Infection Prevention, Control & Immunizations

Infection Control: This facility task must be used to investigate compliance at F880, F881, F882, F883, F885, F886, F887, and F888. For the purpose of this task, "staff" includes all facility employees (regardless of clinical responsibilities or resident contact), licensed practitioners, adult students, trainees, and, volunteers; and individuals who provide care, treatment or other services for the facility and/or its residents, under contract or by other arrangement. The infection prevention and control program (IPCP) must be facility-wide and include all departments and contracted services. If a specific care area concern is identified, it should be evaluated under the specific care area, such as for pressure ulcers, respiratory care, catheter care, and medication pass observations which include central lines, peripheral IVs, and oral/IM/respiratory medications.

Entry and screening procedures as well as resident care guidance have 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.

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."

Please Note:

- **Focused Infection Control (FIC) Survey (not associated with a recertification or stand-alone complaint survey): Surveyors must evaluate the facility's compliance at all critical elements (CE) with the exception of CE#9, *CE#10, CE #14, CE #15, and CE #16.* The surveyor must examine the facility's compliance at §483.73(b)(6) or E0024 (at Appendix Z) if the full Emergency Preparedness survey is not being conducted.**
- ***If the facility was determined to be in substantial compliance with F888 within the previous six weeks and no substantive changes have been made to the policies and procedures for staff COVID-19 vaccinations, do not conduct a full compliance review of F888.***

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Coordination:

☐ Each surveyor is responsible for assessing the facility for breaks in infection control throughout the survey and is to answer CEs of concern (e.g., standard and transmission-based precautions, source control).

☐ One surveyor performs or coordinates (e.g., immunization review) the facility task to review for:

- Standard and transmission-based precautions
- Resident care for COVID-19
- Infection Prevention and Control Program (IPCP) standards, policies, and procedures
- Infection surveillance
- Visitor entry
- Staff and resident COVID-19 testing
- Suspected or confirmed COVID-19 reporting to residents, representatives, and families
- *Water management*
- Laundry services
- Antibiotic stewardship program (review at least one resident who is receiving an antibiotic if there are concerns)
- Infection Preventionist
- Influenza, pneumococcal, and COVID-19 immunizations

☐ Sample residents/staff as follows:

- Sample three staff, include at least one staff member who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19 (if this has occurred in the facility), for purposes of determining compliance with infection prevention and control national standards such as exclusion from work, testing, and reporting.
- Sample three residents for purposes of determining compliance with infection prevention and control national standards such as transmission-based precautions, as well as resident care, screening, testing, and reporting.
  - Include at least one resident who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19 (if any).
  - Include at least one resident on transmission-based precautions (if any), for any reason other than COVID-19.
- Sample five residents for influenza, pneumococcal, and COVID-19 immunizations (select COVID-19 unvaccinated residents).
  Note: If there are less than five COVID-19 unvaccinated residents, review all unvaccinated COVID-19 residents first. Then, select residents who are fully vaccinated to complete the sample.
- Sample eight staff (four staff and four contracted staff) for COVID-19 immunization review.

Standard and Transmission-Based Precautions (TBPs)

State and Federal surveyors should not cite facilities for not having certain supplies (e.g., Personal Protective Equipment (PPE) such as gowns, N95 respirators, surgical masks) if they are having difficulty obtaining these supplies for reasons outside of their control (e.g., national or regional shortage). However, we do expect facilities to take actions to mitigate any resource shortages and show they are taking all appropriate

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steps to obtain the necessary supplies as soon as possible. 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/hcp/us-healthcare-facilities.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:

☐ Staff are 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:

☐ Appropriate hand hygiene practices (i.e., alcohol-based hand rub (ABHR) or soap and water) are followed.

☐ Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected C. difficile infection (CDI) or norovirus during an outbreak, or if endemic rates of CDI are high. ABHR is not appropriate to use under these circumstances.

☐ 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, eye protection, 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, resident hand hygiene is performed after toileting and before meals. How are residents reminded to perform hand hygiene?

☐ 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) Use For Standard Precautions:

☐ Determine if staff appropriately use and discard PPE including, but not limited to, the following:

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- 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 (and hand hygiene performed);
- Gloves are changed and hand hygiene is performed before moving from a contaminated body site to a clean body site during resident care;
- An isolation gown is worn for direct resident contact if the resident has uncontained secretions or excretions (e.g., changing a resident and their linens when excretions would contaminate staff clothing);
- Appropriate mouth, nose, and eye protection (e.g., facemasks, goggles, face shield) along with isolation gowns are worn for resident care activities or procedures that are likely to contaminate mucous membranes, or generate splashes or sprays of blood, body fluids, secretions or excretions;
- All staff are following appropriate source control (i.e., facemasks or respirators) in accordance with national standards;
- When COVID-19 is present in the facility, staff are wearing an N95 or equivalent or higher-level respirator, instead of a facemask for aerosol generating procedures;
- PPE is appropriately discarded after resident care, prior to leaving room (except in the case of extended use of PPE per national and/or local recommendations), followed by hand hygiene;
- During the COVID-19 public health emergency, if facilities are experiencing PPE shortages outside of their control, they are using PPE optimizing strategies in accordance with national standards; and
- Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (e.g., nursing units, therapy rooms).

☐ Interview appropriate staff to determine if PPE supplies are readily available, accessible, and used by staff, and who they contact for replacement supplies.

- 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?
- How do you obtain PPE supplies before providing care?
- Who do you contact for replacement supplies?

Source Control for COVID-19:

☐ Ensure residents (when receiving visitors or while outside of their room), visitors, and others at the facility are wearing appropriate source control, in accordance with national standards, while in the facility or while around others outside.

Transmission-Based Precautions (TBP):

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

- 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 and eye protection (goggles or face shield) within six feet of a resident and prior to resident room entry;

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- For a resident on airborne precautions: staff don a fit-tested N95 or higher-level respirator prior to room entry of a resident;
- For a resident with an undiagnosed respiratory infection (and tested negative for COVID-19): 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. .
    - 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; and
        - Clean and disinfect the room surfaces with an appropriate disinfectant. Use disinfectants on EPA's List N: Disinfectants for Coronavirus (COVID-19) 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 reusable resident medical equipment is cleaned and disinfected according to manufacturers' instructions using an EPA-registered disinfectant for healthcare settings and effective against the identified organism (if known) 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 settings and effective against the organism identified (if known) at least daily and when visibly soiled.
- Signage on the use of specific PPE (for staff) is posted in appropriate locations in the facility (e.g., outside of a resident's room, wing, or facility-wide).

☐ Observe staff to determine if they use appropriate infection control precautions when moving between resident rooms, units and other areas of the facility.

☐ 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 the 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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Resident Care for COVID-19

☐ Residents on *TBP* are restricted to their rooms except for medically necessary purposes. If these residents have to leave their room, they are wearing source control, 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).

☐ The facility ensures only COVID-19 negative, and those not on TBP or under quarantine for COVID-19, participate in group outings, group activities, and communal dining. The facility is ensuring that residents are performing hand hygiene, wearing source control *and maintaining social distancing as appropriate (e.g. during peak times of visitation and large gathering, facilities should encourage physical distancing),* in accordance with national standards.

☐ The facility has a plan (including appropriate placement and PPE use) to manage residents that are new/readmissions, those exposed to COVID-19, and those suspected of COVID-19. These actions are based on national (e.g., CDC), state and/or local public health authority recommendations.

☐ The facility has a plan to prevent transmission, including a dedicated space in the facility for cohorting and managing care for residents with COVID-19. These actions are based on national (e.g., CDC), state and/or local public health authority recommendations.

☐ For residents who develop severe symptoms of illness and require transfer to a hospital for a higher level of care, the facility alerts emergency medical services and the receiving facility of the resident's diagnosis (suspected, observation/quarantine, or confirmed COVID-19) and precautions to be taken by transferring and receiving staff as well as placing source control on the resident during transfer (as tolerated).

☐ For residents who need to leave the facility for care (e.g., dialysis, etc.), the facility ensures that residents wear source control in accordance with national standards.

☐ In response to an outbreak, interview staff to determine how the facility ensures that residents wear source control in accordance with national standards.

2. Did staff provide appropriate resident care for COVID-19 related concerns? ☐ Yes ☐ **No F880**

IPCP Standards, Policies, Procedures and Education:

☐ The facility established a facility-wide IPCP including written IPCP standards, policies, and procedures that are current and based on the facility assessment [according to §483.70(e)] and national standards (e.g., for undiagnosed respiratory illness and COVID-19).

☐ The facility's policies or procedures include which communicable diseases are reportable to local and/or state public health authorities and contain when to notify if there are clusters of respiratory illness or cases of COVID-19 that are identified or suspected. The facility has a current list of reportable communicable diseases.

☐ Staff (e.g., nursing and unit managers) can identify and describe the communication protocol with local/state public health officials (e.g., to whom and when communicable diseases, healthcare-associated infections (as appropriate), and potential outbreaks must be reported).

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☐ There is evidence the facility has provided education to staff on COVID-19 (e.g., symptoms, how it is transmitted, self-monitoring for symptoms, work exclusions). How does the facility convey updates on COVID-19 to all staff?

☐ The policies and procedures are reviewed at least annually.

☐ 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, procedures and education that are current, based on national standards, and reviewed at least annually? ☐ Yes ☐ **No F880**

Infection Surveillance:

☐ The facility has a system in place for staff to report a communicable illness, including symptoms of COVID-19; a positive test for COVID-19; and if he/she meets criteria for quarantine/work exclusion. The facility has a policy for monitoring and evaluating clusters or outbreaks of illness among staff. The facility is documenting staff with signs/symptoms (e.g., fever) of COVID-19 according to their surveillance plan.

☐ Interview staff to determine what actions the facility took if they have had signs/symptoms of COVID-19 (e.g., work exclusion, COVID-19 testing).

☐ If staff develop symptoms at work (as stated above), the facility:

- Informs the facility's infection preventionist and includes information on individuals, equipment, and locations the person came in contact with; and
- Follows current guidance about returning to work (e.g., local health department, CDC: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html).

☐ The facility identifies the number of residents and staff in the facility, if any, that have fever, respiratory signs/symptoms, or other signs/symptoms related to COVID-19.

☐ The facility identifies the number of residents and staff, if any, that have been diagnosed with COVID-19 and when the first case was confirmed.

☐ The facility prohibits employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit disease. Staff are excluded from work according to national standards.

☐ The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of infections and outbreaks. For COVID-19 that includes resident surveillance of fever, respiratory illness, or other signs/symptoms of COVID-19 at least daily, and immediately isolate anyone who is symptomatic.

☐ The plan includes early detection, management of a potentially infectious, symptomatic resident that requires laboratory testing and/or the implementation of appropriate transmission-based precautions/PPE (the plan may include tracking this information in an infectious disease log).

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☐ The plan uses evidence-based surveillance criteria (e.g., CDC NHSN Long-Term Care or revised McGeer Criteria) to define infections and the use of a data collection tool.

☐ The plan includes ongoing analysis of surveillance data and review of data and documentation of follow-up activity in response.

☐ The facility has a process for communicating at time of transfer to an acute care hospital or other healthcare provider the diagnosis to include infection or multidrug-resistant organism colonization status, special instructions or precautions for ongoing care such as transmission-based precautions, medications [e.g., antibiotic(s)], laboratory and/or radiology test results, treatment, and discharge summary (if discharged).

☐ The facility has a process for obtaining pertinent notes such as discharge summary, lab results, current diagnoses, treatment, and infection or multidrug-resistant organism colonization status when residents are transferred back from acute care hospitals.

☐ 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**

Visitor Entry

☐ Determine if:

- Visitation is conducted according to residents' rights for visitation and in a manner that does not lead to transmission of COVID-19; and
- Signage posted at facility entrances alerting visitors when they should not enter the facility (e.g., symptoms of illness, under quarantine, tested positive for COVID-19).

☐ The facility informs those who enter 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 follow other current infection prevention and control standards (e.g., source control). What is the facility's process for communicating this information?

☐ The facility informs those who enter to monitor for signs and symptoms of COVID-19 and appropriate actions to take if signs and/or symptoms occur.

5. Did the facility inform visitors when they should not enter the facility and inform the visitor of appropriate infection prevention and control actions to take while in the facility? ☐ Yes ☐ **No F880**

Suspected or Confirmed COVID-19 Reporting to Residents, Representatives, and Families

This CE is relevant to facilities that have had confirmed cases or clusters of suspected COVID-19 infection.

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

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- ☐ The facility informed all residents, their representatives, and families by 5 PM the next calendar day following the occurrence of a single confirmed COVID-19 infection or of three or more residents or staff with new onset of respiratory symptoms that occurred within 72 hours of each other.
- ☐ The information included mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., visitation or group activities).
- ☐ The information did not include personally identifiable information.
- ☐ The facility provides cumulative updates to residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either: each time a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occurs within 72 hours of each other.
- ☐ Interview a resident and a resident representative or family member to determine whether they are receiving timely notifications.

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

Staff and Resident COVID-19 Testing *(Refer to QSO-20-38-NH revised)*

Review the facility's testing documentation (e.g., logs of community transmission levels, testing schedules, staff and resident records, other documentation). If possible, observe how the facility conducts testing, including the use of PPE and specimen collection. If such observation is not possible, interview an individual responsible for testing and inquire how testing is conducted (e.g., "what are the steps taken to conduct each test?").

- ☐ The facility conducts testing of staff, *as appropriate, in accordance with current CDC recommendations.*
- ☐ Based on observation or interview, the facility conducts testing and specimen collection in a manner that is consistent with current standards of practice for conducting COVID-19 tests.
- ☐ The facility's documentation demonstrates the facility conducts testing of residents or staff with signs or symptoms of COVID-19 in a manner that is consistent with current standards of practice for conducting COVID-19 tests.
- ☐ The facility's documentation demonstrates the facility conducts testing of residents and staff based on the identification of an individual diagnosed with COVID-19 in the facility in a manner that is consistent with current standards of practice for conducting COVID-19 tests.
- ☐ The facility takes actions to prevent the transmission of COVID-19 upon the identification of an individual with symptoms consistent with or who tests positive for COVID-19.
- ☐ The facility has procedures for addressing residents and staff that refuse testing or are unable to be tested.
- ☐ If there was an issue related to testing supplies or processing tests, ensure the facility made adequate attempts to obtain supplies by contacting the state and/or local health departments, local laboratories for assistance. If the facility conducts their own tests, they should also contact the supplier.

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7. Is the facility in compliance with requirements for staff and resident COVID-19 testing? ☐ Yes ☐ **No F886**

Water Management:

Through interview (or record review as necessary), determine whether the facility has:

☐ Assessed (e.g., description of the building water systems using text and flow diagrams) where Legionella and other opportunistic waterborne pathogens can grow and spread;

☐ Measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems that is based on nationally accepted standards (e.g., ASHRAE, CDC, U.S. Environmental Protection Agency or EPA). For example, control measures can include visible inspections, disinfectant, temperature control (that may require mixing valves to prevent scalding);

☐ A way to monitor the measures they have in place (e.g., testing protocols, acceptable ranges), and established ways to intervene when control limits are not met; and

☐ Had a resident with legionellosis since the last recertification survey. Interview the infection preventionist (IP) to determine whether the facility has had a case(s). Interview the IP (and perform record review as necessary) to determine what actions the facility took in response to the identified case in the facility. The State Survey Agency should work with local/state public health authorities, if possible, to determine if the water management program was inadequate to prevent the growth of Legionella or other opportunistic waterborne pathogens and whether the facility implemented adequate prevention and control measures once the issue was identified.

8. Did the facility have measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems? ☐ Yes ☐ **No F880** ☐ N/A, not a recertification survey

Laundry Services:

☐ Determine whether staff handle, store, and transport linens appropriately including, but not limited to:

- Using standard precautions (e.g., gloves, gowns when sorting and rinsing) and minimal agitation for contaminated linen;
- Holding contaminated linen and laundry bags away from his/her clothing/body during transport;
- Bagging/containing contaminated linen where collected, and sorted/rinsed only in the contaminated laundry area (double bagging of linen is only recommended if the outside of the bag is visibly contaminated or is observed to be wet on the outside of the bag);
- Transporting contaminated and clean linens in separate carts; if this is not possible, the contaminated linen cart should be thoroughly cleaned and disinfected per facility protocol before being used to move clean linens. Clean linens are transported by methods that ensure cleanliness, e.g., protect from dust and soil;
- Ensuring mattresses, pillows, bedding, and linens are maintained in good condition and are clean (Refer to F584); and
- If a laundry chute is in use, laundry bags are closed with no loose items.

☐ Laundry Rooms – Determine whether staff:

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- Maintain/use washing machines/dryers according to the manufacturer's instructions for use;
- If concerns, request evidence of maintenance log/record; and
- Use detergents, rinse aids/additives, and follow laundering directions according to the manufacturer's instructions for use.

9. Did the facility store, handle, transport, and process linens properly? ☐ Yes ☐ **No F880** ☐ N/A, not a recertification survey

Antibiotic Stewardship Program:

☐ Determine whether the facility has an antibiotic stewardship program that includes:

- Written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics;
- Protocols to review clinical signs and symptoms and laboratory reports to determine if the antibiotic is indicated or if adjustments to therapy should be made and identify what infection assessment tools or management algorithms are used for one or more infections (e.g., SBAR tool for urinary tract infection (UTI) assessment, Loeb minimum criteria for initiation of antibiotics);
- A process for a periodic review of antibiotic use by prescribing practitioners: for example, review of laboratory and medication orders, progress notes and medication administration records to determine whether or not an infection or communicable disease has been documented and whether an appropriate antibiotic has been prescribed for the recommended length of time. Determine whether the antibiotic use monitoring system is reviewed when the resident is new to the facility, when a prior resident returns or is transferred from a hospital or other facility, during each monthly drug regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic drug regimen review as requested by the QAA committee;
- Protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic; and
- A system for the provision of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data, and prescribing practices for the prescribing practitioner.

☐ *If there are concerns with the antibiotic stewardship program, surveyors must complete an investigation utilizing the Unnecessary Medication Review CE Pathway for at least one resident on an antibiotic to assess whether the resident(s) is being prescribed an antibiotic unnecessarily. Expand the sample as needed to determine scope and severity of findings.*

- *Determine whether a resident is already included in the sample from the initial pool or as one of the five residents selected for the unnecessary medication review.*
- *If there are not any sampled residents, select a high-risk resident receiving an antibiotic from the facility's infection surveillance log (e.g., UTI without a culture, long-term use, no signs or symptoms noted) to add to the sample.*

10. Did the facility conduct ongoing review for antibiotic stewardship? ☐ Yes ☐ **No F881** ☐ N/A, not a recertification survey

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Infection Preventionist (IP):

During interview with facility administration and Infection Preventionist(s), determine the following:

☐ The facility designated one or more individual(s) as the infection preventionist(s) who are responsible for the facility's IPCP.

☐ The Infection Preventionist (s) works at least part-time at the facility.

☐ The Infection Preventionist(s) completed specialized training in infection prevention and control.

Review facility records for the following related to the designated IP:

☐ *Professional training: the facility must provide documentation of the IP's primary professional training. There must be one of the following:*

- *Certificate/diploma or degree in nursing; or*
- *Bachelor's degree (or higher) in microbiology or epidemiology; or*
- *Associate's degree or higher in medical technology or clinical laboratory science; or*
- *Completion of training in another related field such as that for physicians, pharmacists, and physician's assistants.*

☐ *Specialized training in infection prevention and control.*

- *Completed prior to assuming the role of the IP; and*
- *Evidence of completion is available (e.g., certificate).*

11. Did the facility designate at least one qualified IP, who is responsible for the facility's IPCP? ☐ Yes ☐ **No F882**

Influenza, Pneumococcal, and COVID-19 Immunizations for Residents:

☐ Select five residents in the sample to review for the provision of influenza, pneumococcal, and COVID-19 immunizations.
NOTE: Include COVID-19 unvaccinated residents as indicated on the vaccination status list.

☐ Document the names of residents selected for review.

☐ Review the records of the five residents (influenza, pneumococcal, and COVID-19) for documentation of:

- Screening and eligibility to receive the vaccine(s);
- The provision of education related to the influenza, pneumococcal, and COVID-19 vaccines (such as the benefits and potential side effects);
- The administration of vaccines in accordance with national recommendations, which includes doses administered.
- Facilities must follow the CDC and Advisory Committee on Immunization Practices (ACIP) recommendations for vaccines; and

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- Allowing a resident or representative to accept or refuse the influenza, pneumococcal, and COVID-19 vaccines. If not provided, documentation as to why the vaccine(s) was not provided.

☐ For surveys occurring during influenza season, unavailability of the influenza vaccine can be a valid reason why a facility has not implemented the influenza vaccine program, especially during the early weeks of the influenza season. Similarly, COVID-19 vaccine supplies may be limited. Ask the facility to demonstrate that:

- The vaccine has been ordered and the facility received a confirmation of the order indicating that the vaccine has been shipped or that the product is not available but will be shipped when the supply is available;
- It made efforts to obtain the COVID-19 vaccine and provided information to residents on obtaining the vaccine if it is not available; and
- Plans are developed on how and when the vaccines are to be administered when they are available.

☐ As necessary, determine if the facility developed influenza, pneumococcal, and COVID-19 vaccine policies and procedures for all facility residents. Review policies and procedures and interview facility staff and residents and/or resident representatives to determine:

- How residents and/or resident representatives receive education on the benefits and potential side effects before being offered a vaccine. If multiple doses are required, how residents and/or resident representatives, will again receive education on the benefits and potential side effects before being offered the vaccine;
- How residents' vaccination status is tracked; and
- How screening is conducted for eligibility (e.g., medical contraindications, previous vaccination), the vaccines are offered, and consent or refusal is obtained.

12. Did the facility provide influenza and/or pneumococcal immunizations as required or appropriate for residents?
☐ Yes ☐ **No F883**

13. Did the facility provide COVID-19 immunization as required or appropriate for residents? ☐ Yes ☐ **No F887**

COVID-19 Vaccination for Facility Staff:

Policy and Procedure for Staff COVID-19 Vaccinations:

Note: If the facility was determined to be in substantial compliance with F888 within the previous six weeks and no substantive changes have been made to the policies and procedures for staff COVID-19 vaccinations, *DO NOT* conduct a full compliance review of CE #14, CE # 15, and *CE #16.*

☐ Determine whether the facility's COVID-19 vaccination policies and procedures for staff include the following:

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- All staff (except pending or granted requests for exemptions/temporarily delayed) have received, at a minimum, one dose of COVID-19 vaccine prior to providing care/treatment/services for the facility and/or its residents;
- A process to ensure that all staff (except those who have been granted an exemption or have a temporary delay) are fully vaccinated for COVID-19;
- Additional precautions that may include but are not limited to:
    - Reassigning staff who have not completed their primary vaccination series (including those who have pending requests or been granted an exemption, or who have a temporary delay) to non-resident areas, to duties that can be performed remotely (i.e., telework), or to duties which limit exposure to those most at risk (e.g., assigning to residents who are not immunocompromised, unvaccinated).
    - Requiring staff who have not completed their primary vaccination series (including those who have pending requests or been granted an exemption, or who have a temporary delay) to follow additional, CDC-recommended precautions, such as adhering to universal source control and physical distancing measures in areas that are restricted from resident access (e.g., staff meeting rooms, kitchen), even if the facility or service site is located in a county *where* community transmission *is not high.*
    - Requiring at least weekly testing for staff who have not completed their primary vaccination series (including those who have pending requests or been granted an exemption, or a temporary delay) for or until the regulatory requirement is met. Weekly testing should be conducted in the facility or services site regardless of the level of community transmission.
    - Requiring staff who have not completed their primary vaccination series (including those who have a pending request or been granted an exemption or who have a temporary delay) to use a NIOSH-approved N95 or equivalent or higher-level respirator for source control, regardless of whether they are providing direct care to or otherwise interacting with residents.
    - NOTE: The examples above are not all inclusive and represent actions that can be implemented, however, facilities can choose other precautions that align with the intent of the regulation which is intended to "mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated."
- Track and securely document the COVID-19 vaccination status for all staff, including booster doses;
- Process by which staff may request an exemption from the COVID-19 Health Care Staff vaccination requirements;
- Track and securely document staff who have requested or have been granted an exemption by the facility for COVID-19 vaccination;
- Documentation for each staff who requests medical exemption must include:
    - The authorized COVID-19 vaccines that are contraindicated and the clinical reasons; and
    - A practitioner statement that the staff member be exempted from the facility's COVID-19 vaccination requirements; and
    - Must be signed and dated by a licensed practitioner, who is not the individual requesting the exemption.
- Track/secure documentation of delayed staff vaccination for clinical precautions/considerations; and
- Contingency plans for staff that are not fully vaccinated for COVID-19:
    - What are the actions the facility will take when staff indicate they will not get vaccinated and do not qualify for an exemption?
    - Review the facility's plan to ensure it addresses staff who are not fully vaccinated due to an exemption or temporary delay in vaccination. The plan should prioritize those staff that have obtained no doses of any vaccine over staff that have received a single dose of a multi-dose vaccine.

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- Does the contingency plan include a deadline for staff to have obtained the COVID-19 vaccine?
- Does the plan indicate the action taken if the deadline is not met?

14. Did the facility develop policies and procedures that address the above components? ☐ Yes ☐ **No F888** ☐ N/A, *(investigation not required or* in substantial compliance with no substantive changes since last review in the previous six weeks)

***Surveyors are NOT required to verify the accuracy* of National Healthcare Safety Network (NHSN) data *unless there is a concern or complaint specific to NHSN*:** Please fill in the blanks with data directly from this link.

Note: Regardless of the timeframe of the NHSN concerns/complaint, surveyors review the most recent NHSN data to perform this task. There is no ability to retrieve archived NHSN data for this task.

NHSN as reported for week ending on (report header): _____

Recent Percentage of Staff who are Fully Vaccinated: _____

Note: if there is no data present in NHSN, please ask the facility staff the rationale while onsite.

☐ Review the COVID-19 Staff Vaccination Matrix or the facility's list of all staff and their vaccination status, which is obtained on the first day of the survey. Calculate the percentage of the current staff who received completed vaccinations using the formula listed in Figure 1 on the Surveyor Instructions on the COVID-19 Staff Vaccination Matrix (do not round). Compare the facility's data with the above NHSN data.

- If there is a 10% or less difference between the facility documentation and the NHSN data, no further investigation is required.
- If there is a greater than 10% difference, ask the facility to verify and explain why there is a significant variation.
  - If the information presented to the surveyor is incorrect (and NHSN is correct), or if both sources are incorrect, this likely demonstrates the facility's failure to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff [per §483.80(i)(3)(iv)], consider citing F888.
  - If the information reported to NHSN is incorrect (and the information reviewed onsite is correct) or there is no data present in NHSN, inform the facility to immediately correct the information in the NHSN system.

15. Did the facility implement their policy and have a process to track and securely document the COVID-19 vaccination status for all staff (per 483.80(i)(3)(iv))? ☐ Yes ☐ **No F888** ☐ N/A, *(investigation not required or* in substantial compliance with no substantive changes since last review in the previous six weeks)

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Determine the percentage of staff vaccinated and when to cite F888 in ASE-Q or LTCSP: (*Refer to the surveyor instructions section III on the COVID-19 Staff Vaccination Matrix)*

☐ If the percent vaccinated is less than 100% of all staff have received at least **one dose of a single-dose vaccine**, or **all doses of a multiple vaccine series**, or have been **granted** a qualifying exemption, or identified as having a temporary delay recommended by the CDC, cite F888.

Record Review, Staff Interviews, and Observations:

☐ Randomly select 4 staff from the completed COVID-19 Staff Vaccination Matrix, as described below, unless concerns exist for specific staff (e.g., complaints, infection control practice observations).

- 2 vaccinated direct care staff
  - 1 certified nurse aide (CNA).
  - 1 additional direct care staff.
- 2 unvaccinated staff (if available)
  - 1 unvaccinated staff with exemption or temporary delay.
  - 1 unvaccinated staff with a medical exemption.

Note: *If there are no staff available who are not vaccinated, you may substitute a staff who has been granted a non-medical exemption, if available, to ensure additional precautions are in place*. If the surveyor identifies any staff that were not vaccinated and were not granted an exemption or have a temporary delay (and weren't marked as such on the staff matrix), that individual(s) should be added to the sample.

☐ Ask the facility for information on how they ensure that their contractor staff are compliant with the vaccination requirement.

☐ From the list of contracted companies provided by the facility during the entrance conference, select 2 contract companies (1 direct care and 1 non-direct care). Ask the facility for a list of contracted staff from each of the two companies selected who are scheduled to provide services during the survey. Randomly select 2 contracted staff from each list.

- 2 direct care contracted staff
- 2 non-direct care contracted staff

☐ Ask the facility to obtain the contracted staff vaccination status for these individuals from the contract company.

Note: If there are no contracted staff scheduled to be onsite during the survey or observed by the surveyor, you do not need to increase the sample size for another category. Failure of contract staff to provide evidence of vaccination status reflects noncompliance and should be cited at F888

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under the requirement to have policies and procedures for ensuring that all staff are fully vaccinated, except for those staff who have been granted exemptions or a temporary delay at §483.80(i)(3)(ii).

☐ Observe and interview sampled staff who are not vaccinated to ensure additional precautions noted in the facility's policies and procedures, are in place to help prevent the spread of COVID-19.

- If reassigned: When were you reassigned duties?
- Are you being tested for COVID-19? If so, how often?
- Observe staff to determine whether they are using additional CDC-recommended precautions, *such as* universal source control (use a NIOSH-approved N95 or equivalent or higher-level respirator for source control) and maintaining physical distance including areas that are restricted from resident access (e.g., staff meeting rooms, kitchen).
- Determine whether other additional precautions are in place to mitigate the transmission of COVID-19.
- NOTE: The examples above are not all inclusive, and represent actions that can be implemented, however, facilities can choose other precautions that align with the intent of the regulation which is intended to "mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated."
- *NOTE: Regardless of a facility's compliance with the staff vaccination requirements, closely investigate infection prevention and control practices at F880 to ensure proper practices are in use, such as proper use of personal protective equipment, transmission precautions which reflect current standards of practice, and/or other relevant infection prevention and control practices are in place, which are designed to minimize transmission of COVID-19.*

☐ For sampled staff, determine whether the COVID-19 vaccination documentation includes the following:

- Screening and eligibility to receive the vaccine(s); and
- The provision of education related to the COVID-19 vaccines such as the benefits and potential side effects; and offering of the COVID-19 vaccines to staff by the facility per requirements at 42 CFR §483.80(d)(3), F887.

Note: These provisions do not apply to sampled staff that received their vaccination outside of the facility.

☐ For sampled **vaccinated staff and contracted staff**, determine whether the facility or contract company documented the vaccination status for:

- a single-dose COVID-19 vaccine, or
- all required doses for a multi-dose COVID-19 vaccine, and
- a booster dose.

☐ For the sampled **unvaccinated staff**:

- For staff who **do not have an exemption or reason for temporary delay,** ask the following:
  - Are you scheduled to receive a COVID-19 vaccine? If so, confirm the staff is scheduled.
  - If the staff isn't scheduled to receive a vaccine: Do you have a request for exemption pending?
  - When did the facility become aware staff did not have an exemption or reason for temporary delay?

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- What actions did the facility take to educate and offer COVID-19 vaccines to staff?
- What actions did the facility take when staff indicated that they will not get vaccinated and do not qualify for an exemption?

- For staff who have requested and/or are granted **medical exemption,** verify facility records are tracked, secure, and include the following:
  - Which COVID-19 vaccine is clinically contraindicated;
  - The recognized clinical reasons for the contraindication;
  - A statement by the practitioner recommending the staff member be exempted from the COVID-19 vaccination requirement; and
  - A signature and date by a licensed practitioner who is not the individual requesting the exemption.
- Review facility records and interview staff and/or contracted staff to confirm the facility has instituted the contingency plan, if needed:
  - Verify the actions taken by the facility for any staff who indicated they would not get vaccinated and were not qualified for an exemption?
  - When was staff given a deadline to receive the first dose of a vaccine? Confirm the date.
  - If the deadline has passed: What actions were taken?

16. Did the facility implement their policy and procedures to ensure:

a) all staff are vaccinated for COVID-19;

b) vaccination status is tracked, and documentation is secure for staff with an exemption; and

c) contingency plans are developed and followed?

☐ Yes ☐ **No F888** ☐ N/A, *(investigation not required or* in substantial compliance with no substantive changes since last review in the previous six weeks)

Educate and Offer COVID-19 Immunizations for Staff at Requirement 483.80(d)(3)

☐ May use the same sampled staff used for the testing requirement at CE #7 (i.e., three staff, including at least one staff member who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19) to determine compliance with CE #17.

☐ Review the facility's policies and procedures related to COVID-19 vaccination and ask the facility:

- What efforts has the facility made to obtain the COVID-19 vaccine? How was information provided to staff on obtaining the vaccine if it was not available?
- How are staff educated on the benefits and potential side effects before being offered a vaccine including any additional dose?
- How are staff vaccination status tracked or documented?
- How are staff screened for eligibility (e.g., medical contraindications, previous vaccination), vaccines offered, and consent or refusal is obtained?

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17. Did the facility maintain staff documentation of screening, education, offering, and current COVID-19 vaccination status?

☐ Yes ☐ **No F887**