note any resident out of the facility).
❑ 3. A list of residents who are confirmed or suspected cases of COVID-19.
❑ 4. Name of facility staff responsible for Infection Prevention and Control Program.
❑ 5. Conduct a brief Entrance Conference with the Administrator.
❑ 6. Signs announcing the survey that are posted in high-visibility areas.
❑ 7. A copy of an updated facility floor plan, if changes have been made.
❑ 8. The actual working schedules for licensed and registered nursing staff for the survey time period.
❑ 9. List of key personnel, location, and phone numbers. Note contract staff (e.g., rehab services). Also include the staff responsible for notifying all residents, representatives, and families of confirmed or suspected COVID-19 cases in the facility.
❑ 10. Provide each surveyor with access to all resident electronic health records – do not exclude any information that should be a part of the resident's medical record. Provide specific information on how surveyors can access the EHRs outside of the conference room. Please complete the attachedform on page 2 which is titled "Electronic Health Record Information."
❑ 11. Explain that the goal is to conduct as much record review offsite as possible to limit potential exposure or transmission. Determine what information can be reviewed offsite, such as electronic medical records (EMRs), or other records and policies/procedures. If offsite review of EMRs is not possible, surveyors will request photocopies (that can be made by surveyors instead of facility staff). If the facility has an electronic health record (EHR) system that may be accessed remotely, request remote access to the EHR to review needed records for a limited period of time. If this is not an option, discuss with the facility the best options to get needed medical record information, such as fax, secure website, encrypted email, etc.
❑ 12. Facility Policies and Procedures: • Infection Prevention and Control Program Policies and Procedures, to include theSurveillance Plan. • Emergency Preparedness Policy and Procedure to include Emergency StaffingStrategies **NOTE**– A comprehensive review of policies should be completed offsite.
❑ 13. The facility's mechanism(s) used to inform residents, their representatives, and families of confirmed or suspected COVID-19 activity in the facility and mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., supply the newsletter, email, website, etc.). If the system is dependent on the resident or representative to obtain the information themselves (e.g., website), provide the notification/information given to residents, their representatives, and families informing them of how to obtain updates.

***NOTE**: The timelines for requested information in the table are based on normal circumstances. Surveyors should be flexible on the time to receive information based on the conditions in the facility. For example, do not require paperwork within an hour if it interrupts critical activities that are occurring to prevent the transmission of COVID-19.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

ENTRANCE CONFERENCE WORKSHEET
ELECTRONIC HEALTH RECORD (EHR) INFORMATION

Please provide the following information to the survey team within one hour of Entrance.

Provide specific instructions on where and how surveyors can access the following information in the EHR (or	
1. Infections	
2. Hospitalization	
3. Change of condition	
4. Medications	
5. Diagnoses	

Please provide name and contact information for IT and back-up IT for questions:

IT Name and Contact Info: _____

Back-up IT Name and Contact Info: _____

05/08/2020

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Staff Competencies

- Hand Hygiene
  - Hand washing technique
  - ABHR technique
- Personal Protective Equipment (PPE)
- Transmission-Based Precautions
- Standard Precautions
- Isolation Procedures
- Disinfection Procedures/Techniques
- Linen Handling Procedures
- Food Service/Handling Procedures
- Social Distancing
- Communication & Documentation

- Identification of Signs/Symptoms: Residents and Staff
  - Fever or chills
  - Cough
  - Shortness of breath or difficulty breathing
  - Fatigue
  - Muscle or body aches
  - Headache
  - Sore throat
  - New loss of taste or smell
  - Congestion or runny nose
  - Nausea or vomiting
  - Diarrhea
  - Change in cognition

https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html

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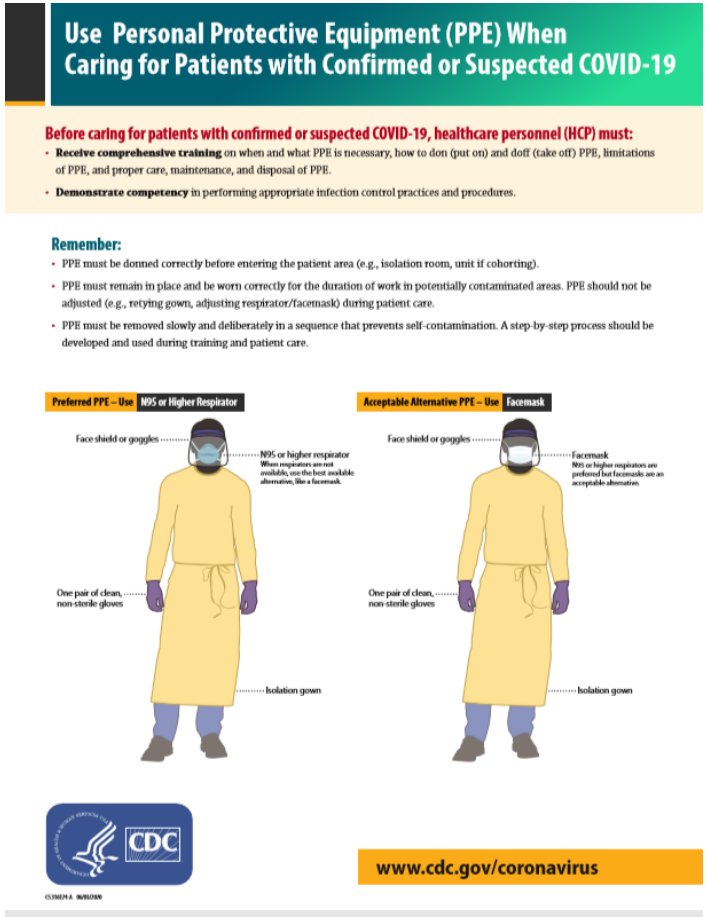
PPE– Donning/Doffing

https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf



Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19

Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must:

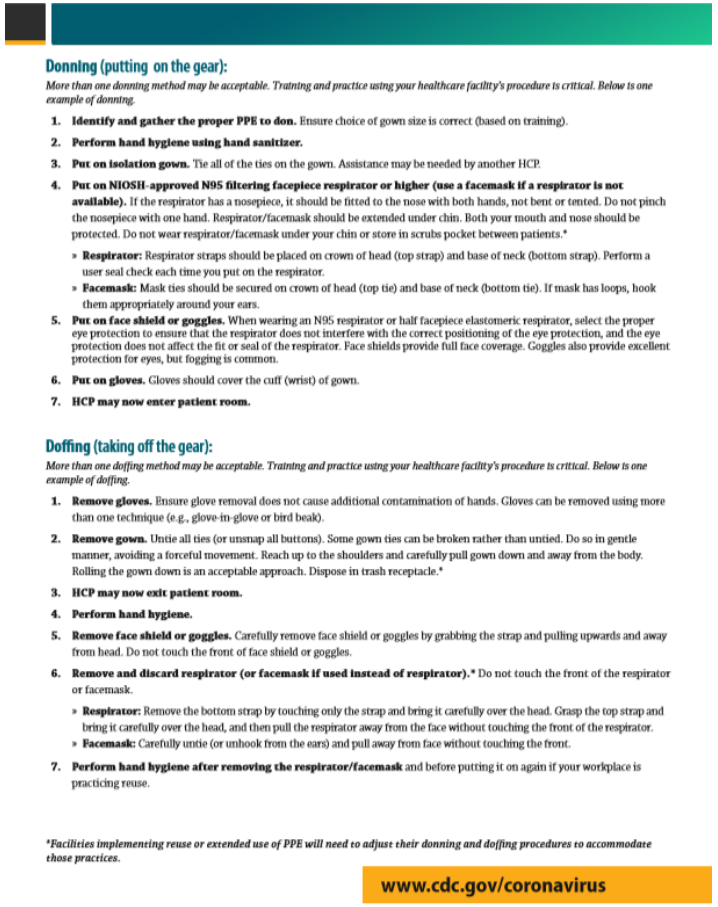
- **Receive comprehensive training** on when and what PPE is necessary, how to don (put on) and doff (take off) PPE, limitations of PPE, and proper care, maintenance, and disposal of PPE.
- **Demonstrate competency** in performing appropriate infection control practices and procedures.

Remember:

- PPE must be donned correctly before entering the patient area (e.g., isolation room, unit if cohorting).
- PPE must remain in place and be worn correctly for the duration of work in potentially contaminated areas. PPE should not be adjusted (e.g., retying gown, adjusting respirator/facemask) during patient care.
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A step-by-step process should be developed and used during training and patient care.

CDC

www.cdc.gov/coronavirus



Donning (putting on the gear):

More than one donning method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of donning.

1. **Identify and gather the proper PPE to don.** Ensure choice of gown size is correct (based on training).
2. **Perform hand hygiene using hand sanitizer.**
3. **Put on isolation gown.** Tie all of the ties on the gown. Assistance may be needed by another HCP.
4. **Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available).** If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both your mouth and nose should be protected. Do not wear respirator/facemask under your chin or store in scrubs pocket between patients.*
   - **Respirator:** Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
   - **Facemask:** Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around your ears.
5. **Put on face shield or goggles.** When wearing an N95 respirator or half facepiece elastomeric respirator, select the proper eye protection to ensure that the respirator does not interfere with the correct positioning of the eye protection, and the eye protection does not affect the fit or seal of the respirator. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
6. **Put on gloves.** Gloves should cover the cuff (wrist) of gown.
7. **HCP may now enter patient room.**

Doffing (taking off the gear):

More than one doffing method may be acceptable. Training and practice using your healthcare facility's procedure is critical. Below is one example of doffing.

1. **Remove gloves.** Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
2. **Remove gown.** Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle.*
3. **HCP may now exit patient room.**
4. **Perform hand hygiene.**
5. **Remove face shield or goggles.** Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
6. **Remove and discard respirator (or facemask if used instead of respirator).*** Do not touch the front of the respirator or facemask.
   - **Respirator:** Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
   - **Facemask:** Carefully untie (or unhook from the ears) and pull away from face without touching the front.
7. **Perform hand hygiene after removing the respirator/facemask** and before putting it on again if your workplace is practicing reuse.

**Facilities implementing reuse or extended use of PPE will need to adjust their donning and doffing procedures to accommodate those practices.*

www.cdc.gov/coronavirus

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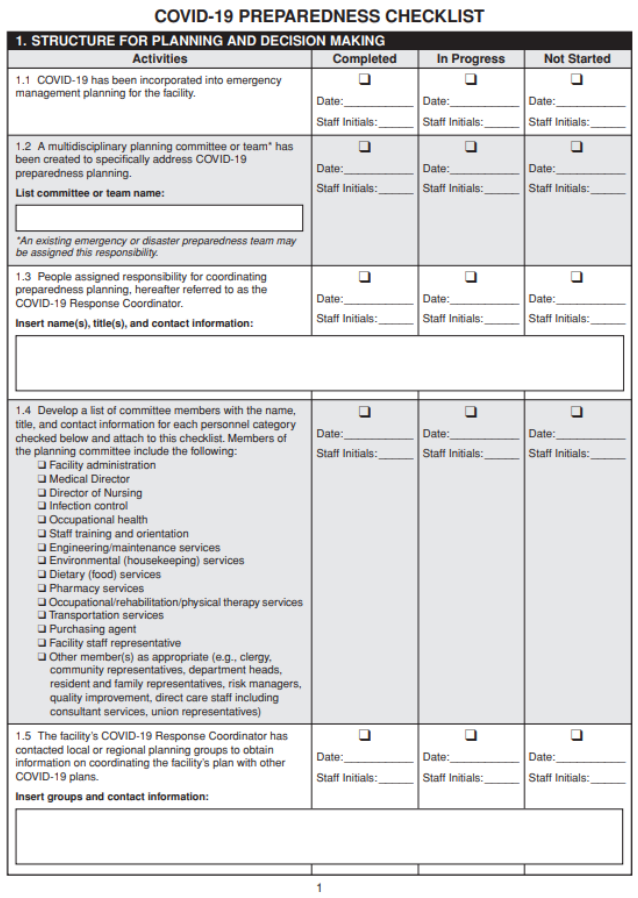
COVID-19 Preparedness Checklist

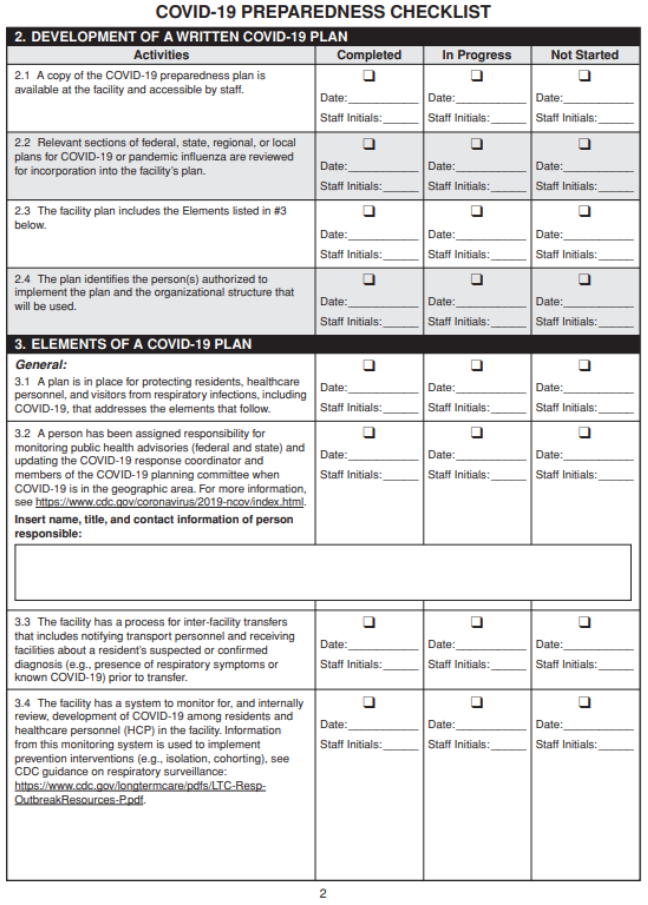


COVID-19 PREPAREDNESS CHECKLIST

1. STRUCTURE FOR PLANNING AND DECISION MAKING			
Activities	**Completed**	**In Progress**	**Not Started**
1.1 COVID-19 has been incorporated into emergency management planning for the facility.	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
1.2 A multidisciplinary planning committee or team* has been created to specifically address COVID-19 preparedness planning. **List committee or team name:** **An existing emergency or disaster preparedness team may be assigned this responsibility.*	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
1.3 People assigned responsibility for coordinating preparedness planning, hereafter referred to as the COVID-19 Response Coordinator. **Insert name(s), title(s), and contact information:**	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
1.4 Develop a list of committee members with the name, title, and contact information for each personnel category checked below and attach to this checklist. Members of the planning committee include the following: ❑ Facility administration ❑ Medical Director ❑ Director of Nursing ❑ Infection control ❑ Occupational health ❑ Staff training and orientation ❑ Engineering/maintenance services ❑ Environmental (housekeeping) services ❑ Dietary (food) services ❑ Pharmacy services ❑ Occupational/rehabilitation/physical therapy services ❑ Transportation services ❑ Purchasing agent ❑ Facility staff representative ❑ Other member(s) as appropriate (e.g., clergy, community representatives, department heads, resident and family representatives, risk managers, quality improvement, direct care staff including consultant services, union representatives)	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
1.5 The facility's COVID-19 Response Coordinator has contacted local or regional planning groups to obtain information on coordinating the facility's plan with other COVID-19 plans. **Insert groups and contact information:**	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____

1

COVID-19 Preparedness Checklist_Briggs Healthcare



COVID-19 PREPAREDNESS CHECKLIST

2. DEVELOPMENT OF A WRITTEN COVID-19 PLAN			
Activities	**Completed**	**In Progress**	**Not Started**
2.1 A copy of the COVID-19 preparedness plan is available at the facility and accessible by staff.	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
2.2 Relevant sections of federal, state, regional, or local plans for COVID-19 or pandemic influenza are reviewed for incorporation into the facility's plan.	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
2.3 The facility plan includes the Elements listed in #3 below.	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
2.4 The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
3. ELEMENTS OF A COVID-19 PLAN			
General: 3.1 A plan is in place for protecting residents, healthcare personnel, and visitors from respiratory infections, including COVID-19, that addresses the elements that follow.	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
3.2 A person has been assigned responsibility for monitoring public health advisories (federal and state) and updating the COVID-19 response coordinator and members of the COVID-19 planning committee when COVID-19 is in the geographic area. For more information, see https://www.cdc.gov/coronavirus/2019-ncov/index.html. **Insert name, title, and contact information of person responsible:**	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
3.3 The facility has a process for inter-facility transfers that includes notifying transport personnel and receiving facilities about a resident's suspected or confirmed diagnosis (e.g., presence of respiratory symptoms or known COVID-19) prior to transfer.	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____
3.4 The facility has a system to monitor for, and internally review, development of COVID-19 among residents and healthcare personnel (HCP) in the facility. Information from this monitoring system is used to implement prevention interventions (e.g., isolation, cohorting), see CDC guidance on respiratory surveillance: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf.	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____	❑ Date:____ Staff Initials:____

2

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Document - everything!

- Staff screening/surveillance – policies/procedures, results, decisions and changes to previous decisions
- Resident screening/surveillance – admissions to facility, symptom assessment & management
- Resident care: strategy decisions & deployment during lockdown & reopening; involvement of Infection Preventionist and your Medical Director
- Resident and staff testing – decisions, policies/procedures
- Communication with families/responsible parties
- Visitation policies/procedures – decisions and changes to previous decisions
- Communication & reports to external agencies – local health department, state agencies, NHSN, CDC
- PPE procurement/all attempts to secure; requisitions
- Staffing contingencies - use of outside/temp agencies (TIP: try to keep up with PBJ submission. Navigating the PBJ Chaos_On-Demand Webinar)
- Plans for resident location – cohorting; separate units; transfer & discharge
- Education of staff, residents, families, allowed visitors, consultants, business associates
- Financial tracking – cost reporting; receipt & use of stimulus payments; grants; loans
- Waiver utilization – state & Federal

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Keep/Retain

- Copies of all regulations – local, state and Federal; OSHA; CDC
- All documentation from previous slide
- Meetings – QAPI, crisis management, policy/procedure changes
- Emails & correspondence re: PHE
- Tools used during PHE – i.e., COVID-19 Preparedness Checklist, surveillance, screening

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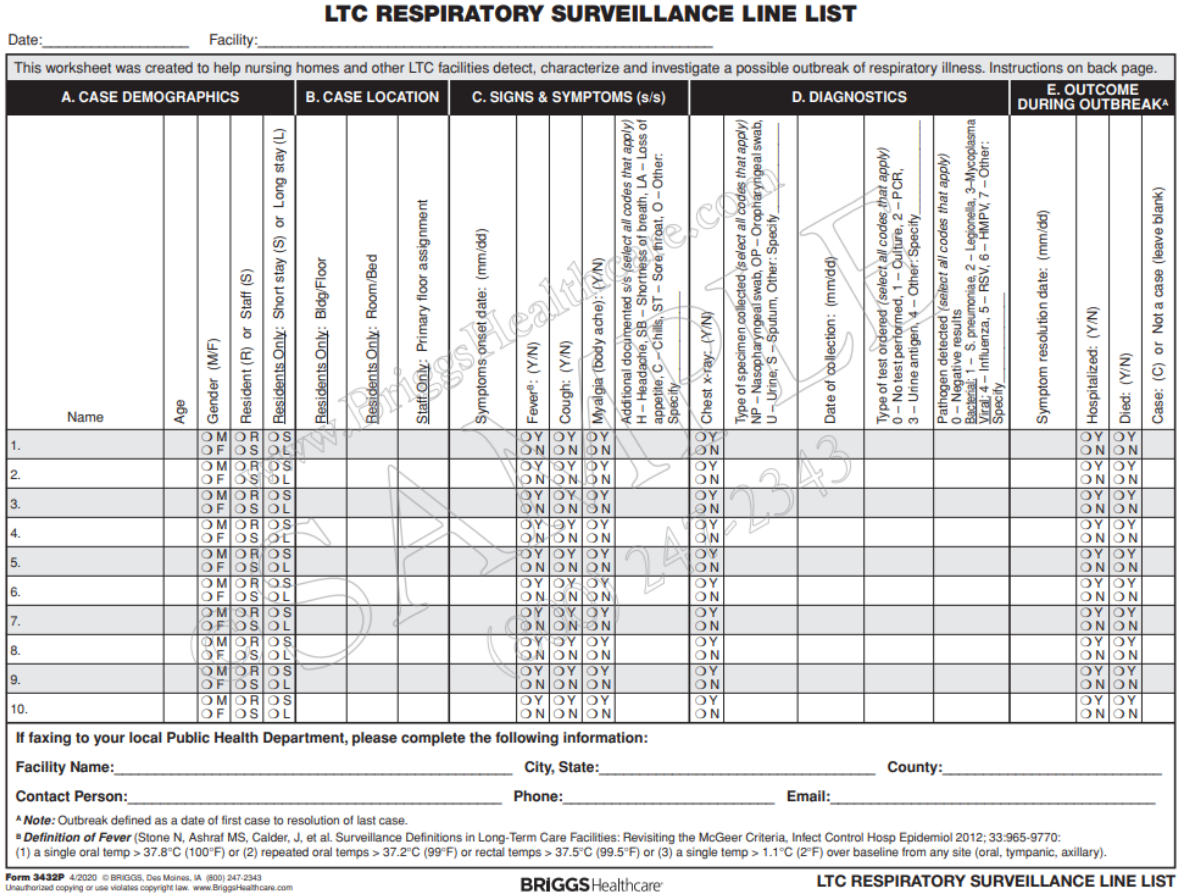
Surveillance

https://www.briggshealthcare.com/LTC-Respiratory-Surveillance-Line-List

https://www.briggshealthcare.com/LTC-Respiratory-Surveillance-Line-List-DIGITAL-FORM



LTC RESPIRATORY SURVEILLANCE LINE LIST

Date:_____ Facility:_____

This worksheet was created to help nursing homes and other LTC facilities detect, characterize and investigate a possible outbreak of respiratory illness. Instructions on back page.

A. CASE DEMOGRAPHICS					B. CASE LOCATION			C. SIGNS & SYMPTOMS (s/s)					D. DIAGNOSTICS					E. OUTCOME DURING OUTBREAK[A]			
Name	Age	Gender (M/F)	Resident (R) or Staff (S)	Residents Only: Short stay (S) or Long stay (L)	Residents Only: Bldg/Floor	Residents Only: Room/Bed	Staff Only: Primary floor assignment	Symptoms onset date: (mm/dd)	Fever[B]: (Y/N)	Cough: (Y/N)	Myalgia (body ache): (Y/N)	Additional documented s/s (select all codes that apply) H – Headache, SB – Shortness of breath, LA – Loss of appetite, C – Chills, ST – Sore throat, O – Other: Specify_____	Chest x-ray: (Y/N)	Type of specimen collected (select all codes that apply) NP – Nasopharyngeal swab, OP – Oropharyngeal swab, U – Urine, S – Sputum, Other: Specify_____	Date of collection: (mm/dd)	Type of test ordered (select all codes that apply) 0 – No test performed, 1 – Culture, 2 – PCR, 3 – Urine antigen, 4 – Other: Specify_____	Pathogen detected (select all codes that apply) 0 – Negative results Bacterial: 1 – S. pneumoniae, 2 – Legionella, 3–Mycoplasma Viral: 4 – Influenza, 5 – RSV, 6 – HMPV, 7 – Other: Specify_____	Symptom resolution date: (mm/dd)	Hospitalized: (Y/N)	Died: (Y/N)	Case: (C) or Not a case (leave blank)
1.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	
2.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	
3.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	
4.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	
5.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	
6.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	
7.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	
8.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	
9.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	
10.		○M ○F	○R ○S	○S ○L					○Y ○N	○Y ○N	○Y ○N		○Y ○N						○Y ○N	○Y ○N	

If faxing to your local Public Health Department, please complete the following information:

Facility Name:_____ **City, State:**_____ **County:**_____

Contact Person:_____ **Phone:**_____ **Email:**_____

[A] ***Note:*** Outbreak defined as a date of first case to resolution of last case.

[B] ***Definition of Fever*** (Stone N, Ashraf MS, Calder, J, et al. Surveillance Definitions in Long-Term Care Facilities: Revisiting the McGeer Criteria, Infect Control Hosp Epidemiol 2012; 33:965-9770: (1) a single oral temp > 37.8°C (100°F) or (2) repeated oral temps > 37.2°C (99°F) or rectal temps > 37.5°C (99.5°F) or (3) a single temp > 1.1°C (2°F) over baseline from any site (oral, tympanic, axillary).

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LTC RESPIRATORY SURVEILLANCE LINE LIST

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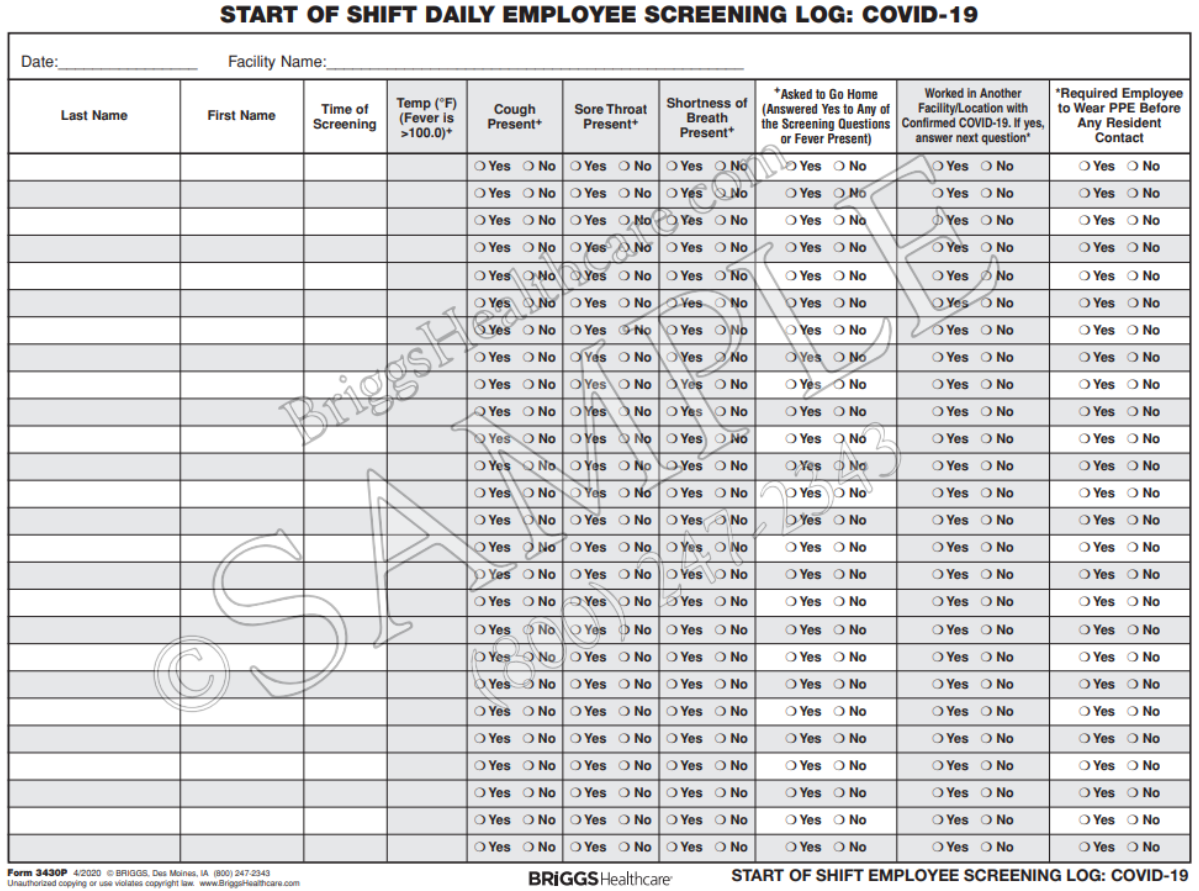
Staff Screening

https://www.briggshealthcare.com/Start-of-Shift-Daily-Employee-Screening-Log-COVID-19

https://www.briggshealthcare.com/Start-of-Shift-Daily-Employee-Screening-Log-COVID-19-DIGITAL-FORM



START OF SHIFT DAILY EMPLOYEE SCREENING LOG: COVID-19

Date:_____ Facility Name:_____

Last Name	First Name	Time of Screening	Temp (°F) (Fever is >100.0)+	Cough Present+	Sore Throat Present+	Shortness of Breath Present+	*Asked to Go Home (Answered Yes to Any of the Screening Questions or Fever Present)	Worked in Another Facility/Location with Confirmed COVID-19. If yes, answer next question*	*Required Employee to Wear PPE Before Any Resident Contact
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
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				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
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				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No
				❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No	❍ Yes ❍ No

BRIGGS Healthcare START OF SHIFT EMPLOYEE SCREENING LOG: COVID-19

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Resources

- COVID-19 Resources Website
- .zip file provided along with today's presentation handout (download)
- Hyperlinks provided on presentation slides
- Survey Guide - Interpretive Guidelines for Long-Term Care_Briggs Healthcare or Survey Guide – Interpretive Guidelines for Long-Term Care - eManual
- CMS_Guidance for Laws and Regulations-Nursing Homes
- Briggs Healthcare Blog
- CMS Podcasts and Transcripts

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