Focused Infection Control Surveys in Nursing Facilities

Long-Term Care Regulatory

HHSC

March 2020

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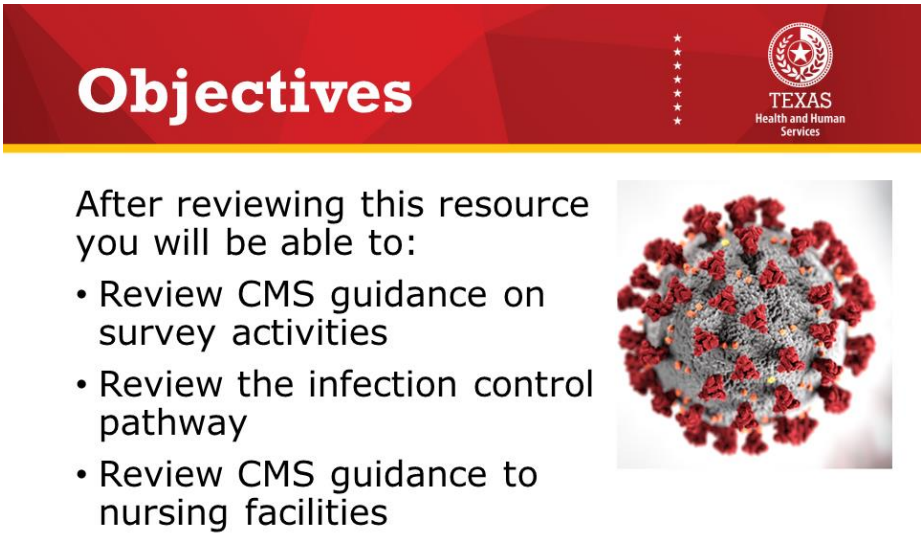
1. Introduction

Nursing facility (NF) infection control rules are usually focused on hand hygiene PPE usage use and disinfection of the environment. The facility should plan for an outbreak that can strike any facility—whether it is COVID-19, the flu, or any other infectious disease. In this presentation, we will look at the existing regulations, and give examples relevant to the COVID-19 outbreak.



The state rules for infection control are in the Texas Administrative Code (40 TAC §19.1601).

This resource reviews relevant sections of the rules, starting with the state rules.

2. CMS Guidance on Survey Activities

QSO-20-12-ALL: Focus on Infection Control

NEW guidance from CMS on survey activities:
https://www.cms.gov/files/document/qso-20-12-allpdf.pdf-3

Allowed Activities

The QSO-20-12-all letter captures CMS's vision for ensuring that America's healthcare facilities are ready to respond to outbreaks of respiratory illnesses.

1. First, CMS is directing HHSC to suspend all non-emergency inspections.
2. Next, CMS is guiding HHSC as to how to prioritize surveyor time.

From highest to lowest priority, HHSC will conduct:

1. All immediate jeopardy allegations; all ANE allegations
2. All complaints (regardless of priority) alleging infection control concerns
3. Recertification (annual) surveys
4. Revisits needed for current enforcement actions
5. Focused infection control surveys: IJ level
6. Focused infection control surveys: non-IJ level

CMS is still committed to protecting health and safety; therefore, HHSC will still investigate Priority 1 (or P1) allegations and all ANE allegations. The second priority is to investigate any complaint (no matter what priority it is assigned) that has to do with infection control concerns. The third priority is to conduct required NF recertification surveys. This survey work is required by law. The fourth priority is to make whatever visits are needed, such as revisits, that are tied to a current enforcement action.

Once that work is done, CMS is directing HHSC to do focused infection control surveys of facilities that have a history of infection control deficiencies, first at the IJ level, and, once those are completed, at lower severity levels.

Other activities HHSC will still conduct include:

- Activities related to Special Focus Facilities, which is also mandated by federal law
- Regional off-site reviews and desk reviews, as time and staffing permit

Other, lower priority activities won't go away; they'll remain on the books until CMS lifts the suspension and HHSC resumes its normal workload.

State Priorities

HHSC's state priorities align with the federal priorities. From highest to lowest priority, HHSC will conduct:

1. All immediate threat (IT) allegations; all ANE allegations
2. All complaints (regardless of priority) alleging infection control concerns
3. Relicensure surveys, which are statutorily required
4. Revisits needed for current enforcement actions
5. Focused infection control surveys: IT level
6. Focused infection control surveys: non-IT level

Other activities that will continue:

- Trust fund monitoring
- Nursing Facility Administrator investigations
- Nursing facility liaisons will continue their work, as reaching out to facilities to help them assess their regulatory compliance with infection control and emergency preparedness requirements is critical.
- Delivery of webinars; in-person training for surveyors will be delivered via webinar and in-person training for providers will be suspended until further notice.
- Nursing facility changes of ownership, as these are statutorily required

What if?

What if a Texas NF has an actual or suspected case of COVID-19?

- CMS coordinates with the Centers for Disease Control (CDC), which will take the lead.
- **If** CDC clears the facility for survey and CMS deems a survey necessary, CMS tell HHSC when to enter.
- CMS will ask HHSC to do an onsite survey if reported conditions at the facility are triaged at the IJ level or involve infection control concerns.
- If the situation doesn't warrant an onsite visit, CMS may ask HHSC to do a regional offsite review and authorize the onsite investigation after all active and suspected cases of COVID-19 have been cleared from the facility.
- CMS will be reviewing all enforcement actions so that enforcement is consistent across the country.

COVID-19 Investigations

If HHSC is asked to enter a facility with COVID-19, CMS has certain guidelines in place.

- We will send the fewest surveyors needed to get the job done. We will avoid sending surveyors who are ill or who have underlying conditions that make them especially susceptible to COVID-19 complications.
- During offsite, in addition to looking at the intake and facility information as usual, surveyors will also look at any information from CDC or from hospital admissions. It is especially important to plan carefully offsite so as to minimize the time spent onsite.
- Onsite, surveyors will strive to be as efficient as possible. CMS has established a goal of no more than two days onsite for these investigations. Surveyors will let the administrator know of the limited focus of the visit upon entrance and schedule as many observations as possible on the first day. If possible, surveyors will ask to make arrangements to review records offsite, via remote access to electronic health records, fax or encrypted email. Surveyors will wear appropriate PPE. They will prioritize information gathering so that onsite time is used primarily for observations and resident interviews (which can be difficult to obtain offsite). They will fill in any extra time with staff interviews and record review.
- After leaving the facility, surveyors will follow up with any remaining staff interviews by telephone. They'll review policies and procedures or quality assurance documentation offsite, as well as clinical records if the facility has arranged access to those.
- They will conduct the exit conference by telephone, and draft the CMS-2567 offsite as well.

Special Guidance on Relicensure/Recertification

Survey documentation provides critical information about the facility's readiness for an outbreak. Therefore, for EVERY recertification and EVERY relicensure survey, HHSC surveyors have been directed to focus on these two areas. HHSC will still survey the remaining regulations, but in the current circumstances, HHSC needs to ensure that surveyors are very focused and thorough in those two areas.

If a surveyor is already in a facility for a recertification/relicensure survey, they MAY address other complaints that aren't part of the priorities given, if time permits.

For EVERY recertification/ relicensure, surveyors will:

- THOROUGHLY review the complete state and/or federal rules for infection control
- THOROUGHLY review the complete state and/or federal rules for emergency preparedness
- THOROUGHLY document their findings

Scheduling

- The focused infection control survey list is prioritized by tier. Tier 1 facilities have had significant (IJ-level) infection control issues.
- If a facility is on this list and they are due for recertification/relicensure in the next 30 days, HHSC will work the focused infection control survey at the same time as the recert/relicensure survey.
- At entrance, surveyors will inform the administrator that they are BOTH conducting a recertification/relicensure survey AND conducting a focused infection control survey, and document that they informed the facility on the 2567.
- Tier 2 facilities have had a pattern of infection control issues.
- Once surveyors have completed the Tier 1 work, they will combine Tier 2 focused infection control surveys with relicensure/recertification work where possible.
- Tier 3 facilities have less severe histories of infection control issues.
- HHSC will also attempt to combine focused and regular surveys of Tier 3 providers where possible.

3. Infection Control

Surveyors use the infection control pathway to assess the facility's compliance with F880, F881, and F883, during investigations related to infection control and for focused infection control surveys. The facility's infection prevention and control program, or IPCP, applies to anyone providing services to residents on behalf of the facility, including staff, contractors and volunteers. The IPCP should cover the entire facility and all of its services.

What's Included

The team reviews:

- The overall IPCP
- Surveillance/antibiotic stewardship
- Immunization tracking
- Laundry
- A resident on transmission-based precautions, if any
- 5 sampled residents for immunizations

As part of the pathway, surveyors assess the facility's overall IPCP, including the annual review of the IPCP policies and practices. They'll also assess the facility's review of its surveillance and antibiotic stewardship programs and immunization tracking. Team members will also review the facility's laundry handling. If the facility has any residents on transmission-based precautions, HHSC will review them. Surveyors also want to review residents for immunizations.

Hand Hygiene (F880)

- Standard precautions
  - Are facility staff following standard precautions? Are they using PPE appropriately? Are they following appropriate hand hygiene practices?

- Appropriate hand hygiene
  - Are soap, water, and a sink readily accessible in places like resident care areas, food and medication preparation areas?

- Alcohol-based hand rub (ABHR)
  - Is alcohol-based hand rub accessible and placed in appropriate places throughout the facility, such as at the entrances to resident rooms or workstations?

- Hand washing when ABHR is not appropriate
  - There are times when hand sanitizer is not enough. Staff must wash hands when they are visibly soiled or when *c. difficile* or norovirus are present.

- Hand hygiene even with gloves when necessary
  - Even when gloves are used, the staff must wash their hands before and after resident contact, as well as after contact with blood, body fluids or visibly soiled

surfaces. Staff must also wash their hands before performing aseptic procedures, such as dressing changes or catheterizations.

- Hand hygiene for residents
  - When residents require staff assistance, staff ensure residents perform hand hygiene after toileting and before meals.

- Staff interviews
  - When interviewing staff, surveyors will ask whether hand hygiene supplies are available and how they request such supplies.

PPE (F880)

Do facility staff use personal protective equipment (PPE) appropriately?

- Gloves
  - Gloves must be worn if there is potential for contact with blood, body fluids, mucus membranes, or non-intact skin, and they must be discarded after such contact. Gloves must be discarded (and hand hygiene performed) when the caregiver moves from a contaminated body site to a clean body site.

- Gowns
  - Staff wear gowns when the resident has uncontained secretions or excretions.

- Masks
  - Staff wear masks when within 3 feet of a resident with a new acute cough or respiratory symptoms. If staff perform aerosol-generating procedures or procedures likely to result in the spray of bodily fluids, they must wear appropriate mouth, nose and eye protection.

Staff discard PPE appropriately and perform hand hygiene after performing resident care and before leaving the resident's room.

Supplies necessary for PPE must be available and accessible to staff. Surveyors will interview staff to determine whether necessary supplies are available and how they are ordered.

Transmission Based Precautions (F880)

Has the facility implemented appropriate transmission-based precautions (TBP)?

- Staff's use of PPE
  - Are staff using PPE appropriately? In other words, do staff don gloves and gowns before contact with the resident and/or his/her environment while on contact precautions; don facemask within three feet of a resident on droplet precautions; don a fit-tested N95 or higher-level respirator prior to room entry of a resident on airborne precautions?

- Non-critical resident-care equipment (cuffs, glucometers, etc.)
    - For non-critical equipment, such as blood pressure cuffs or blood glucose monitoring devices, the facility either uses dedicated, disposable items or cleans and disinfects the equipment with an EPA-registered disinfectant prior to using them with another resident.
- High touch objects
    - Likewise, the facility disinfects objects and surfaces that are close to the resident and that the resident frequently touches (such as toilets, bedrails, bedside tables, etc.) with an EPA-registered disinfectant at least daily and when soiled.
- Least restrictive TBP
    - The facility should use the least restrictive transmission-based precautions that are appropriate to the resident's condition.
    - Surveyors will interview staff to verify that they are aware of TBP protocols. They'll also ask how staff are monitored for compliance with TBP.

Laundry (F880)

How does the facility handle, store, and transport linens?

- Soiled linens present a huge opportunity for the spread of infection from one part of the facility to another.
    - Staff must use gloves when handling soiled linens and must agitate the linens as little as possible during transport. Likewise, staff should hold soiled linens and bags of soiled linens away from their body.
    - Staff should bag the soiled linen where it was collected and only sort or rinse it in the laundry room. There is no need for staff to double bag the linens unless the outside of the first bag is visibly contaminated or wet on the outside.
    - Staff should transport clean and soiled linens in separate carts. If they plan to use a dirty linen cart to transport clean linen, they must clean and disinfect it according to facility protocols first.
    - The facility must ensure that mattresses, pillows, sheets, and other linens are clean and in good condition.
    - If the facility uses a laundry chute, all bags must be securely tied with no loose items before being placed in the chute.

Examine the laundry room:

- Washers and dryers
    - In the laundry room, surveyors will verify that the washers and dryers are maintained according to manufacturer's recommendations. If the surveyor has concerns, they will request the facility's maintenance log or record.

- Supplies (detergent, rinse aides, etc.)
    - Surveyors will verify that staff use detergent, rinse aides, and other supplies in accordance with manufacturer's directions.

IPCP (F880)

Does the facility have an IPCP?

- Does it include policies and procedures?
- Is it current?
- Is it based on national standards?
- Has it been reviewed at least annually?

Surveyors should verify compliance through record review.

Infection Surveillance (F880)

- Surveillance plan
  - The facility must establish and implement a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of infections. The plan must include early detection, management of a potentially infectious, symptomatic resident and the implementation of appropriate transmission-based precautions. It must also use 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

- Communication and coordination
  - Residents often move between healthcare settings. The facility must have a process for communicating the diagnosis, antibiotic use, if any, and laboratory test results when transferring a resident to the 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 the hospital.

- Communicable diseases
  - The facility must maintain a current list of reportable diseases. Staff should know what to report, when, and to whom.
  - Surveyors will interview staff to determine if infection control concerns are identified, reported, and acted upon.

Antibiotic Stewardship (F881)

The facility's antibiotic stewardship program includes:

- Written protocols
  - The facility's protocols address prescribing, as well as the documentation of indication, dosage, and duration of use. Protocols also include review of 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). The facility must also have protocols to optimize the treatment of infections by ensuring that residents who require antibiotics are prescribed the appropriate antibiotic.

- Review of antibiotic use by practitioners
    - The facility must have 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 former 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.

- System for feedback
    - The facility must also have 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.

Immunizations (F883)

- Influenza and pneumococcal vaccines
- Surveyors use a 5 resident sample
- Record review: screening/eligibility, education, administration, refusal
    - Surveyors review records for the resident sample for documentation that they were screened for eligibility for immunizations. Did the facility document educating the residents on the vaccines, including potential side effects and benefits? Did the facility administer the vaccines in accordance with CDC/ACIP recommendations? Residents and families have the right to refuse to be vaccinated; surveyors will look for documentation on refusals.

- Flu vaccine unavailability
    - Sometimes, flu vaccines are temporarily unavailable during flu season, and this is a valid reason for the facility to not administer immunizations. If this is the situation, surveyors expect to see documentation of the facility's attempts to obtain the vaccine, such as backorder confirmations. The facility should be able to explain its plans for administering the vaccinations once they are available.

- Policies & procedures
    - The facility must also have policies and procedures for flu and pneumococcal vaccines, including how the facility tracks resident vaccination status.

QSO-20-14-NH: CMS Guidance to Nursing Homes

NEW guidance from CMS for nursing homes:
https://www.cms.gov/files/document/qso-20-14-nhpdf.pdf

4. Highlights

- Monitor CDC website
  - First, CMS encouraged NFs to monitor the CDC website for updates. In Texas, DSHS also has a coronavirus website, as does HHSC. Both of these are updated frequently and include a plethora of tips, tools, and guides. If surveyors or facilities have questions, they can confidently access these websites. All three agencies have links to their coronavirus pages on their home page.

- Contact health department for questions or suspected COVID-19
  - CMS also reminded facilities to contact their local health department if they have questions or have a suspected case of COVID-19. They should also communicate with the local health authorities if they experience an increased number of respiratory illnesses (whether suspected COVID-19 or otherwise).

- Monitor resident health vigilantly
  - CMS encouraged facilities to be especially vigilant in monitoring resident health so that they can quickly implement detection, triage, and isolation protocols.

- Maintain resident-centered care
  - Resident-centered care is especially important in this type of situation. The facilities should communicate well, clearly, and compassionately with residents and families.

- Monitor/limit visitors
  - The facility is advised to screen visitors. The facility can prohibit visitors from entering the facility if they have traveled internationally in a restricted country within the last 14 days, have signs/symptoms of respiratory illness, or have had contact with someone with (or under investigation for having) COVID-19.

- Staff monitoring
  - Similarly, the facility should monitor its own staff, contractors, and volunteers, using the same criteria. If they have symptoms, they should not come to work. If they develop symptoms while at work, staff should immediately stop work, put on a face mask, and self-isolate at home. They should also notify the facility's infection preventionist and the local health department.

- Hospital transfers
  - Not all residents with COVID-19 may require hospitalization. This will vary, based on the symptoms and disease progression, as well as the facility's ability to provide appropriate TBPs. If the resident is transferred to the hospital, the facility should alert EMS and the hospital to the diagnosis. It may also be appropriate in some situations for the NF to discharge the resident to home. Pending transfer or discharge, the facility should put a facemask on the resident and isolate them in their room. The facility can accept transfer of a resident from the hospital to the nursing home, provided it can follow the TBPs.

- Environment supports infection control
    - The letter offers facilities some general guidance on how to ensure their environment supports good infection control, such as by increasing sanitizers, trash cans, and signage promoting positive infection control practices. Finally, it lists many valuable resources.

5. Infection Control Checklist (NF)

FEDERAL			
Met?	Not Met?	TAG	Rule
		F-880	Hands: Staff implement standard hand hygiene precautions, including PPE
		F-880	Hands: Alcohol-based hand rubs (ABHR) accessible in appropriate locations
		F-880	Hands: Staff wash hands when visibly soiled or when ABHR not appropriate
		F-880	Hands: Hand hygiene performed even with gloves before/after resident contact
		F-880	Hands: Hand hygiene performed after contact with blood/fluids/contaminated surfaces
		F-880	Hands: Resident hand hygiene after toileting/before meals when assisted by staff
		F-880	Hands: Soap/water/sink readily accessible in appropriate locations
		F-880	Gloves: worn if potential contact with blood/fluid/membranes/non-intact skin
		F-880	Gloves: removed after contact with blood/fluid/membranes/non-intact skin
		F-880	Gown: direct resident contact if resident has uncontained secretions/excretions
		F-880	Facemask: worn if in 3 ft of resident w/ new acute cough/symptoms of respiratory infection
		F-880	Mask/Shield: worn for certain procedures (aerosol-generating/spraying of fluids)
		F-880	PPE discarded after resident care, before leaving room, followed by hand hygiene
		F-880	PPE supplies accessible in resident care areas
		F-880	Transmission-based precautions (TBP): PPE use by staff
		F-880	TBP: Dedicated/disposable non-critical resident equip OR equip cleaned/disinfected
		F-880	TBP: Least restrictive TBP under circumstances
		F-880	TBP: high touch surfaces cleaned/disinfected daily/when soiled
		F-880	Laundry: staff handle/store/transport linens appropriately
		F-880	Laundry: equipment maintained per manufacturer instructions
		F-880	Laundry: supplies (detergent, etc.) used per manufacturer instructions
		F-880	P&P: facility has IPCP based on standards
		F-880	P&P: facility reviews P&P at least annually
		F-880	Surveillance: facility has surveillance plan to identify/track/monitor/report infections
		F-880	Surveillance: plan incl detection, management of resident, TBP
		F-880	Surveillance: plan uses evidence-based criteria to define infections & uses data tool

FEDERAL			
		F-880	Surveillance: plan includes ongoing analysis & documentation of follow-up activity
		F-880	Surveillance: process for communicating/obtaining test results for transfers
		F-880	Surveillance: facility has current list of reportable diseases
		F-880	Surveillance: staff can identify who/when to report to
		F-880	Surveillance: employees w/ communicable disease have no direct resident/food contact
		F-881	Stewardship: written antibiotic use protocols (incl: document indication/dosage/duration)
		F-881	Stewardship: protocols to review signs/symptoms/labs to evaluate antibiotic usage
		F-881	Stewardship: process for periodic review of antibiotic use by prescribers
		F-881	Stewardship: protocols to optimize treatment of infections
		F-881	Stewardship: system for providing feedback reports on use/resistance patterns/prescribing
		F-883	Vaccines: screening & eligibility for receiving vaccine
		F-883	Vaccines: provision of education (e.g., benefits, potential side effects)
		F-883	Vaccines: administration of vaccines per national recommendations (CDC, ACIP)
		F-883	Vaccines: documentation of resident/representative refusal
		F-883	Vaccines: if not implemented due to shortage, documentation
		F-883	Vaccines: facility P&P

STATE—Until 3/29			
Met?	Not Met?	TAG	Rule
		1342	Program: Establish/maintain infection control program to provide safe/sanitary/comfortable environment & prevent spread of infection
		1343	Program: Investigate/control/prevent infection
		1344	Program: Decide what procedures (e.g., isolation) to apply to individual residents
		1345	Program: Document incidents/corrective actions
		1346	Prevention: acceptable resident isolation per program
		1347	Prevention: employees w/ communicable disease no direct resident/food contact
		1348	Prevention: handwashing after direct resident contact
		1349	Prevention: report names with reportable disease & follow health authority's direction
		1350	Have/implement policies for control of disease; maintain evidence of compliance with state/local codes
		1351	Documented review of facility's tuberculosis risk per CDC
		1352	TB screening for staff prior to providing services, documented
		1353	If facility determines employee exposed to communicable disease, act appropriately
		1354	If facility determines employee exposed to communicable disease, reassess risk
		1355	TB screening for residents at admission per doctor recommendation/CDC
		1356	Policy: develop/implement policy to protect from vaccine-preventable disease per HSC 224
		1357	Policy: employee/contractor receive vaccines per facility policy based on risk assessment
		1358	Policy: specifies which vaccines employees/contractors must receive
		1359	Policy: includes procedures to verify compliance of employees/contractors with policy
		1360	Policy: includes procedures to exempt employees/contractors with contraindications
		1361	Policy: if employee/contractor exempted, procedures to protect residents
		1362	Policy: prohibits retaliation against employee/contractor who was exempted
		1363	Policy: requires documentation of employee/contractor compliance/exemption
		1364	Policy: includes disciplinary action facility may take against empl/contractor fails to comply
		1365	Policy: may include procedures for employee/contractor be exempt for conscience/religion
		1366	Policy: may prohibit exempt employee/contractor from resident contact in disaster

STATE—Until 3/29			
		1367	Offer vaccinations per ACIP/CDC
		1368	Offer pneumococcal at admission and to resident 65+/candidate for vaccine; administer unless contraindicated
		1369	May give 2nd pneumococcal 5 yrs later, based on assessment unless contraindicated/refused
		1370	Must offer flu vaccine to residents/employees with resident contact, unless contraindicated or refused by resident
		1371	Flu vaccines completed by 11/30 each year; admissions 11/30-3/31 receive vaccine unless contraindicated/refused
		1372	P&P: resident/representative receives education re: benefits/side effects & document
		1373	Hep B vaccines for employees: method to identify risk, offer vaccine to those at risk
		1374	Resident records: documentation of receipt, refusal, or contraindication
		1375	Linens: handle/store/process/transport to prevent spread of infection & per §19.325
		1376	QAAC monitors the infection control program.
		1377	Follow universal precautions; comply with OSHA