Infection prevention

What your skilled nursing facility needs to do NOW
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/
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
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%)

[Graph showing reported cases by state and age group]

[Table showing number of cases by age group]

# 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.

<table>
<thead>
<tr>
<th>KEY FINDINGS</th>
<th>DAVID GRABOWSKI, PHD</th>
<th>VINCENT MOR, PHD</th>
<th>R. TAMARA KONETZKA, PHD</th>
</tr>
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<tbody>
<tr>
<td>LOCATION OF FACILITY DETERMINED OUTBREAKS</td>
<td><em>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.</em> ¹</td>
<td>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</td>
<td>“Outbreaks of COVID-19 in nursing homes are often a signal of the communities into which the virus is spreading.” ¹</td>
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<td>ASYMPTOMATIC SPREAD AND LACK OF TESTING WAS A KEY FACTOR</td>
<td>Grabowski: “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.”</td>
<td>“COVID-19’s ability to hide in plain sight will continue to crush expectations of halting its spread unless more and quicker testing of nursing homes sweep the country, said a top U.S. researcher (Mor).” ³</td>
<td>“Given asymptomatic sneeze and inadequate testing, staff often do not know which residents are infected. With policymakers and the public initially focusing on the spread of infection within hospital settings, nursing homes often lost that competition.” ⁴</td>
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<td>QUALITY RATING OF FACILITY WAS NOT A FACTOR IN OUTBREAKS</td>
<td>“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</td>
<td>“He (Mor) added that counter to some assumptions, regression analyses allow that infection rates are unrelated to quality rankings...” ⁵</td>
<td>“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</td>
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<td>NO SIGNIFICANT DIFFERENCE BETWEEN FOR-OR NOT-FOR-PROFITS IN OUTBREAKS</td>
<td>“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</td>
<td>N/A</td>
<td>“We found no significant difference 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</td>
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³ Provider: Medicare ⁵ Provider: Mor ⁴ Testimony to United States Senate Special Committee on Aging, 5/7/20
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.
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.
**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.
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 within 45-days to demonstrate compliance with Infection Control deficiencies.*
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.
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 Admission 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 Admission 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).
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 with 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.
## Scope & Severity

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

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
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.
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.
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
Reporting Frequency

**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.

**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.
COVID-19 Module for LTCF: Pathways

Four Pathways for Reporting

1. Resident Impact and Facility Capacity
2. Staff and Personnel Impact
3. Supplies and Personal Protective Equipment
4. Ventilator Capacity and Supplies

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## Nursing Home COVID-19 Data

<table>
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<tr>
<th>State</th>
<th>Total Nursing Home Residents</th>
<th>Resident Cases</th>
<th>Total Nursing Home COVID-19 Deaths</th>
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</table>

**Source:** CDC National Healthcare Safety Network (NHSN). This data reflects data entered into the NHSN system by nursing homes as of May 24.

Additional background: This data reflects reconciled survey information entered into the NHSN system by State Survey Agencies. It represents complete surveys and those where a survey has lagged several hours, but not yet completed surveys, as of May 24. The lag is of between 60-91 days until the findings from these surveys are generated.

Limitations on 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 report cumulative data prospectively 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 high because this reflects the data that occurred over a longer period of time (i.e., through January 1, 2020, rather than the last seven days).

The availability of testing may impact the number of confirmed COVID-19 cases if 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, as asymptomatic cases can vary by state, region, or facility, data may differ in states with different testing and reporting data, particularly state dash data.

### 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.

<table>
<thead>
<tr>
<th>Offsite Survey Activity</th>
<th>Onsite Survey Activity</th>
<th>Facility Self-Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>- 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.</td>
<td>- Limit the onsite team to one to two surveyors.</td>
<td>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.</td>
</tr>
<tr>
<td>- Ensure surveyors are medically cleared, and have personal protective equipment (PPE) that could be required onsite.</td>
<td>- Identify and prioritize onsite assignments for activities, such as: 1. Resident Care Observations: a. Hand hygiene practices b. Proper use/discard of PPE c. Cleansing medical equipment d. Effective Transmission-Based Precautions Environmental observations: a. Signage at entrances and resident rooms b. Screening (staff at shift change, entrance, limiting nonessential staff) c. Hand hygiene stations Interviews with relevant staff: a. Policy/Procedure knowledge b. Surveillance for signs/symptoms c. Notifying local health officials d. Information provided to residents, their representatives, and families concerning COVID-19 activity in the facility</td>
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<tr>
<td>- Conduct offsite planning to limit interruptions to care while onsite. Obtain information on: a. Facility-reported information; b. CDC, state/local public health reports; c. Available hospital information regarding patients transferred to the hospital; and/or d. Complaint allegations.</td>
<td>- First onset of symptoms Communication to facility leaders and health officials 1. Resident, representatives and families (if feasible, otherwise conduct onsite)</td>
<td></td>
</tr>
<tr>
<td>- Identify survey activities that will be conducted offsite, such as: a. Medical record review b. Telephonic interviews, such as: i. Surveillance policies ii. First onset of symptoms iii. Communication to facility leaders and health officials iv. Resident, representatives and families (if feasible, otherwise conduct onsite) v. Policy/Procedure Review vi. Infect. Control/Prev. Plan vii. Emerg. Prep. Plan, including contingency strategies (e.g., staffing) viii. Review communication(s) to residents, representatives and families (e.g., newsletter, etc)</td>
<td>- Conduct survey exit discussion telephonically and draft the CMS-2567 offsite.</td>
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</table>
COVID-19 FOCUSED SURVEY FOR NURSING HOMES

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 OSIO memos released at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-State-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 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 in accordance with the existing guidance in Appendix P 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 (TPBs)

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 a 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.phf.gov/PreparednessPlanning/toppages/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 PPE 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/engineering/AGP-controls.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

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, mucus membranes, or non-intact skin;
  - Gloves are removed after contact with blood or body fluids, mucus 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 uncontrolled 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?
COVID-19 FOCUSED SURVEY FOR NURSING HOMES

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

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?
# COVID-19 Focused Survey for Nursing Homes

## 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?  
- Yes  
- No F880

- 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?  
- Yes  
- No F880

- Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.

## 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 offer 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?

6. 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 F880
COVID-19 FOCUSED SURVEY FOR NURSING HOMES

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

   □ 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; 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-pwaivers.
Survey Entrance Information Needed

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. Sign announcing the survey that is 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 contact 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 EHR outside the conference room. Please complete the attachment on page 7 which is titled “Electronic Health Record Information.”

11. Explain the goal is to conduct as much record review efforts as possible to limit potential exposure or transmission. Determine what information can be reviewed offline, such as electronic medical records (EMRs), or other records and policies procedures. If offline review of EMRs is not possible, surveyors will request photographs 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 the Surveillance Plan.
   - Emergency Preparedness Policy and Procedure to include Emergency Staffing Strategies

NOTE: A comprehensive review of policies should be completed offsite.

13. The facility (mechanically) 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 representative, and families informing them of how to obtain updates.

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

01/08/2020
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

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

Remember:
- PPE must be donned correctly before entering the patient area (e.g., isolation rooms, ward if患病).
- 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., after-gowning, adjusting(respresentative) during patient care
- PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A simple step-by-step process should be
developed and used during training and patient care.

Donning (putting on the day)

1. Identify and gather the proper PPE to don. Identify type of gown to don (based on setting).
2. Perform hand hygiene using hand sanitizer.
3. Use non-latex gloves. For all of the non-tipped gloves, resistance may be needed for another PIP.
4. Put on N95-mask approved N95 respirator or N95 respiratory mask if not available. If the N95 respirator has a face, it should be donned in the order with face masks, not vice versa, or either. Use the face
   - Donning: Respirator should be placed on a crown of hand (top strap) and base of each (bottom strap). Perform a
   - mask and adjust it to fit on the face.
   - PPE may vary with different treatment settings.

5. Place face shield or goggles. When working in N95 respirator or half facepiece elastomeric respirator, select the proper protection as
   - The equipment does not interfere with the correct positioning of the eye protection, and the eye
   - protection does not affect the fit of the respirator. Face shields provide full face coverage. Goggles also provide excellent
   - protection with N95 respirators.

6. PPE may vary with different treatment settings.

7. PPE must be removed slowly and deliberately in a sequence that prevents self-contamination. A simple step-by-step process
   - Donning (taking off the day)

1. Remove gown. Expose one shoulder, then remove additional contaminated areas. Gloves can be removed using
   - Know the donning of the equipment.
   - Do not touch the front of the respirator
   - Respirator has a face, it should be donned in the order with face masks, not vice versa, or either. Use the face
   - We recommend the use of four straps to secure the respirator over the head. Grasp the top strap and
   - Do not touch the front of the respirator
   - Respirator: Carefully make an opening from the main to the face without touching the face of the respirator.

2. Perform hand hygiene after removing the respirator/face mask and before putting in another workplace in

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COVID-19 Preparedness Checklist

COVID-19 Preparedness Checklist_Briggs Healthcare

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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
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
# LTC Respiratory Surveillance Line List

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**A. Case Demographics**

<table>
<thead>
<tr>
<th>Case ID</th>
<th>First Name</th>
<th>Last Name</th>
<th>Date of Birth</th>
<th>Gender</th>
<th>Race</th>
<th>Address Line 1</th>
<th>Address Line 2</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>John</td>
<td>Smith</td>
<td>01/01/1980</td>
<td>Male</td>
<td>White</td>
<td>123 Main St.</td>
<td>Apt 4L</td>
<td>New York</td>
<td>NY</td>
<td>12345</td>
</tr>
<tr>
<td>2</td>
<td>Jane</td>
<td>Brown</td>
<td>02/02/1981</td>
<td>Female</td>
<td>Black</td>
<td>456 Oak St.</td>
<td>Apt 2F</td>
<td>Boston</td>
<td>MA</td>
<td>02110</td>
</tr>
</tbody>
</table>

**B. Case Location**

<table>
<thead>
<tr>
<th>Location Type</th>
<th>Type of Location</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nursing Home</td>
<td>Private Nursing Home</td>
<td>Health Care Facility</td>
</tr>
<tr>
<td>Hospital</td>
<td>Acute Care Hospital</td>
<td>Emergency Room</td>
</tr>
</tbody>
</table>

**C. Signs & Symptoms**

- [ ] Fever (>100°F) or cough
- [ ] Shortness of breath
- [ ] Tachypnea
- [ ] Changes in mental status
- [ ] Diabetic symptoms
- [ ] Asthma symptoms

**D. Diagnostics**

<table>
<thead>
<tr>
<th>Diagnostic Code</th>
<th>Description</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>12345</td>
<td>Blood Test</td>
<td>Normal</td>
</tr>
<tr>
<td>67890</td>
<td>Chest X-Ray</td>
<td>Clear</td>
</tr>
<tr>
<td>1122333</td>
<td>CT Scan</td>
<td>Normal</td>
</tr>
</tbody>
</table>

**E. Outcome During Outbreak**

- [ ] Discharged
- [ ] Died
- [ ] Transferred
- [ ] Other (Specify) |

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

- Facility Name:
- City, State:
- County:

Contact Person: ____________________________
- Phone: ____________________________
- Email: ____________________________

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

**Definition of Fever**

- Oral: 100.4°F (38°C)
- Axillary: 100°F (38°C)
- Rectal: 100.1°F (38°C)

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Staff Screening


**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