Indiana State Department of Health
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Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

April 2, 2020

The Indiana State Department of Health has created a COVID-19 toolkit for Long-Term Care Facility Staff.

The toolkit includes:

- COVID-19 LTC Facility Infection Control Guidance SOP
- COVID-19 Guidance for Hospital Discharge to Long-Term Care Facilities (new)
- Infection Control Steps when you have a Healthcare Worker (HCW) or Resident Test Positive of COVID-19
- Letter from Dr. Kristina Box – recommendations regarding use of masks by direct care providers
- COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings – CDC
- Long Term Care (LTC) Respiratory Surveillance Line List
- Long Term Care (LTC) Respiratory Surveillance Outbreak Summary
- COVID-19 Guidance for Healthcare Workers
- Guidance for out-of-hospital mitigation strategies
- Guidance for out-of-hospital facilities
- Centers for Medicare & Medicaid Services (CMS) – QSO-20-20-All- Prioritization of Survey Activities
- COVID-19 Focused Survey for Nursing Homes
- COVID-19 Focused Infection Control Survey: Acute and Continuing Care
- Nursing Home Infection Prevention Assessment Tool for COVID-19
- Visitor Alert Sign – English & Spanish
- COVID-19 Specimen Collection and Submission Guidelines
- LTC Newsletter subscription form

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COVID-19 LTC Facility Infection Control Guidance SOP

Updated 3/27/2020

1. All LTC facilities who have not already done so, need to use this CDC checklist to prevent the spread of coronavirus in their facilities. https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf

2. All LTC facilities should use this sheet to track their infection control activities and to track employees and patients with respiratory illness. https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf

3. All LTC facilities should have a plan to rapidly implement, or implement now, how they will cohort confirmed or presumed COVID-19 patients in their facilities. This can be by wing, floor, or if available, by building. This should be done with expediency.

4. All LTC facilities should limit patient contact to only essential direct care providers (Nurse, CNA, QMA, Hospice, EMS etc.)- https://www.in.gov/coronavirus/files/IN_COVID-19_out_of_hospital_03.18.2020.pdf

5. Once you have access to EMResource, every facility needs to update its status daily. This information is critically important for tracking PPE needs.

6. All LTC facilities should require those involved in direct patient care to wear a mask during their entire shift. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html
    - If national and local supplies are at conventional capacity then all staff in LTC facilities should wear a facemask per standard recommendations.
    - If national and local supplies are at contingency levels, only direct care staff should wear a mask and they should use one mask per shift. -
    - If national and local supplies are scarce <1 week supply then only direct care staff should wear a mask and they should use the same mask for multiple days
    - If national and local supplies are at crisis capacity then direct patient care staff should wear a mask if available. If masks are not available, they should use alternative methods to cover their mouth and nose and decrease respiratory droplet spread.

7. All LTC facilities need to have updated lists of all residents' code status. Plans should be in place for how to provide hospice and comfort care to those patients with DNR orders who develop critical symptoms from COVID-19.

8. ISDH has a team available to come into facilities to rapidly test residents and staff who are suspected of having COVID-19. If your facilities have patients or providers who are symptomatic and need to be tested, please send an email to striketeamrequest@isdh.in.gov

9. If you would like to discuss COVID-19 prevention such as PPE donning and doffing, please contact Casey Cummins, COVID-19 Outbreak Response Chief Nurse Consultant, at 317-954-2591 or ccummins@isdh.in.gov.

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Infection Control Steps when you have a Health Care Worker (HCW) or Resident Test Positive for COVID-19

1. Immediately place all residents that have tested positive for COVID-19 in **Contact-Droplet Precautions** in a single room and limit movement around the building, including memory care units to the degree that is possible.
   a. Facilities should follow the CDC guidelines for health care workers and positive protective equipment: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html
   b. Place a sign on the door indicating **Droplet- Contact Precautions**.
   c. Single resident room placement to minimize exposures and adherence to PPE and HH compliance.
   d. Minimize resident's movement around the building- confined to room or as in memory care consider placement in single room with dedicated staff to care for this resident.
   e. Cohort staff and equipment for COVID-19 residents to minimize transmission in the building

2. **Mask** all HCW that are ill and remove from duty

3. **Mask** all direct care staff and conserve PPE as directed

4. Increase **Hand Hygiene** with all staff in the building.

5. Assure HH ABHR at point of care for all HCW and hand washing after contact with COVID- 19 resident care.

6. Increase **Environmental cleaning on all high touch surfaces** in building with approved disinfectants
   a. Cleaning and Disinfection: Follow CDC cleaning and disinfection guidance for EVS personnel with proper PPE for cleaning COVID-19 rooms https://www.cdc.gov/coronavirus/2019-ncov/prepare/cleaning-disinfection.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Fcommunity%2Fhome%2Fcleaning-disinfection.html
   b. Use approved Cleaning agents from List N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
   c. For shortage of approved disinfecting solutions: consider the following
      - Use of resident dedicated glucometers
      - Bleach 1:10 mixture (must be changed and remixed every 24 hours) which is 1 ½ cups of bleach per gallon.

7. **HCW scrubs** should be changed into street clothes each day before leaving facility.
   a. HCW should perform hand washing upon entry to the building before work and prior to exit after changing into street cloths.
   b. HCW should refrain from wearing scrubs home or the next day without being laundered, this includes jackets.

8. **Glove Hygiene:** Use non-sterile gloves upon entry into the resident room for direct care area.
    a. Change gloves if they become torn or heavily contaminated.
    b. Remove and discard gloves when leaving the resident room or care area
    c. Immediately perform hand hygiene after removal of gloves.

9. **Gown Conservation**: If there are shortages of gowns, they should be prioritized for:
    - aerosol-generating procedures should
    - care activities where splashes and sprays are anticipated
    - High-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP. Examples include:
        - dressing
        - bathing/showering
        - providing hygiene
        - changing briefs or assisting with toileting
        - changing linens
        - wound care
        - transferring
        - device care or use

10. **Preservation of protective eyewear/goggles or face shield:**
    a. Do not touch eye or face protection during use.
    b. Hand hygiene must be performed before and after donning and doffing eye or face protection.

11. **Equipment Dedicated to Resident Rooms:**
    a. Isolation carts or bins outside or each room for don and doffing
    b. Trash cans for doffing beside each isolation cart
    c. Cohort supplies, do not share room to room
    d. Use disposable or single B/P cuff and stethoscopes/ no mobile units
    e. Use Pitchers for each resident and disposable cups
        - Do not use ice coolers to take room to room for filling cups
    f. Single use B/P O2 Sat per resident as much as possible
    g. Single use bedpans or bathroom supplies for all residents

12. **Visitors and Community dining:**
    a. Restrict all visitation except for certain compassionate care situations, such as end of life situations.
    b. Restrict all volunteers and non-essential healthcare personnel (HCP), including non-essential healthcare personnel (e.g., barbers).
    c. Cancel all group activities and communal dining.

13. **Routine testing:**
    a. Consider unnecessary testing for routine labs, chest X-rays, across your facility during this outbreak.
    b. Consider changing aerosolizing treatments moving to metered dose inhalers during this outbreak, especially when N95 is not available.

We will continue to work closely with you on behalf of the safety of your residents and staff at this unprecedented time.

Date	Summary of Changes
3/27/2020	• Reviewed and updated all external links • Added page numbers • Updated contact information for strike team #8, p.1

Indiana State Department of Health
Epidemiology Resource Center

COVID-19 Guidance for Hospital Discharge to Long-Term Care Facilities

PURPOSE

This guidance is consistent with the recommendations of the Centers for Disease Control and Prevention (CDC) and was done in collaboration with Indiana's hospital and long-term care organizations. The purpose of this document is to provide guidance to long-term care facilities (LTCFs), including nursing facilities and skilled nursing facilities, about discharging, admitting, and readmitting a resident from a hospital who has presumed or confirmed COVID-19. This guidance is based on currently available information about COVID-19 and will be refined and updated as more information becomes available and response needs change in Indiana.

BACKGROUND

Due to the COVID-19 pandemic, the healthcare system as a whole is expected to experience increased patient volumes and limited availability of beds and personal protective equipment (PPE) supplies. Both hospitals and long-term care facilities (LTCFs) will have to expand the care for their patients and residents. To create and maintain the hospital capacity needed to continue to serve those who need emergency and intensive care during the COVID-19 outbreak, it is critical that there is a safe and expedient way for currently-hospitalized presumed or confirmed COVID-19 positive patients who no longer have a need for acute hospital care to transition to LTCFs. By working together, hospitals and LTCFs will be able to deliver the best care possible during the COVID-19 pandemic.

LOCAL AGREEMENTS

Local LTCFs and hospitals may collaborate to create their own transfer policies, which may require frequent adjustment based on local conditions. This can be done if local conditions warrant based on hospital resources (e.g., PPE, staffing, and bed occupancy), the care needs of the patients and LTCF resources (e.g. facility capacity for isolation and non-isolation care, PPE and staffing).

EMERGENCY DEPARTMENT AND HOSPITAL TRANSFERS

The coronavirus pandemic has heightened the need for accurate and timely communication between LTCFs and emergency departments (ED) for transfer of patients between both settings. Residents should **not** be sent to the hospital for COVID-19 testing alone. If LTCFs have residents or staff who they suspect have COVID-19, ISDH will work with them to determine if a strike force testing team is warranted. Requests can be sent to: Striketeamrequest@isdh.in.gov.

Transfers of a presumed or confirmed COVID-19 LTCF resident to an ED should be based on:

- The resident's medical needs determined by the LTCF clinical staff and attending physician;
- The LTCF's ability to provide the resident's medical care at the LTCF; and
- The patient's goals of care, including advance directives and decision for hospitalization.

The LTCF must accurately and timely communicate with EMS and the hospital on the transfer of a presumed or confirmed COVID-19 LTCF resident to a hospital. The hospital must accurately and timely communicate with EMS and the LTCF on the transfer of a presumed or confirmed COVID-19 LTCF resident to a LTCF.

COVID-19 Guidance for Hospital Discharge to Long-Term Care Facilities

ADMISSION/RE-ADMISSION TO AN LTCF

Meeting criteria for discontinuation of Transmission-Based Precautions is not a prerequisite for hospital discharge. **LTCFs are expected to accommodate hospital discharges of patients regardless of their COVID-19 status. However, local conditions will vary with LTCF capacities to care for presumed or confirmed COVID-19 patients. Hospitals and LTCFs must communicate about resource availability prior to admission/readmission to provide patient care while reducing risk of virus spread.**

The following protocols are recommended based on patient clinical status and COVID-19 testing. The determination of clinical concern for COVID-19 is to be made by the receiving facility in consultation with local clinical staff at the transferring facility. We encourage mutual communication with local hospitals, local health departments and the Indiana State Department of Health (ISDH) about their ability to meet these needs.

1. **Category 1: Patients for whom there is no clinical concern for COVID-19 (e.g., no fever, no new cough and no shortness of breath)**:
   These patients are acceptable for transfer to LTCF facility without COVID-19 testing. If requested, the hospital and ER staff should provide the basis for not testing.

2. **Category 2: Patients for whom there is clinical concern for COVID-19, but negative testing**:
   If patients have negative COVID-19 testing during hospitalization, then they are acceptable for transfer to LTCFs. If testing is not in accordance with Centers for Disease Control and Prevention's (CDC's) test-based strategy for discontinuation of transmission-based precautions, then such precautions should continue after transfer per CDC's non-test based strategy.

3. **Category 3: Patients for whom there is clinical concern for COVID-19, and test results are pending**:
   The patients will **not** be transferred to an LTCF facility until test results are confirmed. To ensure that test results are completed in a timely fashion, testing should be done in coordination with the ISDH (e.g., collected specimens may need to be couriered to ISDH lab).

   If testing is not in accordance with CDC's test-based strategy for discontinuation of transmission-based precautions, then such precautions should continue after transfer per CDC's non-test based strategy. During surge capacity in an ISDH defined regions, stable patients may need to be transferred to LTCFs with COVID-19 test results pending, but remain on transmission-based precautions.

4. **Category 4: Patients positive for COVID-19, but for whom transmission-based precautions have been discontinued**:
   Criteria for discharge includes the patient meeting the CDC non-test based strategy for discontinuing transmission based precautions: the patient has been afebrile for at least 3 days (72 hours) without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**, at least 7 days have passed since COVID-19 symptoms first appeared.

COVID-19 patients for whom transmission-based precautions have been discontinued and whose symptoms have resolved may be transferred without restrictions.

5. **Category 5: Patients positive for COVID-19 and for whom transmission-based precautions are still required:**

   A patient actively infected with COVID-19 but deemed ready for discharge by the hospital may be transferred to an adequately-prepared facility. This includes the LTCFs being able to cohort patients and have appropriate infection control measures in place. (e.g. facility capacity for isolation and non-isolation care, PPE and staffing).

   As outlined by ISDH and CDC, LTCFs can cohort residents by the creation of separate wings, units, floors, or building according to their COVID-19 status. These separated units should be clearly marked. LTCFs are strongly encouraged to install engineering controls in these units to reduce or eliminate exposures, including physical barriers or partitions to guide residents through triage areas and curtains between patients in shared areas.

   LTCFs that need support to meet this criteria prior to admitting or readmitting a resident will, if requested and ISDH resources allow, be contacted by a nurse surveyor response team who can provide virtual and/or onsite consultation to assist LTCFs and their staff with implementation of their plans to mitigate infection spread and can provide staff training.

In addition, ISDH, through local health departments, will supply PPE when available. It is critical that LTCFs continue updating their information in EMResource and practice conservation and re-use of current PPE supplies. To request the need for testing or COVID-19 prevention strategies, such as PPE donning and doffing at LTCFs, LTCFs should email ISDH at Striketeamrequest@isdh.in.gov.

Category 1 NO COVID Concern	Category 2 Clinical concern; (-) test results	Category 3 Clinical concern and pending test results	Category 4 COVID (+) patients and TBPs discontinued	COVID (+) patients and TBPs still required
•Acceptable to return via standard process	•Acceptable to return via standard process. Transmission-based precautions may be needed under CDC's non-test-based strategy.	•**NO** transfer until test results completed. Transmission-based precautions may be needed under CDC's non-test-based strategy but may be reevaluated during surge conditons.	•Acceptable to return via standard process after completion of CDC's non-test-based strategy to end transmission-based precautions.	•Must be discharged to a facility prepared to isolate and manage patient, or place with cohorted residents of same status

ADDITIONAL INFORMATION

The ISDH call center for healthcare providers and members of the public who have concerns about COVID-19 is available 24/7 toll-free at 877-826-0011.

Additional information and resources for COVID-19 are available at the links below.

- CDC COVID-19 webpage: https://www.cdc.gov/coronavirus
- ISDH COVID-19 webpage: https://in.gov/coronavirus

Indiana State Department of Health
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Eric J. Holcomb
Governor

Kristina Box, MD, FACOG
State Health Commissioner

March 23, 2020

Dear Long-Term Care Facility Director:

The Indiana State Department of Health (ISDH) is working to protect Hoosiers during the COVID-19 pandemic. To help protect vulnerable seniors, ISDH recommends masks be worn by direct care providers in nursing homes.

Direct Care providers should wear masks while in facility: There is emerging evidence that many persons with COVID-19 may only have mild symptoms or no symptoms at all. These persons, however, can still be infectious. To prevent the spread of COVID-19 in your facilities among providers with no or mild symptoms, we recommend the following:

- Only essential providers should come in direct contact with patients.
- Those essential providers should wear a surgical mask for the duration of their shifts. Masks should be conserved and only a single mask should be worn by staff each shift.
- Limit patient access to only those proving direct medical care (e.g., Nurses, QNA, QMAs, Hospice, EMS)
- Those staff who do not provide direct care (e.g., housekeeping, meal delivery, maintenance) should not, if possible enter patients' rooms.
- Cohort confirmed or presumed COVID-19 positive patients.
- Cohort, if possible, direct care providers caring for confirmed or presumed COVID-19 patients into one area of the building
- Other strategies to decrease spread can be found here: https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf

Why are we making this recommendation: While the most common symptoms reported in persons with coronavirus are fever and cough, there is emerging evidence that many persons can have the infection with few if any symptoms. Despite having a mild clinical course, these persons can still be infectious. In addition, persons may be infectious days before their symptoms begin. This is why social distancing works in the community. Decreasing the number of mildly ill, or asymptomatic, infectious persons that come in contact with the elderly and vulnerable populations can be done by keeping everyone in their home and 6 feet apart. Obviously, that cannot happen in a skilled nursing facility. Persons need to come into contact with the residents for their care and wellbeing. This is why we recommend that all direct care providers in skilled nursing and rehab facilitated wear a mask.

Limit resident contact to only direct care providers: We recognize that no definition can adequately capture all those who might need to come into direct contact with a resident. A suggested list, however, includes the following:

- Nurses
- Certified Nurse Assistants (CNAs)
- Qualified Medical Assistants (QMAs)
- Paramedics
- Hospice staff

Although we are continually working on increasing access to PPE, it is currently limited. Because of this, facilities should decrease the number of staff who come into direct contact with residents. This may require, for instance, limiting administrative, housekeeping, meal delivery, and other, staff from going into patients' rooms. We recommend facilities develop processes that allow them to continue their operations, but restrict direct patient contact to only those involved in medical care.

Conserving PPE: Unfortunately supplies of PPE are currently limited. This is why many cities in the US, and around the world, are taking unprecedented steps to reduce PPE usage. As we stated above, the best way to reduce transmission within a facility is to decrease provider to patient transmission. An important step in doing this is preventing residents from coming into contact with respiratory droplets from providers. The easiest way to accomplish this is for providers to wear a mask. This does not mean providers need to wear an N95 mask.

While these should be worn, if possible, if doing procedures that generate respiratory aerosols (e.g., nebulizer treatments) they are not needed for routine medical care. For this a standard hospital/surgical mask is adequate. If supplies are limited, we recommend that each employee that provides direct care to patients wear a mask for the duration of their shift. This may require wearing a single mask each day. Should supplies become critically low, this may mean wearing a single mask on multiple days. While googles and face shields can be cleaned and sterilized, we are not aware, at this time, of any methods that can clean and sterilize surgical masks. Continue to check the CDC website for additional strategies to conserve PPE: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

EMResource: In the next several days we will be working to add all the statewide skilled nursing facilities to our EMResource database. Once added, each facility will provide a daily upload of their current PPE stores. This will allow us, and local health departments, to better know where resources need to be sent during local outbreaks.

Widespread Testing: Many of you have asked about testing. We are working closely with hospitals, Lilly, and commercial laboratories to increase the number of daily tests. This is why in the last couple of days you have seen dramatic increases in both the number of confirmed cases and number of tests. Despite this, we still do not have enough testing capacity to do widespread community surveillance. Because of this, we are focusing testing on vulnerable populations, such those in skilled nursing facilities, and those who provide for them. To facilitate this ISDH has developed teams that can go to facilities with residents, and providers, who are suspected to have COVID-19 and do testing. These strikeforce teams, will also have with them nurse surveyors. They are not there in their typical regulatory role. Rather, they are partnered with our teams to help staff and facilities to mitigate the spread of infections within their faculties. They will be training staff, if needed, on appropriate PPE and infection control.

We know these times are unprecedented and stressful. We also know that information around this pandemic is changing daily. We ask that you continue to provide outstanding care for those in your facilities and work with local health departments if you have questions or concerns about COVID-19. In addition we recommend regularly checking the CDC and ISDH websites regarding long-term care.

Sincerely,

Kristina M. Box, MD, FACOG
State Health Commissioner

Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings

Nursing homes and other long-term care facilities can take steps to assess and improve their preparedness for responding to coronavirus disease 2019 (COVID-19). Each facility will need to adapt this checklist to meet its needs and circumstances based on differences among facilities (e.g., patient/resident characteristics, facility size, scope of services, hospital affiliation). This checklist should be used as one tool in developing a comprehensive COVID-19 response plan. Additional information can be found at www.cdc.gov/COVID-19. Information from state, local, tribal, and territorial health departments, emergency management agencies/authorities, and trade organizations should be incorporated into the facility's COVID-19 plan. Comprehensive COVID-19 planning can also help facilities plan for other emergency situations.

This checklist identifies key areas that long-term care facilities should consider in their COVID-19 planning. Long-term care facilities can use this tool to self-assess the strengths and weaknesses of current preparedness efforts. Additional information is provided via links to websites throughout this document. However, it will be necessary to actively obtain information from state, local, tribal, and territorial resources to ensure that the facility's plan complements other community and regional planning efforts. This checklist does not describe mandatory requirements or standards; rather, it highlights important areas to review to prepare for the possibility of residents with COVID-19.

A preparedness checklist for hospitals, including long-term acute care hospitals is available.
https://www.cdc.gov/coronavirus/2019-ncov/downloads/hospital-preparedness-checklist.pdf

Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings:
https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Strategies to Prevent the Spread of COVID-19 in Long-Term Care Facilities (LTCF):
https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html

1. Structure for planning and decision making

	Completed	In Progress	Not Started
▪ COVID-19 has been incorporated into emergency management planning for the facility.	☐	☐	☐
▪ A multidisciplinary planning committee or team* has been created to specifically address COVID-19 preparedness planning.	☐	☐	☐

List committee's or team's name:

**An existing emergency or disaster preparedness team may be assigned this responsibility.*

continue on next page

	Completed	In Progress	Not Started
cont.			
▪ People assigned responsibility for coordinating preparedness planning, hereafter referred to as the COVID-19 response coordinator. **Insert name(s), title(s), and contact information:**	☐	☐	☐
▪ Members of the planning committee include the following: (Develop a list of committee members with the name, title, and contact information for each personnel category checked below and attach to this checklist.) ▪ 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)	☐	☐	☐
▪ 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:**	☐	☐	☐

2. Development of a written COVID-19 plan.

	Completed	In Progress	Not Started
▪ A copy of the COVID-19 preparedness plan is available at the facility and accessible by staff.	☐	☐	☐
▪ Relevant sections of federal, state, regional, or local plans for COVID-19 or pandemic influenza are reviewed for incorporation into the facility's plan.	☐	☐	☐
▪ The facility plan includes the Elements listed in #3 below.	☐	☐	☐
▪ The plan identifies the person(s) authorized to implement the plan and the organizational structure that will be used.	☐	☐	☐

3. Elements of a COVID-19 plan.

	Completed	In Progress	Not Started
General:			
▪ A plan is in place for protecting residents, healthcare personnel, and visitors from respiratory infections, including COVID-19, that addresses the elements that follow.	☐	☐	☐
▪ 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.			
▪ 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.	☐	☐	☐
▪ 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.	☐	☐	☐
▪ The facility has infection control policies that outline the recommended Transmission-Based Precautions that should be used when caring for residents with respiratory infection. (In general, for undiagnosed respiratory infection, Standard, Contact, and Droplet Precautions with eye protection are recommended unless the suspected diagnosis requires Airborne Precautions; see: https://www.cdc.gov/infectioncontrol/guidelines/isolation/appendix/type-duration-precautions.html.) For recommended Transmission-Based Precautions for residents with suspected or confirmed COVID-19, the policies refer to CDC guidance; see: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html.	☐	☐	☐
▪ The facility periodically reviews specific IPC guidance for healthcare facilities caring for residents with suspected or confirmed COVID-19 (available here: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html) and additional long-term care guidance (available here: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html).	☐	☐	☐
Facility Communications:			
▪ Key public health points of contact during a COVID-19 outbreak have been identified. (Insert name, title, and contact information for each.)	☐	☐	☐
Local health department contact:			
State health department contact:			
State long-term care professional/trade association:			

continue on next page

cont.	Completed	In Progress	Not Started
▪ A person has been assigned responsibility for communications with public health authorities during a COVID-19 outbreak. **Insert name and contact information:**	☐	☐	☐
▪ Key preparedness (e.g., Healthcare coalition) points of contact during a COVID-19 outbreak have been identified. **Insert name, title, and contact information for each:**	☐	☐	☐
▪ A person has been assigned responsibility for communications with staff, residents, and their families regarding the status and impact of COVID-19 in the facility. (Having one voice that speaks for the facility during an outbreak will help ensure the delivery of timely and accurate information.)	☐	☐	☐
▪ Contact information for family members or guardians of facility residents is up to date.	☐	☐	☐
▪ Communication plans include how signs, phone trees, and other methods of communication will be used to inform staff, family members, visitors, and other persons coming into the facility (e.g., consultants, sales and delivery people) about the status of COVID-19 in the facility.	☐	☐	☐
▪ A list has been created of other healthcare entities and their points of contact (e.g., other long-term care and residential facilities, local hospitals and hospital emergency medical services, relevant community organizations—including those involved with disaster preparedness) with whom it will be necessary to maintain communication during an outbreak. Attach a copy of contact list.	☐	☐	☐
▪ A facility representative(s) has been involved in the discussion of local plans for inter-facility communication during an outbreak.	☐	☐	☐
Supplies and resources:			
The facility provides supplies necessary to adhere to recommended IPC practices including:			
▪ Alcohol-based hand sanitizer for hand hygiene is available in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).	☐	☐	☐
▪ Sinks are well-stocked with soap and paper towels for hand washing.	☐	☐	☐
▪ Signs are posted immediately outside of resident rooms indicating appropriate IPC precautions and required personal protective equipment (PPE).	☐	☐	☐
▪ Facility provides tissues and facemasks for coughing people near entrances and in common areas with no-touch receptacles for disposal.	☐	☐	☐
▪ Necessary PPE is available immediately outside of the resident room and in other areas where resident care is provided. **continue on next page**	☐	☐	☐

cont.	Completed	In Progress	Not Started
▪ Facilities should have supplies of facemasks, respirators (if available *and* the facility has a respiratory protection program with trained, medically cleared, and fit-tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).	☐	☐	☐
▪ Trash disposal bins should be positioned near the exit inside of the resident room to make it easy for staff to discard PPE after removal, prior to exiting the room, or before providing care for another resident in the same room.	☐	☐	☐
▪ Facility ensures HCP have access to EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. ▫ *Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.*	☐	☐	☐
▪ The facility has a process to monitor supply levels.	☐	☐	☐
▪ The facility has a contingency plan, that includes engaging their health department and healthcare coalition when they experience (or anticipate experiencing) supply shortages. Contact information for healthcare coalitions is available here: https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx	☐	☐	☐
Identification and Management of Ill Residents:			
▪ The facility has a process to identify and manage residents with symptoms of respiratory infection (e.g., cough, fever, sore throat) upon admission and daily during their stay in the facility, which include implementation of appropriate Transmission-Based Precautions.	☐	☐	☐
▪ The facility has criteria and a protocol for initiating active surveillance for respiratory infection among residents and healthcare personnel. CDC has resources for performing respiratory surveillance in long-term care facilities during an outbreak, see: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf	☐	☐	☐
▪ Plans developed on how to immediately notify the health department for clusters of respiratory infections, severe respiratory infections, or suspected COVID-19.	☐	☐	☐
▪ The facility has criteria and a protocol for: limiting symptomatic and exposed residents to their room, halting group activities and communal dining, and closing units or the entire facility to new admissions.	☐	☐	☐
▪ The facility has criteria and a process for cohorting residents with symptoms of respiratory infection, including dedicating HCP to work only on affected units.	☐	☐	☐
Considerations about Visitors:			
▪ The facility has plans and material developed to post signs at the entrances to the facility instructing visitors not to visit if they have fever or symptoms of a respiratory infection.	☐	☐	☐
▪ The facility has criteria and protocol for when visitors will be limited or restricted from the facility. **continue on next page**	☐	☐	☐

cont.	Completed	In Progress	Not Started
▪ Should visitor restrictions be implemented, the facility has a process to allow for remote communication between the resident and visitor (e.g., video-call applications on cell phones or tablets) and has policies addressing when visitor restrictions will be lifted (e.g., end of life situation).	☐	☐	☐
For more information about managing visitor access and movement in the facility see: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html			
Occupational Health:			
▪ The facility has sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill healthcare personnel (HCP) to stay home.	☐	☐	☐
▪ The facility instructs HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of respiratory infection, as a part of routine practice.	☐	☐	☐
▪ The facility has a process to actively screen HCP for fever and symptoms when they report to work.	☐	☐	☐
▪ The facility has a process to identify and manage HCP with fever and symptoms of respiratory infection.	☐	☐	☐
▪ The facility has a plan for monitoring and assigning work restrictions for ill and exposed HCP. (See: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html)	☐	☐	☐
▪ The facility has a respiratory protection plan that includes medical evaluation, training, and fit testing of employees.	☐	☐	☐
Education and Training:			
▪ The facility has plans to provide education and training to HCP, residents, and family members of residents to help them understand the implications of, and basic prevention and control measures for, COVID-19. Consultant HCP should be included in education and training activities.	☐	☐	☐
▪ A person has been designated with responsibility for coordinating education and training on COVID-19 (e.g., identifies and facilitates access to available programs, maintains a record of personnel attendance).	☐	☐	☐
Insert name, title, and contact information:			
▪ Language and reading-level appropriate materials have been identified to supplement and support education and training programs to HCP, residents, and family members of residents (e.g., available through state and federal public health agencies such and through professional organizations), and a plan is in place for obtaining these materials.	☐	☐	☐

continue on next page

cont.	Completed	In Progress	Not Started
▪ Plans and material developed for education and job-specific training of HCP which includes information on recommended infection control measures to prevent the spread of COVID-19, including: ▪ Signs and symptoms of respiratory illness, including COVID-19. ▪ How to monitor residents for signs and symptoms of respiratory illness. ▪ How to keep residents, visitors, and HCP safe by using correct infection control practices including proper hand hygiene and selection and use of PPE. Training should include return demonstrations to document competency. ▪ Staying home when ill. ▪ HCP sick leave policies and recommended actions for unprotected exposures (e.g., not using recommended PPE, an unrecognized infectious patient contact).	☐	☐	☐
▪ See: "Strategies to prevent the spread of COVID-19 in long-term care facilities," available at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html	☐	☐	☐
▪ The facility has a plan for expediting the credentialing and training of non-facility HCP brought in from other locations to provide resident care when the facility reaches a staffing crisis.	☐	☐	☐
▪ Informational materials (e.g., brochures, posters) on COVID-19 and relevant policies (e.g., suspension of visitation, where to obtain facility or family member information) have been developed or identified for residents and their families. These materials are language and reading-level appropriate, and a plan is in place to disseminate these materials in advance of the actual pandemic.	☐	☐	☐
Surge Capacity:			
Staffing			
▪ A contingency staffing plan has been developed that identifies the minimum staffing needs and prioritizes critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.	☐	☐	☐
▪ A person has been assigned responsibility for conducting a daily assessment of staffing status and needs during a COVID-19 outbreak.	☐	☐	☐
Insert name, title, and contact information: ☐			
▪ Legal counsel and state health department contacts have been consulted to determine the applicability of declaring a facility "staffing crisis" and appropriate emergency staffing alternatives, consistent with state law.	☐	☐	☐
▪ The staffing plan includes strategies for collaborating with local and regional planning and response groups to address widespread healthcare staffing shortages during a crisis.	☐	☐	☐

continue on next page

cont.	Completed	In Progress	Not Started
Consumables and durable medical equipment and supplies			
▪ Estimates have been made of the quantities of essential resident care materials and equipment (e.g., intravenous pumps and ventilators, pharmaceuticals) and personal protective equipment (e.g., masks, respirators, gowns, gloves, and hand hygiene products), that would be needed during an eight-week outbreak.	☐	☐	☐
▪ Estimates have been shared with local, regional, and tribal planning groups to better plan stockpiling agreements.	☐	☐	☐
▪ A plan has been developed to address likely supply shortages (e.g., personal protective equipment), including strategies for using normal and alternative channels for procuring needed resources.	☐	☐	☐
▪ A strategy has been developed for how priorities would be made in the event there is a need to allocate limited resident care equipment, pharmaceuticals, and other resources.	☐	☐	☐
▪ A process is in place to track and report available quantities of consumable medical supplies including PPE.	☐	☐	☐
Postmortem care:			
▪ A contingency plan has been developed for managing an increased need for postmortem care and disposition of deceased residents.	☐	☐	☐
▪ An area in the facility that could be used as a temporary morgue has been identified.	☐	☐	☐
▪ Local plans for expanding morgue capacity have been discussed with local and regional planning contacts.	☐	☐	☐

Long-Term Care (LTC) Respiratory Surveillance Line List

Instructions for the Long-Term Care (LTC) Respiratory Surveillance Line List

The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak at a nursing home or other LTC facility. Using this tool will provide facilities with a line listing of all individuals monitored for or meeting the case definition for the outbreak illness.

Each row represents an individual resident or staff member who may have been affected by the outbreak illness (i.e., case). The information in the columns of the worksheet capture data on the case demographics, location in the facility, clinical signs/symptoms, diagnostic testing results and outcomes. While this template was developed to help with data collection for common respiratory illness outbreaks the data fields can be modified to reflect the needs of the individual facility during other outbreaks.

Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring.

LTC Respiratory Surveillance Line List

Instruction Sheet for Completion of the Long-Term Care (LTC) Respiratory Surveillance Line List

Section A: Case Demographics

In the space provided per column, fill in each line with name, age and gender of each person affected by the current outbreak at your facility. Please differentiate residents (R) from staff (S).

*Staff includes all healthcare personnel (e.g., nurses, physicians and other providers, therapists, food services, environmental services) whether employed, contracted, consulting or volunteer.

For residents only: Short stay (S) residents are often admitted directly from hospitals, require skilled nursing or rehabilitation care, and are expected to have a length of stay less than 100 days. Long stay (L) residents are admitted to receive residential care or nursing support and are expected to have a length of stay that is 100 days or more. Indicate the stay type for each resident in this column.

Section B: Case Location

For resident only: Indicate the building (Bldg), unit or floor where the resident is located and the room and bed number for each resident being monitored for outbreak illness. *Answers may vary by facility due to differences in the names of resident care locations.

For staff only: For each staff member listed, indicate the floor, unit or location where that staff member had been primarily working at the time of illness onset.

Section C: Signs and Symptoms (s/s)

Symptom onset date: Record the date (month/day) each person developed or reported signs/symptoms (e.g., fever, cough, shortness of breath) consistent with the outbreak illness.

Symptoms: Fill in the box (Y or N) indicating whether or not a resident or staff member experienced each of the signs/symptoms listed within this section.

Additional documented s/s (*select all codes that apply*): In the space provided, record the code that corresponds to any additional s/s the resident or staff member experienced. If a resident or staff member experienced a s/s that is not listed, please use the space provided by "Other" to specify the s/s.
H – headache, SB – shortness of breath, LA – loss of appetite, C – chills, ST – sore throat, O – other: Specify _____

Section D: Diagnostics

Chest x-ray: Fill in the box (Y or N) indicating whether or not a chest x-ray was performed.

Type of specimen collected: (*Select all codes that apply*): In the space provided, record the type of specimen collected for laboratory testing. If the type of specimen collected is not listed, please use the space provided by "Other" to specify the specimen type.
NP – nasopharyngeal swab, OP – oropharyngeal swab, S – sputum, U – urine, O – Other: Specify _____

Date of collection: Record the date (month/day) of specimen collection.

Type of test ordered (*select all codes that apply*): In the space provided, record the code that corresponds to whether a diagnostic laboratory test was performed for each individual. If no test was performed, indicate "zero". If the laboratory test used to identify the pathogen is not listed, please use the space provided by "Other" to specify the type of test ordered.
0 – No test performed, 1 – Culture, 2 –Polymerase Chain Reaction (PCR), also called nucleic acid amplification testing includes multiplex PCR tests for several organisms using a single specimen, 3 – Urine Antigen, 4 – Other: Specify

Pathogen detected (*select all codes that apply*): In the space provided, record the code that corresponds to the bacterial and/or viral organisms that were identified through laboratory testing. If the test performed was negative, indicate "zero". If a pathogen not listed was identified through laboratory testing, please use the space provided by "Other" to specify the organism.
0 – Negative results; Bacterial: 1 – *Streptococcus pneumoniae*, 2 – *Legionella*, 3 – *Mycoplasma*
Viral: 4 – Influenza, 5 – Respiratory syncytial virus (RSV), 6 – Human metapneumovirus (HMPV), 7 – Other: Specify _____

Section E: Outcome During Outbreak

Symptom Resolution Date: Record the date that each person recovered from the outbreak illness and was symptom free for 24 hours.

Hospitalized: Fill in the box (Y or N) indicating whether or not hospitalization was required for a resident or staff member during the outbreak period. ***Note: The outbreak period is the time from the date of symptom onset for the first case to date of symptom resolution for the last case.***

Died: Fill in the box (Y or N) indicating whether or not a resident or staff member expired during the outbreak period.

Case (C) or Not a case (leave blank): Based on the clinical criteria and laboratory findings collected during the outbreak investigation, record whether or not each resident or staff member meets the case definition (C) or is not a case (leave space blank).

LTC Respiratory Surveillance Line List

Date:_____/_____/_____

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

	A. Case Demographics					B. Case Location			C. Signs and 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	Symptom 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.																						
2.																						
3.																						
4.																						
5.																						
6.																						
7.																						
8.																						
9.																						
10.																						

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 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; 33:965-977): (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).

Long-Term Care (LTC) Respiratory Surveillance Outbreak Summary

Instructions for the Long-Term Care (LTC) Respiratory Surveillance Outbreak Summary

The Respiratory Outbreak Summary Form was created to help nursing homes and other LTC providers summarize the findings, actions and outcomes of an outbreak investigation and response. Completing this outbreak form will provide LTC facilities and other public health partners with a record of a facility's outbreak experience and highlight areas for outbreak prevention and response.

Instructions for each section of the form are described below. This form should be filled out by the designated infection preventionist with support from other clinicians in your facility (e.g., front-line nursing staff, physicians or other practitioners, consultant pharmacist, laboratory).

A LTC facility can use this form for internal documentation and dissemination of outbreak response activities. Facilities are encouraged to share this information with the appropriate public health authority by contacting the local health department. Should a facility decide to share this form with the local/state public health officials, please include facility contact information at the bottom of the form.

Contents

LTC Respiratory Surveillance Outbreak Summary

Section 1: Facility Information

Health Dept. Contact Name and Phone Number: A LTC facility should have contact information (name or division, phone number) for the local and/or state health department for outbreak guidance and reporting purposes. Enter the health dept. contact information your facility used to request support during an outbreak.

Date First Notified Local Health Dept: Record the date you first contacted local or state public health during this outbreak at your facility.

Total # of residents at facility: Document the total number of residents in the facility at the time of the outbreak.

Total # of employees: Document the total number of staff working in the facility at the time of the outbreak. Staff includes all healthcare personnel (e.g., nurses, providers, consultants, therapists, food services, environmental services) whether employed, contracted or volunteer.

Summary Form Status: Information in the summary form may be completed over the course of the outbreak. Record the dates your facility started collecting information on the form and completed the outbreak summary report.

Section 2: Influenza Vaccination Status

Total # of residents vaccinated: Record the total number of residents that received the Flu Vaccine within the past year.

Total # of staff vaccinated: Record the total number of staff that received the Flu Vaccine within the past year.

Section 3:Pneumococcal Vaccination Status

Total # of residents vaccinated: Record the total number of residents that received at least one dose of the Pneumococcal Vaccine (either polysaccharide or conjugate).

Section 4: Case Definition

Provide a description of the criteria used to determine whether a resident should be considered a case in this outbreak. The description can include: signs/symptoms, presence of positive diagnostic tests, location within facility, and the timeframe during which individuals may have been involved in the outbreak (e.g., within the past 4 weeks).

Example: A Respiratory illness case includes any resident with the following symptoms: cough, shortness of breath, sputum production and fever residing on Units 2E or 2W, with onset of symptoms between Jan 15th and Feb 1st with or without a sputum specimen positive for Streptococcus pneumoniae.

Section 5: Outbreak Period Information

Outbreak start: (Date of symptom onset of first case): Record the date the first person developed signs/symptoms (e.g., fever, cough, shortness of breath) consistent with the outbreak illness.

Average length of illness: Estimate the average number of days it takes for signs/symptoms to resolve, based on clinical course among residents/staff affected by the outbreak illness.

Outbreak end: (Symptom resolution date of last case): Record the date the last person recovered from the outbreak illness and became symptom free for 24 hours.

Total # of Cases: Document the number of residents and staff (if applicable) who were identified as having the outbreak illness.

LTC Respiratory Surveillance Outbreak Summary

Section 6: Staff Information

Were any ill staff delivering resident care? Check yes or no.

- If yes, try to estimate the number of ill staff involved in resident care based on date when a staff member reported symptoms compared with the date when/if staff member was excused from work.

Did any staff seek medical attention for an acute respiratory infection at any time during the outbreak? Check yes or no.

- If yes, try to estimate the number of staff that sought medical attention based on self-report.

If available, indicate if ill staff received care at an emergency department (ED). Check yes or no and estimate number of staff.

If available, indicate if ill staff was hospitalized as a result of the outbreak illness. Check yes or no and estimate number of staff.

Section 7: Diagnostic and Laboratory Tests

Chest x-ray: Fill in the box (yes or no) indicating whether or not residents and staff had an x-ray done as a part of the diagnosis of the outbreak illness. If yes, please record the # of individuals who received chest x-ray and the # of x-rays that had abnormal findings consistent with the outbreak illness.

List all bacterial (e.g., *S. pneumoniae, Mycoplasma*); viral (e.g., Influenza, RSV) organisms that were identified through laboratory testing; Use the space provided by "Other" to specify if a parasite or non-infectious cause of respiratory illness was identified.

Diagnostic testing results: In the table, each row corresponds to an organism identified during the outbreak. Use the column to specify the type of testing used to identify each organism (either microbiologic culture, PCR (also known as nucleic acid amplification) or specify if a different diagnostic test was used (e.g., Legionella urinary antigen). For each test type, document the total number of residents and staff that received laboratory confirmation by that test.

Section 8: If Influenza Identified During Outbreak:

Antiviral Treatment: Fill in the box (yes or no) indicating whether or not antiviral treatment was offered. If antiviral treatment was offered, please record the total number of residents and staff that received treatment.

Antiviral Prophylaxis Offered: Fill in the box (yes or no) indicating whether or not antiviral prophylaxis was offered to any additional residents, staff or family members at risk for infection due to the outbreak. If antiviral prophylaxis was offered, please record the total number of residents and staff that received prophylaxis.

Section 9: Resident Outcome

Hospitalizations: During the outbreak, fill in the box (yes or no) indicating whether or not hospitalization was required for any residents. If yes, please record how many residents were hospitalized.

Deaths: During the outbreak, fill in the box (yes or no) indicating whether or not any residents died. If yes, please record how many residents died during the outbreak period (deaths should be recorded even if unable to determine if outbreak illness was the cause).

Section 10: Facility Outbreak Control Interventions

In this section, check if any of the infection control strategies listed were implemented at your facility in response to the outbreak. If a practice or policy change was implemented during the outbreak that is not listed (e.g., new cleaning/disinfecting products used, change to employee sick leave policy), specify in the space provided by "Other". For each strategy, record the date the change was implemented (if available).

Section 11: # of New Cases Per Day

Please fill in the chart with the number of new cases that are residents and staff per day. Once each day is complete, add the number of new cases of residents and staff and place the sum in total column for that corresponding day.

In the space provided under the chart, record the date which corresponds to Day 1 on the outbreak period (i.e., date of outbreak start).

For HD Use Only	
Facility Licensed by State: Fill in the box (yes or no) indicating whether or not the facility is licensed by the state.	**# of Licensed Beds:** Document the total number of licensed beds at the facility.
Facility Certified by CMS: Fill in the box (yes or no) indicating whether or not the facility is certified by the Center for Medicare and Medicaid Services (CMS).	**# of staff employees:** Document the total number of facility employed staff working in the facility at the time of the outbreak.
Facility Type: Check that box that best describes the type of care the facility provides: Nursing home, Intermediate Care Facility, Assisted living Facility or Other (specify).	**# of contract employees:** Document the total number of contract/consulting providers working in the facility at the time of the outbreak.

LTC Respiratory Surveillance Outbreak Summary

1. Facility Information

Health Dept. Contact Name:_____ Health Dept. Contact Phone Number:_____
Health Dept. Fax Number:_____ Date First Notified Local Health Dept.:___/___/____
Total # of residents at facility: _____ Total # of employees (staff and contract personnel): _____
Summary Form Status: Date initiated:___/___/_____ Date completed:___/___/____

2. Influenza Vaccination Status

Total # of residents vaccinated: Total # of staff vaccinated:

3. Pneumococcal Vaccination Status

Total # of residents vaccinated:

4. Symptomatic Case Definition

Summarize the definition of a symptomatic case during the outbreak, including symptoms, time range and location (if appropriate) within facility:

5. Outbreak Period Information

Outbreak start: (Date of symptom onset of first case):___/___/_____
Average length of illness:_____ days
Outbreak end: (Symptom resolution date of last case):___/___/_____

Total # of Cases
Residents: Staff:

6. Staff Information

Were any ill staff delivering resident care at the beginning of the outbreak? ☐ Yes ☐ No If yes, how many:____
Did any ill staff seek outside medical care at the beginning or during the outbreak? ☐ Yes ☐ No If yes, how many:____
ED Visit: ☐ Yes ☐ No If yes, how many:____ Hospitalization: ☐ Yes ☐ No If yes, how many:____

7. Diagnostic and Laboratory Tests

Chest x-ray: ☐ Yes ☐ No | # performed: | # abnormal:

Which organisms were identified through laboratory testing:
Bacterial: Specify_____ **Viral**: Specify_____ **Other**: Specify_____

Total # of Laboratory Confirmed Cases	Culture	PCR	Other Diagnostic Tests: Specify _____
Organism 1 _____	Residents:____ Staff:____	Residents:___ Staff:___	Residents:____ Staff:____
Organism 2 _____	Residents:____ Staff:____	Residents:___ Staff:___	Residents:____ Staff:____
Organism 3 _____	Residents:____ Staff:____	Residents:___ Staff:___	Residents:____ Staff:____

8. If Influenza Identified During Outbreak:

Antiviral **treatment** offered: ☐ Yes ☐ No
If yes, indicate total # : Residents_____ Staff_____

Antiviral **prophylaxis** offered: ☐ Yes ☐ No
If yes, indicate total # : Residents_____ Staff_____

9. Resident Outcome

Hospitalizations: ☐ Yes ☐ No If yes, how many:_____

Deaths: ☐ Yes ☐ No If yes, how many:_____

10. Facility Outbreak Control Measures

☐ Educated on hand hygiene practices: Date:_____
☐ Implemented transmission-based precautions: Date_____
☐ Dedicate staff to care for only affected residents: Date: _____
☐ Suspend activities on affected unit: Date: _____
☐ Notified family/visitors about outbreak: If yes, Date: _____
☐ Other: _____

☐ Monitored appropriate HH and PPE use by staff: Date:_____
☐ Cohorted ill residents within unit/building: Date: _____
☐ Placed ill staff on furlough: Date: _____
☐ Restricted new admissions to affected unit: Date: _____
☐ Educated family/visitors about outbreak: If yes, Date: _____
☐ Other: _____

11. # of New Cases Per Day

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14
Residents														
Staff														
Total														

Indicate Date of Day 1: _____/_____/_____ **List units/floors involved in the outbreak:**_____

For HD Use Only

Facility Licensed by State: ☐ Yes ☐ No Facility ID: _____
Facility Certified by CMS: ☐ Yes ☐ No Facility Type: ☐ Nursing home ☐ Assisted living ☐ Other (specify): _____
# of Licensed Beds: _____ # of staff employees: _____ # of contract employees: _____

Indiana State Department of Health
Epidemiology Resource Center

COVID-19 Guidance for Healthcare Workers

WHAT IS COVID-19?

Coronavirus disease 2019 (COVID-19) is a respiratory illness that can spread from person to person. Patients with COVID-19 have experienced mild to severe respiratory illness, including fever, cough and shortness of breath. The virus that causes COVID-19 is a novel (new) coronavirus. It is not the same as other types of coronaviruses that commonly circulate among people and cause mild illness, like the common cold. Those who are older than 60, have underlying health conditions such as heart or lung disease, and diabetes, are particularly at risk.

HOW DOES COVID-19 SPREAD?

The virus that causes COVID-19 is thought to spread mainly from person-to-person, between people who are in close contact with one another (within about 6 feet) through respiratory droplets when an infected person coughs or sneezes. It may be possible that a person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose or possibly their eyes, but this is not thought to be the main way the virus spreads.

FACILITIES SHOULD FOLLOW CDC GUIDELINES FOR HEALTHCARE WORKERS

This guidance also applies to other healthcare workers in the following facilities:

- Nursing Homes
- Residential Care Facilities
- Assisted Living Facilities
- Residential Care & Assistance Program Providers
- Housing with Services Establishments
- Intermediate Care Facilities for IDD, including Group Homes
- Rehabilitation Hospitals
- State Psychiatric Hospitals
- Free Standing Psychiatric Hospitals
- Staff who work in Hospice, EMS and Dialysis Centers

HEALTHCARE WORKERS WITH POTENTIAL COVID-19 EXPOSURE

Healthcare workers that, in a healthcare setting, have been potentially exposed to patients with confirmed COVID-19, should follow CDC guidance linked below. This guidance includes considerations for managing healthcare workers with exposure who are asymptomatic.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

CLOSE CONTACT AND RISK LEVELS

Close contact is defined as being within approximately 6 feet (2 meters) of a COVID-19 case or secondary the provider has a high risk of coming in contact with respiratory droplets (for example, if a healthcare worker not wearing PPE is coughed on during the suctioning of a patient or while giving a nebulizer treatment).

Healthcare facilities need to identify the risk of the healthcare worker:

High Risk: the healthcare worker (HCW) had close contact with COVID-19 patient and neither had a face mask.

Medium Risk: healthcare worker had close contact with COVID-19 patient who wore a face mask and the HCW did not wear a face mask

Low Risk: Brief interaction with the patient with COVID-19 or close contact with patients who were wearing a facemask while healthcare worker was wearing a face mask.

HEALTHCARE WORKERS WITH NO DIRECT PATIENT CONTACT AND NO ENTRY INTO ACTIVE PATIENTS MANAGED AREAS WHO ADHERE TO ROUTINE SAFETY PROCEDURES SHOULD BE CONSIDERED NOT AT RISK.

LEVELS OF MONITORING

- **Self-monitoring** – HCW should not return to work during self-monitoring. They should monitor themselves by taking temperature twice a day and be alert to respiratory symptoms (cough, shortness of breath)
- **Active Monitoring** – HCW should not return to work during active monitoring. State or local health department assumes responsibility for communicating with potentially exposed people to assess for fever or respiratory symptoms. This can be delegated by the health department to the healthcare facility.

SCREENING SYMPTOMS AND RESPONDING APPROPRIATELY

Facilities should develop a plan for how to screen for symptoms and evaluate ill healthcare workers. For instance, on days the healthcare worker is scheduled to work, the facility should take the temperature and assess for symptoms prior to starting work or have the healthcare worker report their temperature and absence of symptoms prior to starting work.

If the healthcare worker begins to exhibit symptoms, such as cough, sore throat, fever or shortness of breath, they must be sent home for self-quarantine and testing immediately.

ADDITIONAL INFORMATION

The Indiana State Department of Health has set up a dedicated provider telephone line that is available 24 hours a day, seven days a week. Healthcare providers with questions should call 877-826-0011 and select menu option 2.

Additional information and resources for COVID-19 are available at the links below.

- ISDH COVID-19 webpage: https://in.gov/coronavirus
- CDC COVID-19 webpage: https://www.cdc.gov/coronavirus/

Indiana State Department of Health
Epidemiology Resource Center

Guidance for out-of-hospital facilities

Below are the update strategies to reduce the spread of infection in facilities with a patient/resident with a confirmed or suspected case of COVID-19.

New in this update on March 29, 2020:

- Updated PPE guidance and the use of N95 masks
- Updated facility guidance for resident management to align with Centers for Disease Control and Prevention (CDC) discontinuation of transmission-based precautions
- Updated external links

GENERAL GUIDANCE

The following is guidance for out of hospital facilities who house patients with a confirmed or suspected case of COVID-19. There are a few guiding principles:

1. Placement of patient /resident in contact-droplet precautions with proper PPE, including gown, glove, mask with face shield or eye protection
2. Proper donning and doffing of personal protection equipment when in contact with COVID-19 residents https://www.cdc.gov/HAI/pdfs/ppe/ppeposter148.pdf
3. Reduce the number of non-essential staff who come into contact with the patient/resident
4. Reduce the movement of staff between patients with and without COVID-19
    - Cohort staff and patients in one area of the building if possible
    - Cohort equipment for these patients/residents to limit spread of infection
5. Perform hand hygiene frequently before and after patient/resident contact, before clean/ aseptic procedures, and after body fluid risk exposure, before and after coming on duty, and when hands are visibly soiled.

PPE GUIDANCE

Facilities should follow the CDC guidelines for healthcare workers and positive protective equipment: https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html

Secondary to limited PPE availability facilities should use fit-tested N95 masks only in essential staff who do procedures that are likely to generate respiratory aerosols (e.g., nebulizer treatments, COVID-19 testing), which would pose the highest exposure risk to the staff.

- *Should N95 masks not be available the staff should wear a tight fitting surgical mask with no gaps around the face and eye-protection as in goggles (not just eye glasses) or face shield.*

Those doing procedures that do not generate respiratory aerosols (e.g., insulin injections, medication delivery, lab draw, X-rays, and wound care) do not need N95 respirators at this time.

These staff should wear eye protection, gown, gloves and standard surgical facemasks to prevent droplet exposure.

- If there are shortages of isolation gowns, they should be prioritized for aerosol-generating procedures, care activities for which splashes and sprays are anticipated, and high-contact patient care activities that provide opportunities for transfer of pathogens to the hands and clothing of essential staff.

- Encourage staff to have a change of clothing on hand to change before leaving work, and remember to perform hand hygiene after removal of uniforms and before leaving work for the day.

STAFFING RECOMMENDATIONS

Non-essential staff* are considered those staff who come into contact with patients/ residents, or patient/resident rooms, but do not provide medical care:

- Ancillary staff
- Administrative staff
- Housekeeping staff
- Maintenance staff (unless needing to repair vital equipment)
- Meal delivery
- Activity staff
- Assisted-living staff

*Non-essential staff, as defined above, may still require access to the facility for its normal operation. The recommendations outlined here are to restrict their access only to the confirmed or presumed COVID-19 patient's room or a cohorted unit designated for confirmed/presumed COVID-19 patients.

To reduce the interaction between non-essential staff and COVID-19 patients, facilities should develop plans to shift duties from these staff to essential staff.

- **ONLY ESSENTIAL staff should go into the room of a confirmed or presumed COVID-19 patient.**

Essential staff are considered those staff who come into contact with patient/resident and provide medical care:

- Certified Nurse Assistants (CNAs)
- Qualified Medical Assistants (QMAs)
- Nurses
- Paramedics: Paramedics, donning appropriate PPE, are to be allowed into facilities to assess and transport patients to hospitals.
- X-ray staff: Those who come in to do emergency radiographs should don appropriate PPE and follow contact-droplet precautions
- Laboratory staff:
  - If the essential staff at the facility can draw blood, the facility should work with their local laboratory to develop a protocol by which the facility staff draw the blood.
  - If essential staff at the facility cannot draw blood the laboratory staff should follow contact-droplet precautions.

To reduce essential staff who care for confirmed, or presumed, COVID-19 patients from interacting with patients ISDH recommends the following:

- Appropriate infection control measures with hand hygiene and contact-droplet precautions
  - https://www.who.int/infection-prevention/campaigns/clean-hands/5moments/en/
  - https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html
- Appropriate donning and doffing of PPE – video training can be watched here: https://iuhealth.plateau.com/content/clarian/wbt/2020/Nursing/standard_iso_donning_and_doffing_update/index_lms_html5.htm (disable pop-up blocker)

- Contract essential staff who recently cared for a COVID-19 confirmed, or presumed positive, patient/resident should, if possible, provide care at only one facility
- Contract essential staff who care for confirmed, or presumptive positive, COVID-19 patients/residents should restrict their movements in facilities to those areas where the patient/resident resides
    - Recommendation is to avoid working in other areas of the facility (e.g., going between assisted living and extended care facilities)
- To conserve PPE and N95 masks, limit the essential staff who perform testing or procedures that generate respiratory aerosols (e.g., suctioning, respiratory treatments). This can be done by identifying only one person who will do these procedures per shift.

FACILITY GUIDANCE-RESIDENT MANAGEMENT

Included are considerations for designating entire units within the facility, with dedicated HCP, to care for known or suspected COVID-19 patients/resident and options for extended use of respirators, facemasks, and eye protection on such units.

- Patients/residents with known or suspected COVID-19 should be cared for in a single-person (private) room with the door closed. *Airborne infection isolation rooms (AIIR) are not required.*
- Patients/residents with known or suspected COVID-19 should not share bathrooms with other patients/residents.
- All patients/residents returning from the hospital with suspected or confirmed COVID-19 should be cared for in a private room, or Cohorted with other patients of the same status in the same unit, wing, hallway, or building.
- Patients with close contact with a confirmed COVID-19 patient (e.g., roommate or infected staff without wearing PPE) should be isolated and follow 14 day self-monitoring guidelines outline by CDC https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html.
    - If they develop symptoms, and are confirmed or suspected to have COVID-19, they should remain in isolation until at least 7 days after symptom onset and 72 hours after resolution of fever, without use of antipyretic medication, and improvement in symptoms (e.g., cough), whichever is longer
        - Please note that elderly patients may not mount a fever with COVID-19
        - Please note that elderly patients/residents may not encounter fever with COVID-19
- Staff who develop symptoms confirmed or suspected to be COVID-19 should call the Indiana State Department of Health at 877-826-0011 (open 24/7) to determine if testing is needed. They should also call their local health department to make them aware.
    - They should follow home quarantine recommendations from the CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html - and can return to work when the following conditions have been met;
        - Fever free for at least 72 hours (that is three full days of no fever without the use medicine that reduces fevers).
          AND
        - Other symptoms have improved (for example, when your cough or shortness of breath have improved).
          AND
        - At least 7 days have passed since your symptoms first appeared.

GUIDANCE FOR MEDICAL DIRECTORS

Thank you for caring for vulnerable populations during this pandemic. To prevent the number of staff who come in contact with a confirmed or presumed COVID-19 patient at your facility please follow some simple guidance:

- Do not order non-urgent labs or -rays. Refrain from ordering labs and X-rays that are to follow the long-term course of a disease (e.g., hemoglobin A1C, routine chemistries, chest X-rays for pulmonary lesion progression).
- Implement alternatives to treatments to generate respiratory aerosols (e.g., inhalers vs. nebulizers)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-20-All

DATE: **March 23, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Prioritization of Survey Activities

Memorandum Summary

- ***The Centers for Medicare & Medicaid Services (CMS) is committed*** to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19).
- On Friday, March 13, 2020, the President declared a national emergency, which triggers the Secretary's ability to authorize waivers or modifications of certain requirements pursuant to section 1135 of the Social Security Act (the Act). Under section 1135(b)(5) of the Act, CMS is prioritizing surveys by authorizing modification of timetables and deadlines for the performance of certain required activities, delaying revisit surveys, and generally exercising enforcement discretion for three weeks.
- During this three-week timeframe, **only** the following types of surveys will be prioritized and conducted:
    - Complaint/facility-reported incident surveys: State survey agencies (SSAs) will conduct surveys related to complaints and facility-reported incidents (FRIs) that are triaged at the Immediate Jeopardy (IJ) level. A streamlined Infection Control review tool will also be utilized during these surveys, regardless of the Immediate Jeopardy allegation.
    - Targeted Infection Control Surveys: Federal CMS and State surveyors will conduct targeted Infection Control surveys of providers identified through collaboration with the Centers for Disease Control and Prevention (CDC) and the HHS Assistant Secretary for Preparedness and Response (ASPR). They will use a streamlined review checklist to minimize the impact on provider activities, while ensuring providers are implementing actions to protect the health and safety of individuals to respond to the COVID-19 pandemic.
    - Self-assessments: The Infection Control checklist referenced above will also be shared with all providers and suppliers to allow for voluntary self-assessment of their Infection Control plan and protections.

Memorandum Summary Continued

- During the prioritization period, the following surveys will not be authorized: Standard surveys for long term care facilities (nursing homes), hospitals, home health agencies (HHAs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and hospices. This includes the life safety code and Emergency Preparedness elements of those standard surveys; and revisits that are not associated with IJ.
- Furthermore, for Clinical Laboratory Improvement Amendments (CLIA), we intend to prioritize immediate jeopardy situations over recertification surveys, and generally intend to use enforcement discretion, unless immediate jeopardy situations arise.
- Finally, initial certification surveys will continue to be authorized in accordance within current guidance and prioritization.

Background

CMS is committed to taking critical steps to ensure America's health care facilities, providers, and clinical laboratories are prepared to respond to the threat of COVID-19 and other respiratory illness. Specifically, under section 1135(b)(5) of the Act, CMS is prioritizing and suspending certain federal and SSA surveys, and delaying revisit surveys, pursuant to federal requirements for the next three weeks, beginning March 20, 2020, for all certified provider and supplier types. Also, for Clinical Laboratory Improvement Amendments (CLIA), we intend to prioritize immediate jeopardy situations over recertification surveys, and generally intend to use enforcement discretion, unless immediate jeopardy situations arise. During this three-week timeframe, SSAs and CMS surveyors will prioritize and conduct surveys (including revisit surveys) related to complaints and facility-reported incidents (FRIs) that are triaged at the Immediate Jeopardy (IJ) level, for all allegations, in addition to a review with a Focused Infection Control survey. Federal surveyors will perform targeted Infection Control surveys of facilities in those areas most in need of additional oversight, as identified through collaboration with the CDC and ASPR.

If state or federal surveyors are unable to meet the Personal Protective Equipment (PPE) expectations outlined by the latest CDC guidance to safely perform an onsite survey due to lack of appropriate PPE supplies, they are instructed to refrain from entering the /provider, and obtain information necessary remotely, to the extent possible. Surveyors should continue the survey once they have the necessary PPE to do so safely.

The Focused Infection Control Survey is available to every provider in the country to make them aware of Infection Control priorities during this time of crisis, and providers and suppliers may perform a voluntary self-assessment of their ability to meet these priorities.

This shift in approach will allow health care providers time to implement the most recent infection control guidance from both CMS and the Centers for Disease Control and Prevention (CDC). At the same time, we are doing our duty to protect patients from harm, and ensuring providers are implementing actions to prevent the spread of COVID-19.

Therefore, during the prioritization period, the following surveys will **not** be authorized:

- Standard surveys for long term care facilities (nursing homes), hospitals, home health agencies (HHAs), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs), and hospices. This includes the life safety code and Emergency Preparedness elements of those standard surveys;

- Revisits that are not associated with IJ. As a result, the following enforcement actions will be suspended, until revisits are again authorized:
    - For nursing homes – Imposition of Denial of Payment for New Admissions (DPNA), including situations where facilities that are not in substantial compliance at 3 months, will be lifted to allow for new admissions during this time;
    - For HHAs – Imposition of suspension of payments for new admissions (SPNA) following the last day of the survey when termination is imposed will be lifted to allow for new admissions during this time;
    - For nursing homes and HHAs – Suspend per day civil money penalty (CMP) accumulation, and imposition of termination for facilities that are not in substantial compliance at 6 months.

- For CLIA, we intend to prioritize immediate jeopardy situations over recertification surveys.

This announcement follows previous action to focus survey activity on infection control. On March 4, 2020, CMS announced a suspension of inspections for federal and state inspectors (https://www.cms.gov/medicareprovider-enrollment-and-certificationsurveycertificationgeninfopolicy-and/suspension-survey-activities). This earlier announcement focused on immediate jeopardy complaints, complaints alleging infection control concerns – especially COVID-19 – statutorily required surveys, revisit surveys to resolve enforcement actions, initial certifications, inspections for facilities with histories of infection control deficiencies in the last three years, and inspections of facilities with histories of infection control deficiencies at low levels of severity. This action supersedes the March 4th announcement, and prioritizes surveys related to complaints and FRIs triaged at the IJ level, while suspending the other types of surveys.

Prioritization of Surveys

When conducting surveys related to complaints and facility-reported incidents (FRIs) that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys necessary to verify removal of IJ which has been previously cited, surveyors and CMS Regional Offices should adhere to the following guidelines:

1. SSAs follow their normal process for triaging complaints and FRIs:
    a. If a complaint or FRI is triaged at the IJ level, the state should follow the normal policies and procedures for surveying the provider. For example, a survey of a long term care facility (LTC) would be conducted within two business days of receipt of the allegation (State Operations Manual (SOM), Chapter 5, Section 5075.9).

b. If a complaint or FRI is triaged at the non- IJ level, the state would enter the allegation into the ASPEN Complaints/Incidents Tracking System (ACTS) per the instructions in the SOM Chapter 5. An onsite survey will not be conducted during the prioritization period. CMS will issue guidance related to these non-IJ complaints or FRIs in the next few weeks.
c. This normal complaint triaging process also applies to CLIA complaints.

2. For facilities that have been cited for IJ-level deficiencies and that surveyors have not verified that the IJ has been removed, surveyors would proceed as normal, and conduct a revisit survey to verify the IJ is removed.
    a. If the revisit survey determines there is continuing noncompliance, but not at the IJ level, surveyors would not conduct another onsite revisit survey. The provider may submit a plan of correction (POC), but an onsite revisit survey will not be conducted during the prioritization period, and these cases will be held. The provider may delay submission of a plan of correction until this prioritization period is over.
    b. If a survey is conducted because a complaint or FRI was triaged at the IJ level, and the provider is cited for noncompliance, but not at the IJ level (e.g., Level 3 – actual harm), surveyors would not conduct a revisit survey. The provider may submit a plan of correction (POC), but an onsite revisit survey will not be conducted during the prioritization period, and these cases will be held. The provider may delay submission of a plan of correction until this prioritization period is over.
    c. For level-3 (LTC) or condition level (Non-LTC) citations (for which an onsite revisit survey would normally be conducted), the provider <u>may</u> submit a plan of correction (POC), but an onsite revisit survey will not be conducted during the prioritization period, and these cases will be held. The provider may delay submission of a plan of correction until this prioritization period is over. CMS will issue guidance on how to verify compliance with these citations in the next few weeks.
    d. For level-2 (LTC) or standard level (non-LTC) citations, the provider <u>may</u> submits a POC, and providers and survey agencies could verify compliance through normal procedures through a desk review. The provider may delay submission of a plan of correction until this prioritization period is over.
    e. For clinical laboratories, surveyors will conduct a revisit survey to verify removal of IJ once a credible allegation of compliance has been received.

3. Federal CMS and State Surveyors will conduct focused Infection Control surveys in areas deemed necessary through collaboration with CDC and ASPR. *Please note this workload for SSAs is contingent on their ability to perform surveys based on PPE availability and fulfillment of other State Emergency Response responsibilities (such as staffing medical shelters or testing stations).*
    a. Revisit surveys: Surveyors will follow the same guidance for revisit surveys explained in section 2 above.
    b. Enforcement actions will also follow the guidance for all other surveys during the prioritization period explained in section 4 below.

4. Enforcement Actions:
    a. For pending enforcement cycles during the prioritization period where the provider is currently not in substantial compliance or has not had a revisit

survey to verify substantial compliance, and a per day civil money penalty (CMP), or DPNA (for nursing homes) or SPNA (for HHAs) was imposed for noncompliance that occurred prior to the prioritization date of surveys: These remedies will be suspended (stopped) as of the start of the survey prioritization date. In other words, the CMP will stop accruing and the DPNA/SPNA will end as of the suspension date. Additionally, CMS will not impose any new remedies to address noncompliance that occurred prior to the start of the survey prioritization period. NOTE: This does not apply to unremoved IJs. Enforcement actions will proceed as usual per the SOM for unremoved IJ deficiencies. CMS will issue guidance on how to reconcile these actions in the next few weeks.

b. For pending enforcement cycles during the prioritization period where the provider is currently not in substantial compliance or has not had a revisit survey to verify substantial compliance, and for pending enforcement cycles with new noncompliance cited after the issuance of this memo, and a per day CMP, or DPNA (for nursing homes) or SPNA (for HHAs) was imposed for IJ level noncompliance (where the IJ has not been removed): Surveyors will follow normal policies and procedures for removing the IJ. CMS will also follow normal policies and procedures for imposing enforcement remedies for remediating the noncompliance. For example, for noncompliance cited at the IJ level, that has not been removed at the time of the survey exit, the CMS Office will impose an enforcement remedy (e.g., CMP, 23 day termination), and the state surveyors will conduct a revisit survey. On the revisit survey, surveyors will either verify substantial compliance, or cite noncompliance at a lower level if warranted.
    i. If the IJ noncompliance is reduced and cited at level 3 (LTC) or condition level (non-LTC), an onsite revisit survey will not be conducted during the prioritization period, and these cases will be held. CMS will issue guidance on how to impose enforcement and verify compliance with these in the next few weeks (see 2.c.).
    ii. If the IJ noncompliance is reduced and cited at level 2 (LTC) or standard level (non-LTC), facilities and survey agencies would verify compliance through normal procedures through a desk review (see 2.d.). However, CMS should not impose remedies during the prioritization period for any noncompliance that was identified before or after the start of the survey prioritization period, unless the noncompliance is an unremoved IJ.
c. The three-month mandatory DPNA and six-month mandatory termination (nursing homes) for not being in substantial compliance (for nursing homes and HHAs) will not take place, and be deferred for an evaluation at a later date. However, enforcement actions related to IJ remain and continue under normal procedures.
d. If CMS has previously imposed an alternative sanction (e.g., SPNA, CMP) on a HHA for noncompliance identified prior to the suspension, the six-month mandatory termination will not take place, and be deferred for an evaluation at a later date.

e. For existing CLIA enforcement cases where a civil money penalty (CMP) per day of non-compliance was imposed, accrual of CMP will stop as of the survey COVID-19 suspension date. CMS will issue guidance on how to reconcile these actions in the next few weeks. Other CLIA enforcement actions that have been initiated will be handled on a case-by-case basis with consultation DCLIQ managers and staff.

5. If during an IJ complaint or FRI survey, the surveyor identifies that there is an active COVID-19 case in the facility:

   If the COVID-19 case is, or is not, related to the IJ, surveyors should report the case and facility to their agency, the state health department (to coordinate with the Centers for Disease Control and Prevention (CDC)), and the CMS Regional Office. These agencies should coordinate and decide on any further actions that should be taken. The Infection Control focused survey process can be used to investigate noncompliance and ensure the provider takes steps to minimize transmission.

For onsite surveys that were started prior to the prioritization period and don't fall under this guidance, survey teams should end the survey and exit the facility.

Lastly, any initial certification surveys remain authorized to increase the health care capacity of the country.

Note: While CMS' directive applies to the CMS' federal surveyors and state agency surveyors, CMS also urges other surveyors, including accrediting organizations (AOs), to follow suit. Additionally, CMS' survey prioritization applies to surveys for compliance with federal regulations, not state surveys pursuant to state licensure.

Additional Instructions for Nursing Homes

We are disseminating the Infection Control survey developed by CMS and CDC so facilities can educate themselves on the latest practices and expectations. We expect facilities to use this new process, in conjunction with the latest guidance from CDC, to perform a voluntary self-assessment of their ability to prevent the transmission of COVID-19. This document may be requested by surveyors, if an onsite investigation takes place. We also encourage nursing homes to voluntarily share the results of this assessment with their state or local health department Healthcare-Associated Infections (HAI) Program. Contact information for each state's health departments is identified on the Centers for Disease Control & Prevention's (CDC's) website at: https://www.cdc.gov/HAI/state-based/index.html.

Furthermore, we remind facilities that they are required to have a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility, and when and to whom possible incidents of communicable disease or infections should be reported (42 CFR 483.80(a)(2)(i) and (ii)). CDC recommends that nursing homes notify their health department about residents with severe respiratory infection, or a cluster of respiratory illness (e.g., > or = 3 residents or HCP with new-onset respiratory symptoms within 72 hours). Local and state reporting guidelines or requirements may vary. Monitor the CDC website for information and resources to help prevent the introduction and spread of COVID-19 in nursing homes (CDC Preparing for COVID-19: Long-term Care Facilities, Nursing Homes: https://www.cdc.gov/coronavirus/2019-

ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html). We urge providers to review the tools and implement actions to protect the health and safety of individuals to respond to the COVID-19 pandemic.

Additional Instructions for Other (Non-Long Term Care) Provider Types

Education and Signage

Where the patient/resident is sleeping at the health care facility, signage on the patient's room is important to ensuring that all staff are aware of the necessary infection control steps. https://www.cdc.gov/infectioncontrol/pdf/droplet-precautions-sign-P.pdf

In the home setting, health care staff may have little control over the home environment, but must 1) educate staff, patients and family members regarding infection control procedures and how to avoid transmission of COVID-19, and 2) maintain clean equipment and supplies and follow appropriate infection control procedures during home visits and transport of reusable patient care items. For further information refer to CDC's interim guidance for home care of people not requiring hospitalization for COVID-19 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-home-care.html).

Limitations on Visitors

To mitigate the spread of the COVID-19 virus, CMS is providing guidance to restrict visitation in health care facilities such as hospitals, critical access hospitals, psychiatric hospitals, inpatient hospice units, and intermediate care facilities for individuals with developmental disabilities. For CMS restrictions on visitation in nursing homes, see QSO-20-14 https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf.

CMS is providing the following expanded guidance to prevent the spread of COVID-19:

a) Visitors should receive the same screening as patients, including whether they have had:
- Fever or symptoms of a respiratory infection, such as a cough and sore throat.
- International travel within the last 14 days to CDC Level 3 risk countries. For updated information on restricted countries visit: https://www.cdc.gov/coronavirus/2019-ncov/travelers/index.html
- Contact with someone with known or suspected COVID-19.

b) Health care facilities should set limitations on visitation. For example, limitations may include restricting the number of visitors per patient, or limiting visitors to only those that provide assistance to the patient, or limiting visitors under a certain age.

c) Health care facilities should provide signage at entrances for screening individuals, provide temperature checks/ ask about fever, and encourage frequent hand washing and use of hand sanitizer before entering the facility and before and after entering patient rooms

d) If visiting and not seeking medical treatment themselves, individuals with fevers, cough, sore throat, body aches or runny nose or not following infection control guidance should be restricted from entry.

e) Facilities should screen and limit visitors for any recent trips (within the last 30 days) on cruise ships as well as close contact with a suspect or laboratory-confirmed COVID-19 patient within the last 14 days, or overseas travel from certain countries.

https://www.cdc.gov/coronavirus/2019-ncov/travelers/after-travel-precautions.html, https://wwwnc.cdc.gov/travel/page/covid-19-cruise-ship

f) Facilities should instruct visitors to limit their movement within the facility (e.g., reduce walking the halls, trips to cafeteria, etc.)
g) Facilities should establish limited entry points for all visitors and/or establish alternative sites for screening prior to entry.
h) Facilities can implement measures to:
   - Increase communication with families (phone, face-time, skype, etc.).
   - Potentially offer a hotline for with a recording that is updated at set times so families can get an update on the facility's general status.
   - If appropriate, consider offering telephonic screening of recent travel and wellness prior to coming in for scheduled appointments. This may help limit the amount of visitor movement throughout the organization and congestion at entry points.
i) Consider closing common visiting areas and encouraging patients to visit with loved ones in their patient rooms.

In home and community-based settings, health care providers should advise patients with COVID-19 of the CDC guidance to mitigate transmission of the virus. This includes isolating at home during illness, restricting activities except for medical care, using a separate bathroom and bedroom if possible, and prohibiting visitors who do not have an essential need to be in the home. The certified Medicare/Medicaid provider is expected to share this information with patients with the COVID-19 virus and his/her caregiver. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-prevent-spread.html

Some states have chosen to establish more restrictive criteria than described above. Health care providers to follow the more restrictive criteria when present.

Access for Healthcare Staff

CMS is aware that some providers (nursing homes, assisted living facilities, etc.) have significantly restricted entry for staff from other Medicare/Medicaid certified providers who are providing direct care to patients. In general, if the staff is appropriately wearing PPE, and do not meet criteria for restricted access, they should be allowed to enter and provide services to the patient (interdisciplinary hospice care, dialysis, organ procurement, home health, etc.).

For hospitals, this would also apply to organ procurement coordinators. Ensuring that individuals have continued access to life-saving organs is critical. We understand that hospitals are preparing for a potential surge in COVID-19 patients however, we would ask that donor hospitals continue with operations in regards to allowing organ procurement coordinators into hospitals to discuss organ donation with families. Hospital and OPO leadership should communicate on risk assessments in their communities and any potential impacts for organ recovery operations.

CMS will continue to evaluate the survey prioritization in light of the situation on the ground in areas with large numbers of COVID-19 cases, to determine if CMS needs to continue this past the initial three weeks.

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 .

Contact: Questions about this document should be addressed to QSOG_EmergencyPrep@cms.hhs.gov.

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

/s/
David R. Wright

cc: Survey and Operations Group Management

COVID-19 Focused Survey for Nursing Homes

Infection Control

This survey tool must be used to investigate compliance at F880 and 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.

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; and
- Facility policies and procedures to address staffing issues during emergencies, such as transmission of COVID-19

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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 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.

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 Pages 1-2)

☐ 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 (i.e., 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 (i.e., 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 (i.e., 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**

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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**

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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**

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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 (i.e., 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**

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5. Visitor Entry

☐ Review for compliance of:

- Screening processes and criteria (i.e., 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**

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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. 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 a 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 a emergency staff was not needed)

7. Did the facility develop and implement policies and procedures for staffing strategies during an emergency?

☐ **Yes** ☐ **No E0024**

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.

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 o Policy/Procedure Review ▪ Infect. Control/Prev. Plan ▪ Emerg. Prep. Plan, including contingency strategies (e.g., staffing) • Conduct survey exit discussion telephonically and draft the CMS-2567 offsite.	• Limit the onsite team to one to two surveyors. • Identify 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: o Policy/Procedure knowledge o Surveillance for sign/symptoms o Notifying local health officials • 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; and 7. Emergency preparedness – staffing in emergencies

Summary of the COVID-19 Focused Survey for Nursing Homes

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.

COVID-19 Focused Infection Control Survey: Acute and Continuing Care

General guidance: 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. Entry and screening procedures as well as patient care guidance has varied over the progression of COVID-19 transmission in facilities. Facilities are expected to be in compliance with CMS 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.

Content within this tool may be generally applied to any setting. However, CMS recognizes that not all acute and continuing care providers have the same acuity or capacity and therfore, depending upon the setting, not all information will be applicable on every survey (e.g.; aerosol generating procedures section). 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 guidance in the appropriate provider/supplier appendix 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 purposes of this document, "staff" includes employees, consultants, contractors, volunteers, and others who provide care and services to patients on behalf of the facility. Additionally, the general term "facility" means inpatient, congregate settings, hospitals, intermediate care facilities for individuals with intellectual disabilities, dialysis facilities, and clinics, and "home" refers to settings such as hospice and home health where care is provided in the home.

Entering the Facility/Triage/Registration/Visitor Handling

Prior to entering the facility:

- Is signage posted at facility entrances with visitation restrictions and screening procedures?
- Are signs posted at entrances with instructions to individuals seeking medical care with symptoms of respiratory infection to immediately put on a mask and keep it on during their assessment, cover their mouth/nose when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after contact with respiratory secretions?

Upon entering the facility:

- Are staff trained on appropriate processes (e.g., questions to ask and actions to take) to rapidly identify and isolate suspect COVID-19 cases?
- Is there a process that occurs after a suspected case is identified to include immediate notification of facility leadership/infection control?

COVID-19 Focused Infection Control Survey: Acute and Continuing Care

Visitation

- Facilities should limit visitation.
- Are facilities actively screening visitors (CDC currently recomends staff are checking for fever and signs and/or symptoms of respiratory infection, and other criteria such as travel or exposure to COVID-19)?
- What is your current screening criteria?
- For permitted visitors are they instructed to frequently perform hand hygiene; limit their interactions with others in the facility; restrict their visit to the patient's room or other location designated by the facility; and offered personal protective equipment (PPE) as supply allows?

Did the facility perform appropriate screening of visitors? ☐ Yes ☐ **No (see appropriate IPC tags for the provider/supplier type)**

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, CMS does 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 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 patients. 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.

General Standard Precautions

☐ Are staff performing the following appropriately:

- Respiratory hygiene/cough etiquette,
- Environmental cleaning and disinfection, and
- Reprocessing of reusable patient medical equipment (i.e., cleaning and disinfection per device and disinfectant manufacturer's instructions for use)?

COVID-19 Focused Infection Control Survey: Acute and Continuing Care

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?

☐ Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), If there are shortages of ABHR, hand hygiene using soap and water is used instead?

☐ Do staff perform hand hygiene (even if gloves are used) in the following situations:

- Before and after contact with patients;
- After contact with blood, body fluids, or visibly contaminated surfaces or other objects and surfaces in the care 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, medication preparation, and/or dressing care).

☐ Interview appropriate staff to determine if hand hygiene supplies are readily available and who they contact for replacement supplies.

Did staff implement appropriate hand hygiene? ☐ Yes ☐ **No (see appropriate IPC tags for the provider/supplier type)**

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 site to a clean site during care (body, equipment, etc);
- An isolation gown is worn for direct patient contact if the patient has uncontained secretions or excretions;
- A facemask, gloves, isolation gown, and eye protection are worn when caring for a patient with new acute cough or symptoms of an undiagnosed respiratory infection unless the suspected diagnosis requires airborne precautions (e.g., tuberculosis)

☐ 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 Infection Control Survey: Acute and Continuing Care

Aerosol – Generating Procedures

- Appropriate mouth, nose, clothing, gloves, and eye protection (e.g., N95 or higher-level respirator, if available; face shield, gowns) is worn for performing aerosol-generating and/or procedures that are likely to generate splashes or sprays of blood or body fluids and COVID-19 is suspected;
- Some procedures performed on patient with known or suspected COVID-19 could generate infectious aerosols. 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 a gown.
    - The number of staff present during the procedure should be limited to only those essential for 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 procedure room surfaces promptly as 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;

Did staff implement appropriate use of PPE? ☐ Yes ☐ **No (see appropriate IPC tags for the provider/supplier type)**

Transmission-Based Precautions

☐ Determine if appropriate transmission-based precautions are implemented, including but not limited to:

- Signage on the patient's room regarding need for transmission-based precautions.
- PPE use by staff (i.e., don gloves and gowns before contact with the patient and their care environment while on contact precautions; don facemask within three feet of a patient on droplet precautions; for facilities that use/have N-95 masks - don an fit-tested N95 or higher level respirator prior to room entry of a patient on airborne precautions);
- Dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs, blood glucose monitor equipment) are used, or if not available, then equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant prior to use on another patient or before being returned to a common clean storage area;
- When transport or movement is medically-necessary outside of the patient room, does the patient wear a facemask?
- Contaminated surfaces, objects and environmental surfaces that are touched frequently and in close proximity to the patient (e.g., bed rails, over-bed table, bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare use (effective against the organism identified if known) at least daily and when visibly soiled.

☐ Interview appropriate staff to determine if they are aware of processes/protocols for transmission-based precautions and how staff is monitored for compliance.

☐ For providers of care in the home, has the provider, educated patients and family members regarding transmission of infectious diseases and specifically mitigating transmission of COVID-19.

☐ 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 patients with transmission-based precautions.

Did the staff implement appropriate transmission-based precautions? ☐ Yes ☐ **No (see appropriate IPC tags for the provider/supplier type)**

Standards, Policies and Procedures

☐ Did the facility establish a facility-wide IPCP including written 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.

Did the facility develop and implement an overall IPCP including policies and procedures for for undiagnosed respiratory illness and COVID-19? ☐ **Yes** ☐ **No (see appropriate IPC tags for the provider/supplier type)**

Infection Surveillance

☐ Does the facility know how many patients in the facility have been diagnosed with COVID-19 (suspected and confirmed)?

☐ The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of fever, respiratory illness, or other signs/symptoms of COVID-19.

☐ The plan includes early detection, management of a potentially infectious, symptomatic patient and the implementation of appropriate transmission-based precautions/PPE.

☐ The facility has a process for communicating the diagnosis, treatment, and laboratory test results when transferring patients to an acute care hospital or other healthcare provider.

☐ Can appropriate staff (e.g., nursing and leadership) 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.

Did the facility provide appropriate infection surveillance? ☐ Yes ☐ **No (see appropriate IPC tags for the provider/supplier type)**

Education, Monitoring, and Screening of Staff

- Is there evidence the provider has educated staff on COVID-19 (e.g., symptoms, how it is transmited, screening criteria, work exclusions)?

- How does the provider 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:
  - have a process for staff to report their illness or developing symptoms;
  - place them in a facemask and have them return home for appropriate medical evaluation;
  - 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).

Did the facility provide appropriate education, monitoring, and screening of staff? ☐ Yes ☐ **No (see appropriate IPC tags for the provider/supplier type)**

Emergency Preparedness - Staffing in Emergencies

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

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

Did the facility develop and implement policies and procedures for staffing strategies during an emergency?

☐ **Yes** ☐ **No (see appropriate Emergency Preparedness tag for the provider/supplier type)**

The following sections are specific nuances to consider and assess when on survey.

Considerations Specifically for Surveys of Hospitals and Critical Access Hospitals

Patient Care

- Is the facility restricting patients (to the extent possible) to their rooms except for medically necessary purposes? If patients have to leave their room, are they wearing a facemask, performing hand hygiene, limiting their movement in the facility, and performing social distancing (stay at least 6 feet away from others). If PPE shortage is an issue, facemasks should be limited to patients diagnosed with COVID-19 or has signs/symptoms of respiratory illness or COVID-19.

COVID-19 Focused Infection Control Survey: Acute and Continuing Care

- 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?

Did staff provide appropriate care for patients with known or suspected COVID-19? ☐ Yes ☐ No (Hospital Tag A-0747, CAH Tag C-0278)

Environmental Cleaning

- During environmental cleaning procedures, personnel wear appropriate PPE to prevent exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection)?
- Environmental surfaces in patient care areas are cleaned and disinfected, using an EPA-registered disinfectant on a regular basis (e.g., daily), when spills occur and when surfaces are visibly contaminated? 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;
- Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).
- The hospital decontaminates spills of blood or other body fluids according to its policies and procedures, using appropriate EPA-registered hospital disinfectants?

Did staff provide appropriate environmental cleaning for facilities with known or suspected COVID-19? ☐ Yes ☐ No (Hospital Tag A-0747, CAH Tag C-0278)

Additional Considerations Specifically for Dialysis Facility Surveys

Hand Hygiene Considerations

- Perform handwashing with soap and water at dedicated handwashing sinks if hands are visibily soiled (see § 494.30(a)(1)(i))
- Remove gloves and perform hand hygiene between each patient or dialysis station

Cleaning and Disinfection Considerations

- Items taken to the dialysis station must be either disposed of, dedicated for use on a single patient or cleaned and disinfected before being taken to a common clean area or used on another patient
- Use proper aseptic technique during vascular access care, medication preparation and administration
- Proper cleaning and disinfection of the dialysis station including the dialysis machine, chair, prime waste receptacle, reuseable acid and bicarbonate containers after the previous patient fully vacates the station.

- Clean areas should be clearly designated for the preparation, handling and storage of medications and unusued supplies and equipment.
- Clean areas should be clearly separated from contaminated areas where used supplies and equipment are handled.
- Proper disposal of bio-hazard waste

Isolation Considerations

- Ensure dedicated machines, equipment, instruments, supplies, and medications that will not be used to care for non-isolation patients.

Did staff implement appropriate hand hygiene, cleaning/disinfection and isolation considerations? ☐ Yes ☐ **No (see Condition 42 CFR 494.30 and Tags V110-V148)**

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.

Summary of the COVID-19 Focused Survey for Acute and Continuing Care Providers

This is a summary of the COVID-19 Focused Survey for acute and continuing care providers (Non-Long term care facilities). Surveyors should review the Focused Infection Control Survey tool in light of the established State Operations Manual Survey Protocol for more detailed information. 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
• If the survey team plans to enter a facility with an active COVID-19 case, the survey team should contact their State Survey Agency (SA), the state health department, and CMS Regional Location to coordinate activities for these facilities. • SAs should ensure surveyors are medically cleared, trained in the appropriate use of and have needed 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 Complaint allegations. • Identify survey activities that will be conducted offsite, such as: o Medical record review o Telephonic interviews o Facility Policy/Procedure review • Conduct any survey exit discussion with the facility by telephone and draft the CMS-2567 offsite.	• If the survey team identifies an active COVID-19 case after entering a facility, the survey team should contact their SA, the state health department, and CMS Regional Location to coordinate activities for the facility. • Limit the onsite team to one to two surveyors. • Identify onsite assignments for activities, such as: Observations: o Hand hygiene practices o Proper use/discarding of PPE o Cleansing medical equipment o Effective Transmission-Based Precautions Interviews: o Policy/Procedure knowledge o Surveillance for sign/symptoms o Notifying local health officials • Adhere to all CDC guidance for infection prevention and control related to COVID-19. • 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 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. Patient care (including patient placement); 3. Infection prevention and control standards, policies and procedures (hand hygiene, PPE, cleaning and disinfection, surveillance); 4. Visitor entry (i.e., screening, restriction, and education); 5. Education, monitoring, and screening of staff; and 6. Emergency preparedness – staffing in emergencies

Summary of the COVID-19 Focused Survey for Acute and Continuing Care Providers

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.

Nursing Home Infection Prevention Assessment Tool for COVID-19

The following infection prevention and control assessment tool should be used to assist nursing homes with preparing to care for residents with COVID-19. Elements should be assessed through a combination of interviews with staff and direct observation of practices in the facility.

The assessment focuses on the following priorities, which should be implemented by all nursing homes.

- **Keep COVID-19 from entering your facility:**
  - Restrict all visitors except for compassionate care situations (e.g., end of life).
  - Restrict all volunteers and non-essential healthcare personnel (HCP), including consultant services (e.g., barber).
  - Actively screen all HCP for fever and respiratory symptoms before starting each shift; send them home if they are ill.
  - Limit those who come in direct contact with the patient to staff providing medical care (e.g., nurses, certified nurse assistants, qualified medical assistants, hospice workers)
  - Cancel all field trips outside of the facility.
  - Have residents who must regularly leave the facility for medically necessary purposes (e.g., residents receiving hemodialysis) wear a facemask whenever they leave their room, including for procedures outside of the facility.
  - Restrict voluntary leaves of absence from facilities.
- **Identify infections early:**
  - Actively screen all residents at least daily for fever and respiratory symptoms; immediately isolate anyone who is symptomatic.
    - Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 if it is widespread in the community.
  - Notify the health department if: severe respiratory infection, clusters (≥3 residents and/or HCP) of respiratory infection, or individuals with known or suspected COVID-19 are identified.
- **Prevent spread of COVID-19:**
  - Cancel all group activities and communal dining.
  - Enforce social distancing among residents.
  - When COVID-19 is reported in the community, implement universal facemask use by all HCP (source control) when they enter the facility;
    - If facemasks are in short supply, they should be prioritized for direct care personnel. All HCP should be reminded to practice social distancing when in break rooms or common areas.
    - If facemasks are in short supply, staff may wear the same mask for an entire shift.
  - If COVID-19 is identified in the facility, restrict all residents to their room and have HCP wear all recommended PPE for all resident care, regardless of the presence of symptoms. Refer to strategies for optimizing PPE when shortages exist.
    - This approach is recommended to account for residents who are infected but not manifesting symptoms. Recent experience suggests that a substantial proportion of long-term care residents with COVID-19 do not demonstrate symptoms.

        - When a case is identified, public health can help inform decisions about testing asymptomatic residents on the unit and in the facility.
- **Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply:**
    - For example, extended use of facemasks and eye protection or prioritization of gowns for certain resident care activities
        - https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
- **Identify and manage severe illness:**
    - Facility performs appropriate monitoring of ill residents (including documentation of pulse oximetry) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.

Which of the following situations apply to the facility? (Select all that apply)

□ No cases of COVID-19 currently reported in their community
□ Cases reported in their community
□ Sustained transmission reported in their community
□ Cases identified in their facility (either among HCP or residents)

How many days supply does the facility have of the following PPE and alcohol-based hand sanitizer (ABHS)?

Facemasks:
N-95 or higher-level respirators:
Isolation gowns:
Eye protection:
Gloves:
ABHS:

Visitor restrictions		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility restricts all visitation except certain compassionate care situations, such as end of life situations. Decisions about visitation during an end of life situation are made on a case by case basis: • Potential visitors are screened prior to entry for fever or respiratory symptoms. Those with symptoms are not permitted to enter the facility. • Visitors that are permitted inside, must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility. They are also reminded to frequently perform hand hygiene.		
Facility has sent a communication (e.g., letter, email) to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations, and that alternative methods for visitation (e.g., video conferencing) will be facilitated by the facility.		
Facility has provided alternative methods for visitation (e.g., video conferencing) for residents.		
Facility has posted signs at entrances to the facility advising that no visitors may enter the facility.		

Education, monitoring, and screening of healthcare personnel (HCP)		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**

Facility has provided education and refresher training to HCP (including consultant personnel) about the following:
• COVID-19 (e.g., symptoms, how it is transmitted)
• Sick leave policies and importance of not reporting or remaining at work when ill
• Adherence to recommended IPC practices, including:
  o Hand hygiene,
  o Selection and use including donning and doffing PPE,
  o Cleaning and disinfecting environmental surfaces and resident care equipment
• Any changes to usual policies/procedures in response to PPE or staffing shortages		

Facility keeps a list of symptomatic HCP.		
Facility screens all HCP (including consultant personnel) at the beginning of their shift for fever and respiratory symptoms (actively takes their temperature and documents absence of shortness of breath, new or change in cough, and sore throat). • If they are ill, they are instructed to put on a facemask and return home.		
Non-essential personnel including volunteers and non-essential consultant personnel (e.g., barbers) are restricted from entering the building.		
Education, monitoring, and screening of residents		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility has provided education to residents about the following: • COVID-19 (e.g., symptoms, how it is transmitted) • Importance of immediately informing HCP if they feel feverish or ill • Actions they can take to protect themselves (e.g., hand hygiene, covering their cough, maintaining social distancing) • Actions the facility is taking to keep them safe (e.g., visitor restrictions, changes in PPE, canceling group activities and communal dining)		
Facility assesses residents for fever and symptoms of respiratory infection upon admission and at least daily throughout their stay in the facility. • Residents with suspected respiratory infection are immediately placed in appropriate Transmission-Based Precautions. • Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms.		

Atypical symptoms may include: new or worsening malaise, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 if it is widespread in the community.		
Facility performs appropriate monitoring of ill residents (including documentation of pulse oximetry) at least 3 times daily to quickly identify residents who require transfer to a higher level of care.		
Facility keeps a list of symptomatic residents.		
Facility has taken action to stop group activities inside the facility and field trips outside of the facility.		
Facility has taken action to stop communal dining.		
Facility has residents who must regularly leave the facility for medically necessary purposes (e.g., residents receiving hemodialysis or chemotherapy) wear a facemask whenever they leave their room, including for procedures outside of the facility. • Consider having HCP wear all recommended PPE (gown, gloves, eye protection, facemask for the care of these residents, regardless of presence of symptoms (if PPE supply allows). N95 masks, if available, should be worn by staff ding procedures that generate respiratory aerosols (e.g., nebulizer treatments) Refer to strategies for optimizing PPE when shortages exist.		
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) • Residents are encouraged to remain in their room. If there are cases in the facility, residents are restricted (to the extent possible) to their rooms except for medically necessary purposes. If residents leave their room, they wear a facemask, perform hand hygiene, limit movement in the facility and perform social distancing. • Consider implementing protocols for cohorting ill residents with dedicated HCP.		
Availability of PPE and Other Supplies		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility has assessed current supply of PPE and other critical materials (e.g., alcohol-based hand rub, EPA-registered disinfectants, tissues).		
If PPE shortages are identified or anticipated, facility has engaged their healthcare coalition for assistance. https://www.phe.gov/Preparedness/planning/hpp/Pages/find-hc-coalition.aspx		
Facility has implemented measures to optimize current PPE supplies, which include options for extended use, reuse, and alternatives to PPE.		

For example, under extended use, the same facemask and eye protection may be worn during the care of more than one resident. Gowns could be prioritized for select activities such as activities where splashes and sprays are anticipated (including aerosol generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP. Additional options and details are available here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html		
Hand hygiene supplies are available in all resident care areas. • Alcohol-based hand sanitizer* with 60-95% alcohol is available in every resident room and other resident care and common areas. • Sinks are stocked with soap and paper towels. *If there are shortages of ABHS, hand hygiene using soap and water is still expected.		
PPE is available in resident care areas (e.g., outside resident rooms). PPE includes: gloves, gowns, facemasks, N-95 of higher-level respirators (if facility has a respiratory protection program and HCP are fit-tested) and eye protection (face shield or goggles).		
EPA-registered, hospital-grade disinfectants with an emerging viral pathogens claim against SARS-CoV-2 are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. *See EPA List N: https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2		
Tissues are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.		
Infection Prevention and Control Practices		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
HCP perform hand hygiene in the following situations: • Before resident contact, even if PPE is worn • After contact with the resident • After contact with blood, body fluids or contaminated surfaces or equipment • Before performing sterile procedure • After removing PPE		
HCP wear the following PPE when caring for residents with undiagnosed respiratory illness unless the suspected diagnosis required Airborne Precautions (e.g., tuberculosis): • Gloves • Isolation gown • Facemask • Eye protection (e.g., goggles or face shield)		

If COVID-19 is suspected, an N-95 or higher-level respirator is preferred, if available and the facility has a respiratory protection program with fit-tested HCP; facemasks are an acceptable alternative.		
PPE are removed in a manner to prevent self-contamination, hand hygiene is performed, and new PPE are put on after each resident except as noted below.		
Additional actions when COVID-19 is identified in the community (some facilities may choose to implement these earlier) • Facility has implemented universal use of facemasks for HCP (for source control) while in the facility. If facemasks are in short supply, they are prioritized for direct care personnel. All HCP are reminded to practice social distancing when in break rooms or common areas.		
Additional actions when COVID-19 is identified in the facility or there is sustained transmission in the community (some facilities may choose to implement these earlier) • Consider having HCP wear all recommended PPE (gown, gloves, eye protection, N95 respirator (or facemask if not available)) for the care of all residents, regardless of presence of symptoms. This is done (if PPE supply allows) when COVID-19 is identified in the facility. Refer to strategies for optimizing PPE when shortages exist. This approach is recommended to account for residents who are infected but not manifesting symptoms. Recent experience suggests that a substantial proportion of long-term care residents with COVID-19 do not demonstrate symptoms.		
Non-dedicated, non-disposable resident care equipment is cleaned and disinfected after each use.		
EPA-registered disinfectants are prepared and used in accordance with label instructions.		
Communication		
Elements to be assessed	**Assessment**	**Notes/Areas for Improvement**
Facility communicates information about known or suspected COVID-19 patients to appropriate personnel (e.g., transport personnel, receiving facility) before transferring them to healthcare facilities.		
Facility notifies the health department about any of the following: • COVID-19 is suspected or confirmed in a resident or healthcare provider • A resident has severe respiratory infection • A cluster (e.g., ≥ 3 residents or HCP with new-onset respiratory symptoms over 72 hours) of residents or HCP with symptoms of respiratory infection is identified.		

COVID 19 CORONAVIRUS DISEASE

VISITOR ALERT

Visitation has been restricted to prevent the spread of novel coronavirus (COVID-19)

PREVENTION

Cover your mouth and nose with a tissue when you cough or sneeze.

Practice hand hygiene – wash your hands with soap and water or use an alcohol-based hand rub.

Don't touch your face with unwashed hands; it's the easiest way for germs to enter your body.

NOTE: Anyone older than 60 years, those with underlying health conditions and those with suppressed immune systems are most at risk for COVID-19.

Indiana State Department of Health

COVID 19 CORONAVIRUS DISEASE

ALERTA PARA LOS VISITANTES

LAS VISITAS HAN SIDO RESTRINGIDAS PARA PREVENIR LA PROPAGACIÓN DEL CORONAVIRUS (COVID-19)

PREVENCIÓN

Cúbrase la boca y la nariz con un pañuelo cuando tosa o estornude.

Practique la higiene de las manos: lávese las manos con agua y jabón o use un desinfectante para manos a base de alcohol.

No se toque la cara con las manos sin lavar; es la forma más fácil para que los gérmenes ingresen a su cuerpo.

NOTA: Personas mayores de 60 años, aquellos con enfermedades subyacentes y aquellos con un sistema inmune debil, tienen mayor riesgo de contrael el COVID-19.

Updated: 3/17/20

Indiana State Department of Health

COVID-19 Specimen Collection and Submission Guidelines

Healthcare providers with patients who meet the eligibility criteria should work with their infection preventionists and laboratory personnel to collect specimens.

ISDH now requires all COVID-19 test requisitions to be submitted through its Laboratory Information Management System (LimsNet).

Unauthorized specimens and specimens not submitted through LimsNet will not be tested.

LimsNet Test Request Submission:

New users

- To sign up for LimsNet, call the LIMS Help Desk 317-921-5506, or email us at LimsAppSupport@isdh.in.gov
- Please provide the following information:
  - Name of your facility.
  - Names and email addresses of all individuals that need LimsNet access at your facility.
  - Please include in the email body or subject line that you are requesting "Virology Test Submission" access.

Existing users

http://limsnet.isdh.in.gov/

Specimen Collection:

Click here for further information about collection guidelines: **Specimens**

Recommended Specimen Type is a **Nasopharyngeal (NP) Swab**

Shipping:

Authorized specimens should be **shipped Category B**, on cold packs, to the mailing address on the LimsNet Cover page.

- In response to the increased demands for COVID-19 testing, ISDH has partnered with Eli Lilly and Company to accelerate testing.
- Please double check the LIMSNET cover page for the proper shipping address when submitting your specimens in LIMSNET.
- Ensure that your package shipping label matches the mailing address on the LIMSNET cover page you printed for your samples.
- Shipment to the incorrect facility will cause delays in receiving, and possible cancellation if transit time exceeds 72 hours.

Document last updated: 03/20/20

- Specimens will not be received after the normal dock receiving hours. Please keep specimens collected after normal dock receiving hours refrigerated and deliver during normal dock receiving hours:

  Monday - Friday 8:15 AM - 4:45 PM Weekends 10:00 AM - 4:00 PM

  Note: FedEx, USPS, and UPS cannot be received over the Weekend.

- The ISDHL testing results will only be reported back to the LimsNet submitter or facility listed in the *Submitter Information* of the paper form. It will be the responsibility of this entity to relay all laboratory results to the patient's healthcare provider.

Please call 317-921-5500 or email isdh-lab-info@isdh.IN.gov for more information.

Newsletters - http://www.in.gov/isdh/27298.htm

The Indiana State Department of Health (ISDH) Healthcare Quality and Regulatory Commission publishes two newsletters - the *Infection Prevention Newsletter* and the *Long Term Care Newsletter*.

The *Infection Prevention Newsletter* is a collaboration between the ISDH's Epidemiology Resource Center and Health Care Quality and Regulatory Commission. The newsletter focuses on healthcare associated infections and provides information on infection control and prevention.

The purpose of the *Long Term Care Newsletter* is to provide program updates related to licensing and healthcare quality information related to long term care facilities. The following are items that are regularly included in the newsletters:

- Emergency information
- Epidemiologic outbreaks and updates
- Program updates
- CMS survey and certification updates
- Healthcare quality improvement projects
- Coming events

Both newsletters are electronic newsletters delivered via email and are available to anyone. The newsletters are free.

SUBSCRIPTION INFORMATION (all information must be completed):

Email Address: _____

Name: _____

Facility/Organization: _____

Facility/Organization County: _____

Position/Job Title: _____