COVID-19 Focused Survey for Nursing Homes

Infection Control

This survey tool must be used to investigate compliance at F880, *F882*, F884 (CMS Federal surveyors only), F885, *F886*, and E0024. Surveyors must determine whether the facility is implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19 and other communicable diseases and infections. Entry and screening procedures as well as resident care guidance has varied over the progression of COVID-19 transmission in facilities. Facilities are expected to be in compliance with CMS requirements and surveyors will use guidance that is in effect at the time of the survey. Refer to QSO memos released at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to- States-and-Regions.

This survey tool provides a focused review of the critical elements associated with the transmission of COVID-19, will help surveyors to prioritize survey activities while onsite, and identifies 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.

Note: It is imperative that surveyors refer to the most recent information for COVID-19 testing parameters and frequency set forth by the Secretary *described in the guidance for F886. County-level data are available on the CDC website:*

https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg

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

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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 *(review care of a resident under observation, suspected of, or confirmed to have COVID-19 infection);*
- Quality of resident care practices, including those *under observation, suspected of, and confirmed to have* COVID-19 *infection*, if applicable;
- The surveillance *and testing* process;
- Visitor entry and facility screening practices;
- Education, monitoring, and screening practices of staff;
- *Actions taken to prevent transmission, such as cohorting and managing care for residents suspected of having or confirmed to have COVID-19*;
- Facility policies and procedures to address staffing issues during emergencies, such as transmission of COVID-19;
- How the facility informs residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility*; and*
- *The infection preventionist role*.

The survey team will select a random sample of three residents, and if not already sampled, add one additional resident who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19, for purposes of determining compliance.

The survey team will select a random sample of three staff, and if not already sampled, add one additional staff who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19, for purposes of determining compliance.

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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 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/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:

☐ 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? *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.

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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, *eye protection (e.g. goggles or face shield), and an N95 or equivalent or higher-level respirator are* worn for direct resident contact if the resident has uncontained secretions or excretions *including splashes or sprays.*

☐ 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 actions 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?

☐ *Are all staff wearing a facemask (e.g., a cloth face covering can be used by staff where PPE is not indicated, such as administrative staff who are not at risk of coming in contact with infectious materials)?*

☐ *When COVID-19 is present in the facility, are staff wearing an N95 or equivalent or higher-level respirator, instead of a facemask, for aerosol generating procedures?*

Source Control:

☐ *Are residents, visitors, and others at the facility donning a cloth face covering or facemask while in the facility or while around others outside?*

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. 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 with *an* appropriate disinfectant. Use disinfectants on List N of the EPA website 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 *(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 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.

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

☐ 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

☐ *Are residents on Transmission-Based Precautions restricted* to their rooms except for medically necessary purposes? If these residents have to leave their room, are they wearing a facemask *or cloth face covering*, 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)?

☐ *When residents not on Transmission-Based Precautions are outside of their room,are they wearing a cloth face covering or facemask as part of source control? If a cloth face covering or facemask is not tolerated, does the resident cover his/her mouth and nose with tissues and is reminded or assisted to perform hand hygiene? Is at least 6 feet maintained between residents?*

☐ *Is* the facility *ensuring only COVID-19 negative residents* and those not suspected or under observation for COVID-19 *are participating in group outings (e.g., if in phase 2 or 3 of CMS' QSO-20-30-NH- " Nursing Home Reopening Recommendations for State and Local Officials"), group activities, and communal dining following State and local official guidance if more restrictive? Is the facility ensuring that residents are maintaining social distancing (e.g., limited number of people in areas and spaced by at least 6 feet), performing hand hygiene, and wearing cloth face coverings?*

☐ *Does the facility have a plan (including appropriate placement and PPE use) to manage residents that are new/readmissions under observation, those exposed to COVID-19, and those suspected of COVID-19? Are these actions based on national (e.g., CDC), state, or local public health authority recommendations?*

☐ *Does* the facility *have a plan to prevent transmission, such as having a dedicated space in the facility for cohorting and managing care for residents with COVID-19? Are these* 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 *or cloth face covering* on the resident during transfer *(as tolerated)*?

☐ For residents who need to leave the facility for care (e.g., dialysis), did the facility notify the transportation and receiving health care team of the resident's suspected or confirmed COVID-19 status?

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?

☐ Do 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 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, 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 requires 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 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);

- Restricting visitation based on federal or state guidance to ensure visitation does not lead to transmission of COVID-19*;* 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(s) designated by the facility*; maintain at least six feet from others in the facility;* and *wear a cloth face covering or facemask during the duration of their visit*? What is the facility's process for communicating this information?

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)?

☐ *Are non-essential staff permitted into the facility based on state or federal guidance (e.g., reopening recommendations include phase 1: non-essential staff limited; phase 2: limited numbers of non-essential staff allowed; phase 3: all non-essential staff allowed)?*

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

- 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**

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7. Reporting to Residents, Representatives, and Families

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

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

☐ Did the information include mitigating actions taken by the facility to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered (e.g., restrictions to visitations or group activities)?

☐ Did the information include personally identifiable information?

☐ Is the facility providing cumulative updates to residents, their representatives, and families at least weekly or by 5 PM the next calendar day following the subsequent occurrence of either: each time a confirmed COVID-19 infection is identified, or whenever three or more residents or staff with new onset of respiratory symptoms 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.

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

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

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

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

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

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9. Emergency Preparedness – Staffing in Emergencies

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

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

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

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10. Infection Preventionist (IP):

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

☐ *Did the facility designate one or more individual(s) as the infection preventionist(s) who are responsible for the facility's IPCP?*

☐ *Does the Infection Preventionist(s) work at least part-time at the facility?*

☐ *Has the Infection Preventionist(s) completed specialized training in infection prevention and control?*

☐ *Does the Infection Preventionist(s) participate in the quality assessment and assurance committee? The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis.*

Note: If no to any of the question above, consider citing F882.

10. Is the facility in compliance with requirements set forth at 483.80(b)?
☐ Yes ☐ **No F882**

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11. Staff and Resident Testing

Review the facility's testing documentation (e.g., logs of county level positivity rate, 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?").

☐ *Did the facility conduct testing of staff based on the county level positivity rate according to the recommended frequency?*

☐ *Based on observation or interview, did the facility conduct testing and specimen collection in a manner that is consistent with current standards of practice for conducting COVID-19 tests?*

☐ *Did the facility's documentation demonstrate the facility conducted testing of residents or staff with signs of symptoms of COVID-19 in a manner that is consistent with current standards of practice for conducting COVID-19 tests?*

☐ *Did the facility's documentation demonstrate the facility conducted 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?*

☐ *Did the facility take 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?*

☐ *Did the facility have 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, did the facility contact the state and local health departments for assistance?*

Note: If no to any of the question above, consider citing F886.

11. Is the facility in compliance with requirements set forth at 483.80(h)?

☐ Yes ☐ **No F886**