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Managing Infection Control Beyond COVID-19

LW Consulting, inc

5925 Stevenson Avenue, Suite G
Harrisburg, PA 17112
1.800.320.5401 | www.LW-Consult.com

Patty Klinefelter, MBA, RN, ICP, BC

Patty is LW Consulting, Inc. (LWCI) Director overseeing quality deliverables for home health, hospice, and skilled nursing facility (SNF) engagements. She leads a team of RN Consultants with deep leadership and operational skills in each of these provider settings. Typical engagements include directed inservices, documentation, coding and billing audits, appeals support and position development; supporting counsel defense in litigation support; mock surveys, strategic planning, acquisition support, agency/facility turnaround, telehealth implementation, new agency development, infection preventionist support, plan of correction consultation, and education including directed in-services.

Patty received a Bachelor of Science in Nursing from Penn State University and an MBA from Averett University. She is a licensed registered nurse with a multi-state Virginia License and holds a Home Health Nursing Certification from the Nurses Association.

Contact Information

pklinefelter@lw-consult.com

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Objectives

- Know the SNF infection control federal regulations and interpretive guidelines.
- Understand the DOH survey process for infection control.
- Analyze the national and state data related to infection control deficiencies.
- List strategies to ensure compliance with the regulations.

Federal Regulations

F Tag 880 IC&P Program

- The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

- A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment.

F Tag 880 IC&P Program

- Written standards, policies, and procedures
- A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
  - When and to whom possible incidents of communicable disease or infections should be reported;
  - Standard and transmission-based precautions to be followed to prevent spread of infections;
  - When and how isolation should be used for a resident; including but not limited to:

    (A) The type and duration of the isolation, depending upon the infectious agent or organism involved,

    (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
- The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
- The hand hygiene procedures to be followed by staff involved in direct resident contact.
- A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.
- Linens.
  - Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

F Tag 881 – Antibiotic Stewardship

The facility must establish an infection prevention and control program that must include an antibiotic stewardship program that includes antibiotic use protocols and a systems to monitor antibiotic use.

F Tag 882 – Infection Preventionist

- Infection preventionist
- The IP must:
  - Have professional training.
  - Be qualified by education, training, experience or certification.
  - Work at least part-time at the facility.
  - Have completed specialized training.
  - Participate in Quality assessment and assurance committee.

F Tag 883 Influenza and Pneumococcal Immunizations

- Provide education.
- Residents are offered an influenza immunization October 1 through March 31 annually or pneumonia.
- Give residents opportunity to refuse immunization.
- Document education, refusal and administration.
- Provide education regarding the benefits and side effects

F Tag 884 Reporting – National Health Safety Network

- Tag to be cited by Federal Surveyors Only
- Review for F884 will be conducted offsite by CMS Federal surveyors (state surveyors should not cite this F-tag). CMS will receive the CDC NHSN COVID-19 reported data and review for timely and complete reporting of all data elements. Facilities identified as not reporting will receive a deficiency citation at F884 on the CMS-2567 with a scope and severity level at an F (no actual harm with a potential for more than minimal harm that is not an Immediate Jeopardy [IJ] and that is widespread; this is a systemic failure with the potential to affect a large portion or all of the residents or employees) and be subject to an enforcement remedy.

F Tag 885 COVID 19 Reporting

- Electronically report information about COVID-19 in a standardized format specified by the Secretary.
- Provide the information at a frequency specified by the Secretary, but no less than weekly to the Centers for Disease Control and Prevention's National Healthcare Safety Network.
- Communicate with residents, representatives and family members
- Have mechanism(s) to inform residents/reps/families.

F Tag 886 Testing

- Test residents and facility staff
- Conduct testing based on parameters
  - Testing frequency
  - Who to test and when
  - Response time
  - Documentation
  - Action
  - Refuse to test

F Tag 887 COVID 19 Immunizations

Develop and implement policies and procedures:

- Residents and staff member are offered the vaccine.
- Before offering vaccines, all staff members, residents or resident reps are provided with education regarding the benefits and risks and potential side effects associated with the vaccine.
- They have the opportunity to accept or refuse a COVID-19 vaccine and change their decision.
- The resident's medical record and staff records includes documentation.
  - They were provided education regarding the benefits and potential risks associated with COVID-19 vaccine.
  - Each dose of COVID-19 vaccine administered.
  - If they did not receive the COVID-19 vaccine due to medical or religious exemptions.

F Tag 887 COVID 19 Immunizations

- All staff must have second dose (as applicable) except for those granted exceptions or those staff for whom the CDC recommends a temporarily delay due to clinical precautions and considerations.
- This includes all employees, licensed practitioners, students, trainees, and volunteers.
- Any individual who provides care, treatments or other services for the facility or its residents under contract or other arrangements.
- Includes contracted pharmacist, hospice staff and rehab therapists.

F Tag 888 COVID-19 Vaccination of Facility Staff

- The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. Staff are considered fully vaccinated if it has been 2 weeks or more since they completed a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

Who Should be Vaccinated?

- The vaccination requirements apply to all eligible staff, both *current and new*, working at a covered provider facility *regardless of clinical responsibility or patient contact*, including:
    a) Facility Employees
    b) Licensed Practitioners
    c) Students
    d) Trainees
    e) Volunteers
    f) Contracted Staff
    g) Staff who perform duties offsite (e.g., home health, home infusion therapy, etc.)
    h) Individuals who enter a CMS regulated facility (e.g., medical staff at hospital)
- The rule *does not apply* to full-time telework staff, and infrequent "one-off" vendors, volunteers, and professionals who render services to covered providers. Providers should consider the frequency of presence, services provided, and proximity to patients and staff when determining applicability.

Basics for Medical Exemptions

- Develop a process for employee requests.
- Ensure all documentation is signed and dated by a licensed practitioner.
- Documentation must contain all information specifying why the COVID-19 vaccines are clinically contraindicated for the staff member.
- Documentation must include a statement by the authenticating practitioner recommending the staff member be exempted.

Medical Exemptions

- Recognized contraindications (for not vaccinating or delaying vaccination) per CDC:
  - Those with severe allergic reaction after previous dose or a component of the vaccine
  - Those with immediate allergic reaction of any severity to a previous dose
  - Those with known allergy to a component of the vaccine
  - Any other recognized clinical contraindication identified by CDC in its “Summary Document for Interim
- Clinical Considerations” found at https://www.cdc.gov/vaccines/covid-19/downloads/summary-
- interim-clinical-considerations.pdf).
- CDC recommends a temporary delay in administering the COVID-19 vaccination due to clinical precautions and considerations such as individuals with acute illness secondary to COVID-19 illness, and individuals who received monoclonal antibodies, or convalescent plasma for COVID-19 treatment.
- Must be documented, signed and dated by licensed practitioner acting within scope of practice. Can’t be signed by same person who is requesting exemption. Documentation must specify why clinically contraindicated.

Basics for Religious Exemptions:

- Facilities must develop a process for permitting staff to request a religious exemption.
- Facilities must ensure all requests for religious exemptions are documented and evaluated in accordance with applicable federal law and as a part of the facility's policies and procedures.

Accommodations for Unvaccinated Staff

- Medical and religious exemptions.
- Must have a process for implementing additional precautions.
- May include (customize to worker role and patient safety needs):
  - Reassignment to duties that limit exposure to those most at risk, non-patient care activities or to duties that can be performed remotely
  - Testing
  - Physical distancing
  - Masking with N95 or equivalent
  - Must minimize the risk of transmission of COVID-19 to at-risk individuals

Recordkeeping

- Each staff member's vaccination status, including specific vaccine received, dates of each dose, date of next scheduled dose if series not completed.
- Same info on booster doses.
- Identify each staff person's role, assigned work area, and how they interact with patients (if applicable).
- Exemption requests, decisions and accommodations if granted.
- Staff for whom vaccination must be temporarily delayed and when the identified staff can resume vaccination.
- Staff who exclusively telework.

Enforcement

- Will be included in Recertification (state agency or accreditation) and Complaint surveys
- Three requirements will be surveyed:
  - Process or plan for vaccinating all eligible staff
  - Process or plan for providing exemptions and accommodations for those who are exempt
  - Process or plan for tracking and documenting staff vaccinations
- CMS has indicated in enforcement guidance to surveyors that if facilities are above 80% compliance by first deadline, and 90% compliance by second deadline, will only receive notice of non-compliance but will be given time to comply (60 days if surveyed after first deadline, 30 days if surveyed after second deadline).
- Any provider out of compliance 90 days after CMS issued guidance for their state will be subject to full enforcement.

CMS Focus Infection Control Survey Tool

Focused Infection Control Survey Tool

- CMS will no longer require the use of the focused infection control (FIC) survey and tool on a national basis, with officials expecting surveyors to assess infection control and prevention through the standard survey process going forward. The move was announced in a revised memorandum to surveyors on Friday, Feb. 4, 2022, effective immediately.

- Facilities have incorporated COVID-19 management strategies into their infrastructure and operations, and there is no longer a need to continue the required use of the special FIC survey and tool on a national basis," according to the updated memo (*QSO-21-08-NLTC*). "Surveyors will continue to evaluate infection prevention and control elements related to COVID-19 through the existing survey process, while incorporating lessons learned about infection control oversight during the PHE."

- Surveyors may continue to use the targeted FIC survey on a case-by-case basis, if warranted, CMS notes.

- "While the contents of the FIC survey tool are generally still applicable, if facilities wish to continue use of the tool as a template for their own self-assessment we encourage them to carefully review the Centers for Disease Control and Prevention (CDC) guidelines as there have been changes to the recommendations since the original tool and update were released," CMS notes.

Personal Protective Equipment

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, non-intact skin, potentially contaminated skin or potentially contaminated equipment;
- Gloves are removed after contact with blood or body fluids, mucous membranes, non-intact skin, potentially contaminated skin or potentially contaminated equipment ;
- Gloves are changed and hand hygiene is performed before moving from a contaminated site to a clean site during care (body, equipment, etc.);
- An isolation gown worn for direct patient contact if the patient has uncontained secretions or excretions;
- Appropriate mouth, nose, and eye protection (e.g., facemasks or respirator with goggles or face shield) along with isolation gowns are worn for patient care activities or procedures that are likely to contaminate mucous membranes, or generate splashes or sprays of blood, body fluids, secretions, or excretions;
- Unless additional source control is needed, facemasks are worn by all staff while they are in the healthcare facility. If PPE use is extended/reused, is it done according to national and/or local guidelines? If it is reused, is it appropriately cleaned/decontaminated/stored/maintained after and/or between uses?

Aerosol–Generating Procedures (AGPs)

Aerosol–Generating Procedures (AGPs)

- Appropriate mouth, nose, clothing, gloves, and eye protection (e.g., N95 or higher-level respirator, if available; gowns, face shield) is worn for performing AGPs and/or any procedures that are likely to generate splashes or sprays of blood or body fluids and COVID-19 is suspected;
- Procedures that are likely to induce coughing (e.g., sputum induction, open suctioning of airways) should be performed cautiously. If performed, the following should occur:
  - Staff in the room should wear an N95 or higher-level respirator, eye protection, gloves, and a gown.
  - The number of staff present during the procedure should be limited to only those essential for care and procedure support.
  - AGPs should ideally take place in an airborne infection isolation room (AIIR). If an AIIR is not available and the procedure is medically necessary, then it should take place in a private room with the door closed.
  - Clean and disinfect procedure room surfaces promptly and with an appropriate EPA-registered disinfectant for healthcare settings. Use disinfectants on EPA's List N: Disinfectants for Coronavirus (COVID-19) or other national recommendations.

Transmission-Based Precautions

- Determine if appropriate transmission-based precautions are implemented, including but not limited to:
  - Signage on the resident's room regarding need for transmission-based precautions;
  - PPE use by staff (i.e., don gloves and gowns before contact with the resident and their care environment while on contact precautions; don facemask within six feet of a patient on droplet precautions; for facilities that use/have N-95 masks - don a fit-tested N95 or higher-level respirator prior to room entry of a patient on airborne precautions);
  - 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 settings (effective against the identified organism if known) prior to use on another Page 8 of 12 patient or before being returned to a common clean storage area. Healthcare settings should refer to List N for EPA registered disinfectants qualified for use against COVID-19;
  - When transport or movement is medically-necessary outside of the resident room, does the resident wear a facemask?
  - Contaminated surfaces, objects and environmental surfaces that are touched frequently and in close proximity to the resident (e.g., bed rails, over-bed table, bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare use (effective against the organism identified if known) at least daily and when visibly soiled.

Standards, Policies and Procedures

- Did the Facility establish an IPC Program (IPCP) including written 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.

Infection Surveillance

- Does the facility know how many residents the facility currently have been diagnosed with COVID-19 (suspected and confirmed)?
- The facility has established/implemented a surveillance plan, based on a scope of services, for identifying, tracking, monitoring and/or reporting of fever, respiratory illness, or other signs/symptoms of COVID-19. The plan includes early detection, management of a potentially infectious, symptomatic patients and the implementation of appropriate transmission-based precautions/PPE.
- The facility has a process for communicating the diagnosis, treatment, and laboratory test results when transferring residents to an acute care hospital or other healthcare provider.
- Can appropriate staff (e.g., nursing and leadership) identify/describe the communication protocol with local/state public health officials? Interview appropriate staff to determine if IPC concerns are identified, reported, and acted upon.

Education, Monitoring, and Screening of Staff

- Does the facility have a screening process for all staff to complete prior to or at the beginning of their workday that reviews for exposure to others with known or suspected COVID-19, signs/symptoms of illness and includes whether fever is present (screened upon arrival or self-reported absence of fever)?
- Is there evidence the provider has educated staff on SARS-CoV-2 and 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?
- If staff develop symptoms (as stated above) at work, does the facility:
  - Have a process for staff to report their illness or developing symptoms;
  - 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 or CDC recommendations): https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html).

Emergency Preparedness

- Staffing in Emergencies Policy development:
- Does the facility have a policy and procedure for ensuring staffing to meet the needs of the patients when needed during an emergency, such as a COVID-19 outbreak?
- Policy implementation: In an emergency, did the facility implement its planned strategy for ensuring staffing to meet the needs of the patient? (N/A if emergency staffing was not needed)

Environmental Cleaning

- During environmental cleaning and disinfection procedures, personnel wears appropriate PPE to prevent exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection).
- Are environmental surfaces in patient care areas cleaned and disinfected, using an EPA-registered disinfectant on a regular basis (e.g., daily), when spills occur, and when surfaces are visibly contaminated? Use disinfectants on List N of the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-COV-2 or other national recommendations.
- Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).
- The facility decontaminates spills of blood or other body fluids according to its policies and procedures, using appropriate EPA-registered disinfectants.

Vaccinations

- Do residents' medical records have documentation of vaccination status and education?
- Fours hours from start of survey must complete Staff Matrix for Staff Vaccination status.

COVID-19 Staff Vaccination Status for Providers

Complete this form or provide a list containing the same information required in this form.

Section I: *Complete based on the Day 1 of the survey:*

Total # of staff:

partially vaccinated staff (5):

completely vaccinated staff (6):

pending exemption (8 and 9):

granted exemption (8 and 9):

temporary delay/new hire (10):

not vaccinated without exemption/delay (11):

Note: The sum of the #'s for columns 5, 6, 8 through 11 should equal the total # of staff.

					Vaccinated			Not Vaccinated			
	Direct facility hire (DH), Contracted hire (C), Other (O)	Title	Position	Assigned work area	Partially vaccinated	Completely vaccinated	Booster dose	Pending (P) or Granted (G) medical exemption	Pending (PN) or Granted (GN) non-medical exemption	Temporary delay per CDC/ new hire	Not vaccinated without exemption/delay
Staff Name	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**

Staff Matrix of Staff Vaccinated Status

- Once the matrix is received, the assigned surveyor selects **eight staff** to review for COVID-19 vaccinations.
  - 2 vaccinated staff (at least one Certified Nurse Aide/CNA and one contractor who provides services, such as hospice and dialysis staff, occupational therapists, mental health professionals, licensed practitioners)
  - 6 unvaccinated staff, if available
  - 3 unvaccinated staff (2 CNAs, if available) without exemption or reason for temporary delay.
  - 1 non-medical exemption.
  - 1 medical exemption (Note: If there are 2 or more staff with medical exemptions, select 50% of the staff from this category).
  - 1 whose primary vaccine series has been temporarily delayed.
- If they identify any staff that weren't vaccinated and weren't granted an exemption or temporary delay (and weren't listed on the staff matrix), that individual(s) should be added to the staff sample.

Data

Selection Criteria

Begin Year: 2021
End Year: 2022
Display Options: Display all results
Provider and Supplier Type(s): Dually Certified SNF/NFs - Medicare and Medicaid, Distinct Part SNF/NFs - Medicare and Medicaid, Skilled Nursing Facilities (SNFs) - Medicare Only, Nu
National
Deficiency Tags:
F0880 - Infection Prevention & Control
F0881 - Antibiotic Stewardship Program
F0882 - Infection Preventionist Qualifications/Role
F0883 - Influenza And Pneumococcal Immunizations
F0884 - Reporting - National Health Safety Network
F0885 - Reporting-Residents,Representatives&Families
F0886 - Covid-19 Testing-Residents & Staff
F0887 - Covid-19 Immunization
Survey Focus: Health

Year Type: Calendar Year **Year:** 2021 **Month:** Full Year

Citation Frequency Report

National Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Active Providers=15392		Total Number of Surveys=19541
F0884	Reporting - National Health Safety Network	11,123	30.5%	56.9%
F0880	Infection Prevention & Control	7,572	32.4%	38.7%
F0886	COVID-19 Testing-Residents & Staff	696	3.4%	3.6%
F0883	Influenza and Pneumococcal Immunizations	643	3.5%	3.3%
F0885	Reporting-Residents,Representatives&Families	338	1.7%	1.7%
F0881	Antibiotic Stewardship Program	303	1.8%	1.6%
F0882	Infection Preventionist Qualifications/Role	266	1.4%	1.4%
F0887	COVID-19 Immunization	167	0.9%	0.9%

Provider and Supplier Type(s): Dually Certified SNF/NFs - Medicare and Medicaid, Distinct Part SNF/NFs - Medicare and Medicaid, Skilled Nursing Facilities (SNFs) - Medicare Only, Nursing Facilities - Medicaid Only

National

Deficiency Tags:
F0880 - Infection Prevention & Control
F0881 - Antibiotic Stewardship Program
F0882 - Infection Preventionist Qualifications/Role
F0883 - Influenza And Pneumococcal Immunizations
F0884 - Reporting - National Health Safety Network
F0885 - Reporting-Residents,Representatives&Families
F0886 - Covid-19 Testing-Residents & Staff
F0887 - Covid-19 Immunization
F0888 - Covid-19 Vaccination Of Facility Staff

Survey Focus: Health

Year Type: Fiscal Year

Year: 2022

Quarter: Full Year

Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
	Totals represent the # of providers and surveys that meet the selection criteria specified above.		Active Providers = 15261	Total Number of Surveys = 6238
F0884	Reporting - National Health Safety Network	4,210	13.7%	67.5%
F0880	Infection Prevention & Control	1,833	9.7%	29.4%
F0886	COVID-19 Testing-Residents & Staff	256	1.4%	4.1%
F0883	Influenza and Pneumococcal Immunizations	139	0.9%	2.2%
F0881	Antibiotic Stewardship Program	99	0.6%	1.6%
F0882	Infection Preventionist Qualifications/Role	86	0.5%	1.4%
F0885	Reporting-Residents,Representatives& Families	86	0.5%	1.4%
F0887	COVID-19 Immunization	82	0.5%	1.3%
F0888	COVID-19 Vaccination of Facility Staff	2	0.0%	0.0%

Selection Criteria

Begin Year: 2022
End Year: 2022
Display Options: Display all results
Provider and Supplier Type(s): Dually Certified SNF/NFs - Medicare and Medicaid, Distinct Part SNF/NFs - Medicare and Medicaid, Skilled Nursing Facilities (SNFs) - Medicare On
State: Pennsylvania
Deficiency Tags:
F0880 - Infection Prevention & Control
F0881 - Antibiotic Stewardship Program
F0882 - Infection Preventionist Qualifications/Role
F0883 - Influenza And Pneumococcal Immunizations
F0884 - Reporting - National Health Safety Network
F0885 - Reporting-Residents,Representatives&Families
F0886 - Covid-19 Testing-Residents & Staff
F0887 - Covid-19 Immunization
Survey Focus: Health

Year Type: Fiscal Year **Year:** 2022 **Quarter:** Full Year

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Pennsylvania Active Providers=685		Total Number of Surveys=137
F0884	Reporting - National Health Safety Network	90	9.3%	65.7%
F0880	Infection Prevention & Control	37	5.3%	27.0%
F0886	COVID-19 Testing-Residents & Staff	13	1.9%	9.5%
F0882	Infection Preventionist Qualifications/Role	8	1.2%	5.8%
F0881	Antibiotic Stewardship Program	6	0.9%	4.4%
F0887	COVID-19 Immunization	5	0.7%	3.6%
F0885	Reporting-Residents,Representatives&Families	4	0.6%	2.9%

Selection Criteria

Begin Year: 2022
End Year: 2022
Display Options: Display all results
Provider and Supplier Type(s): Dually Certified SNF/NFs - Medicare and Medicaid, Distinct Part SNF/NFs - Medicare and Medicaid, Skilled Nursing Facilities (SNFs) - Medicare (
State: Pennsylvania
Deficiency Tags:
F0880 - Infection Prevention & Control
F0881 - Antibiotic Stewardship Program
F0882 - Infection Preventionist Qualifications/Role
F0883 - Influenza And Pneumococcal Immunizations
F0884 - Reporting - National Health Safety Network
F0885 - Reporting-Residents,Representatives&Families
F0886 - Covid-19 Testing-Residents & Staff
F0887 - Covid-19 Immunization
F0888 - Covid-19 Vaccination Of Facility Staff
Survey Focus: Health

Year Type: Fiscal Year **Year:** 2022 **Quarter:** Full Year

Citation Frequency Report

State Tag #	Tag Description	# Citations	% Providers Cited	% Surveys Cited
Totals represent the # of providers and surveys that meet the selection criteria specified above.		Pennsylvania Active Providers=685		Total Number of Surveys=185
F0884	Reporting - National Health Safety Network	120	11.5%	64.9%
F0880	Infection Prevention & Control	47	6.7%	25.4%
F0886	COVID-19 Testing-Residents & Staff	18	2.6%	9.7%
F0882	Infection Preventionist Qualifications/Role	10	1.5%	5.4%
F0881	Antibiotic Stewardship Program	8	1.2%	4.3%
F0887	COVID-19 Immunization	8	1.2%	4.3%
F0883	Influenza and Pneumococcal Immunizations	5	0.7%	2.7%
F0885	Reporting-Residents,Representatives&Families	4	0.6%	2.2%

Citations

Citations F880

Upon entering the room, the Resident had emesis on his/her bedsheets and floor. With gloved hands, CNA #1 had begun by wiping the emesis off the floor with paper towels. As CNA #1 discarded the soiled towels into the trash bin, he/she grabbed the trash bin to bring it closer to the work area. CNA #1 then opened the bottom drawer of the Resident's dresser with the now dirty gloves on, to remove cleaning wipes and continued to clean the floor. During the same observation, CNA #1 proceeded to change the bedsheets on Resident #1's bed. CNA #1 removed the soiled bedsheets and placed them on the floor of the Resident's room. Resident #1 continued to vomit and re-soiled his/her bedsheets. CNA # 1 had left the room to obtain more supplies and returned with CNA #2 During the same observation, CNA #1 and #2 provided cares for the Resident. After the cares, CNA #2 picked up the soiled linens from the floor and placed them in a plastic bag. CNA #2 then removed his/her gloves and placed on clean gloves without first performing hand hygiene.

Citations F880

- Prior to obtaining Resident #1's blood sugar, LN stated Resident #1 was on contact precautions, anyone that entered the room past the entryway of the door had to dress in PPE, in addition to the respirator and face shield. After dressing in PPE, the LN entered Resident #1's room. The LN set the glucometer on the Resident's bedside table and obtained the finger stick. LN then carried the glucometer to the alcohol dispenser located by the doorway, balanced it on top, removed the PPE and sanitized his/her hands. LN then carried the glucometer out of the room, and without cleaning the glucometer, set it on top of the medication cart. The LN picked up the now contaminated glucometer and carried it into Resident #2's room.

Citations F880

- Resident was eating breakfast at the dining table. After completing his meal, the Resident wiped his hands with a damp washcloth laying on the table next to him. Resident ambulated over to the common area, sat down, and began pulling rumpled, clean washcloths out of a large plastic bag. As the Resident folded the washcloths, he placed them on a side table located nearby. Resident was not wearing a face covering and no staff were observed in the immediate area.

Citations F880

- It was observed that LN was wearing a mask, but the mask only covered the mouth and not the LN nose
- Licensed Nurse was seated in the dining room area, among residents, not wearing a mask.
- LPN was observed while attempting to flush Resident’s gastrostomy tube. LPN sanitized her hands and donned gloves as she entered Resident’s room. With her gloved right hand, she pulled on the light cord for the light at the head of the bed. LPN then touched Resident’s tube feed bottle with both hands without changing her gloves or performing hand hygiene. She then picked up the call light off of the floor using both hands and laid it on the bed. LPN next picked up the water flush container off of the bedside table went to the sink and turned it on with her left gloved hand to fill the container. LPN did not change her gloves or perform hand hygiene. She brought the container back to the table and opened a package containing a clean 60 ml syringe. With the same gloved hands, LPN disconnected Resident's tube feeding catheter from the gastrostomy tube and connected the syringe to the tube using her left gloved hand to handle the port and her right gloved hand to handle the syringe and then attempted to flush the gastrostomy tube using gravity. LPN then retrieved more water from the sink without changing her gloves or performing hand hygiene. She then reconnected the syringe to the gastrostomy tube and attempted to flush the tube using the syringe plunger. LPN said the tube was clogged and reconnected the tube feed to Resident's gastrostomy tube

Citations F880

- LN sanitized her hands and donned gloves. After CNA #1 positioned the resident to the left side and unfastened the resident's brief, RN removed a dressing from the resident's coccyx and discarded the old dressing. Then without first removing her contaminated gloves, sanitizing her hands, and re-gloving, RN picked up a can of saline wound cleanser and sprayed Resident's pressure ulcer with the wound cleanser, cleansed the ulcer with a sterile gauze pad, and then patted the ulcer with a clean gauze pad to dry the area. RN then removed her gloves, sanitized her hands, re-gloved, and continued with the application of a new dressing.
- PA performed an examination of Resident #21's ears while he was seated in the day room. The PA examined his ears with an otoscope. Upon completion of the examination, the PA placed the instrument in his back pocket and completed a conversation with Resident #21. Later the PA removed the otoscope from his back pocket and performed an ear examination of Resident #22's ears. This was the same otoscope used for the exam on Resident #21. The otoscope was not disinfected before use on Resident #22.

Citations F881

- Based on record review and interview of administrative staff, the facility failed to develop written antibiotic use protocols on antibiotic prescribing, including the documentation of the indication, dosage, and duration of use of antibiotics as part of the Antibiotic Stewardship Program.
- Facility used the McGeer Criteria when analyzing the appropriateness of ABOs prescribed. Review of the IC reports showed Resident was treated with an ABO for a left groin abscess, with the organism cultured identified as One, and that it met the McGeer Criteria for a soft tissue infection. Review of the medical record showed staff did not document symptoms of a soft tissue infection. When asked if the record showed any symptoms that met the McGeer Criteria for a soft tissue infection, Staff stated not if it's not documented, and acknowledged the facility inaccurately identified Resident displayed symptoms of a soft tissue infection. Another Resident was started on an ABO with cough identified as the organism, and that it met McGeer definition for According to McGeer Criteria, was defined as having at least two respiratory symptoms, negative results for pneumonia if an Xray was performed, and at least one of the Constitutional Criteria symptoms (elevated white blood cell count, or an acute change in mental or functional status). When asked if the record showed that Resident #323 displayed other symptoms that met the McGeer definition for Staff stated, No, not from what I am seeing here, and acknowledged staff inaccurately identified the resident met criteria for the treatment.

Citations F881

- Antibiotic Stewardship Program showed antibiotics would be used only for as long as needed to treat infections, minimize risk of relapse, or control active risk to others. Physician responsibilities in the program related to prescribing antibiotic therapy included avoiding long term antibiotic prophylaxis for preventing infections such as urinary tract infections. A long-term resident medical record was reviewed, and the current physician’s order did not note a stop date for the antibiotic. In an interview the resident had been receiving the antibiotic for over two years. Staff stated she could not locate any recent lab results or documentation addressing the continued antibiotic order.
- Review of the facility's antibiotic tracking showed no documented evidence the facility had monitored the antibiotic use, including documented clinical signs and symptoms with laboratory reports to determine if the resident's prescribed antibiotics were indicated for.

Citations F882

- Facility did not have one or more individuals as the infection preventionist responsible for the facility's infection prevention plan during an outbreak of Covid-19. The Nursing Home Administrator (NHA) confirmed that the DON had abruptly resigned his position and he was the only ICP.
- Facility failed to ensure the designated Infection Preventionist was qualified with specialized training in infection prevention and control. Review of facility key personnel identified there was no evidence that the designated IP had completed specialized training in infection prevention and control.
- Facility failed to effectively implemented the infection program for which the ICP was responsible for investigating infections in an attempt to identify trends and implement interventions, i.e.: education, toileting programs etc to prevent the spread of infection.

Citations F882

- There was no documented evidence of ongoing tracking of infections within the facility. The facility had no monthly infection control tracking logs.
- There was no evidence of a system, which enabled the facility to analyze clusters, changes in prevalent organisms, or increases in the rate of infection in a timely manner. A review of facility infection control logs, revealed that the logs contained only infections treated with antibiotics. There were no entries for fungal or any other types of infections. The facility's infection control log revealed no documented evidence of the method the facility used track infections to identify any trends contained in this tracking data.
- Facility failed to ensure that the facility's designated Infection Preventionist, responsible for the facility's infection prevention and control program, had fulfilled their role and responsibilities in the development and implementation of a functional infection control and prevention program.

Citations F883

- Facility failed to ensure that each resident's medical record included documentation that indicated that the resident and/or their representatives were offered flu and pneumonia vaccines according to their vaccine status and were consistently provided education regarding the benefits and potential side effects of the vaccines for three of five residents reviewed for immunizations.
- Based on clinical record review and staff interview, it was determined that the facility failed to get signed consent prior to administering the influenza vaccine.
- Facility failed to offer and/or provide the influenza and pneumococcal immunization.
- Facility failed to provide and/or document the provision of pertinent information (benefits and side effects) regarding the influenza and pneumonia vaccines to residents or resident representatives.

Citations F885

- Facility failed to provide updates to residents and/or their representatives and families after a single confirmed infection of COVID-19 by 5:00 PM the next calendar day following the occurrence.
- Updates were dependent on the resident or representative obtaining the information themselves (e.g. website), however residents and their reps were not given written provide notification/information informing them of how to obtain updates.
- Letters are sent to families and/or resident representatives on a weekly basis to provide updated information. In addition, there are designated staff members who make face to face contact with residents and make phone contacts with resident's representatives on the status of the COVID outbreak in the facility. However, further interview revealed there was no consistent system in place to contact residents, their representative and/or families regarding confirmed COVID infections.

Citations F885

- Failed to have a process in place to ensure residents and family who do not have internet access were kept informed of COVID status and updates.
- Website data did not match facility data
- Failed to include facility specific information in the updates regarding the mitigating actions being implemented to prevent or reduce the risk of transmission.
- There was no documentation that the resident or their family were notified of the resident’s positive COVID result, or the notification was not timely.

Citations F886

- Facility failed to conduct the required COVID-19 testing which was upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents should be tested , and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection.
- Facility failed to have evidence of required testing for agency nurses and aides.
- Facility failed to test based on the minimum frequency of routine testing of LTC facility staff shall be based on county positivity rates.
- The scanned COVID test result indicated a report date but did not include a date the specimen was collected.
- Facility failed to properly obtain COVID-19 specimens for polymerase chain reaction (PCR) laboratory tests.

Citations F886

- Facility failed to timely conduct testing of one resident exhibiting signs and symptoms of COVID-19.
- Facility failed to follow guidance for placing laboratory testing results in the resident's clinical records.
- Test swabs were collected; however, the specimens were never sent to the laboratory and the testing was not completed for the residents.
- Resident was noted with an intermittent productive cough, expectorating moderate amounts of clear secretions, that his lungs were diminished in the lower bases and that the resident complained of shortness of breath. COVID testing was not performed.
- Facility failed to track COVID-19 testing dates and maintain documentation of all staff members, which contained the required information of the county's positivity rate, current phase, date of the positivity rate, staff testing date, date of test result and the test result as required.

Citations F887

- Residents consented to the COVID-19 vaccine upon admission and had not yet received the vaccine as requested.
- Resident offered COVID-19 vaccine upon admission. Resident refused. There was no evidence that Resident was provided education or educational materials on the risks vs the benefits regarding receiving the COVID-19 vaccine.
- Review of facility's immunization and infection policies and procedures related to COVID-19 revealed no documented evidence that the facility developed a policy regarding COVID-19 immunizations for staff. There was no documented evidence Staff Members were provided with education or educational materials on the risks and benefits of receiving the COVID-19 vaccine.

Strategies

Strategies

- Infection Control Preventionist manages the infection prevention and control program with at least one back up that is qualified.
- Leads infection control program.
- Educates, collects/analyzes data, performs surveillance, monitors employee health.
- Performs a self assessment of facility's IPCP at least annually and prn.
- Develops, reviews and revises IC P&P.
- Participates on the QAPI Committee.
- Reports to the QAPI committee on the IPCP on a regular basis.
- Keeps updated on CDC, state directives, CMS memos, COP/interpretive guidance and survey data.
- Educate NHA, DON, department mangers, staff on new guidance.
- Participates in state and CMS calls and IC education sessions.
- Seeks IC certification.
- Attends IC conferences and maintains knowledge of IC practices. Ongoing education related to ICP and best practices.
- If part of corporation reports to corporate.

Strategies

- Forms infection control committee
- Depending on size of organization
- Multiple disciplines – nursing, rehab, dietary, housekeeping
- QAPI Manager
- Staff educator
- Meets at least quarterly
- Agenda items
  - Survey deficiencies and plans of correction related to infection control
  - CMS/CDC/State directive/updates
  - Competencies
  - Audits -what data to collect, who to collect, set goal, results and action plans

Strategies

Audits

- Observation of care provided
- Medical records
- QAPI minutes
- Infection control logs
- Antibiotic usage
- Staff training including competencies
- Policies and procedures
- Product issues and usage
- Incident reports
- Residents' interviews – Grievances
- Resident council – issues identified

Strategies

- Direct Care Observation
  - Decide on and how to measure and responsible party.
  - Types of observations
    - All disciplines. High risk, problem prone.
    - Nursing – wound care, IVs, CVL care, BGM, INR, trach care, enteral feedings, ostomies, medication administration injections.
    - Patients with MRSA, C-Diff, VRE, COVID 19.
    - Aerosol generating procedures ie nebulizer treatments, trach suctioning.
    - Directly after orientation, then at least 2x/year/employee and more if identify issues.
    - Use standardized form.
    - Educate staff on completing observations.
    - Share expectations with staff.
    - Collect data, analyze, trend, report to IC and QAPI Committee.

Strategies

- Observation Infection Control Focus
  - Hand hygiene
  - PPE donning and doffing
  - Employee COVID – 19 screening
  - Transmission based isolation
  - Cleaning and disinfection of equipment
  - Injection Safety
  - Catheter insertion and care
  - Wound care
  - Housekeeping – cleaning room, carts, mixing disinfectants, using proper disinfectant
  - Dwell times

Equipment Cleaning

Polices and procedures on how often cleaned, with what disinfectant (COVID Killer) and per manufacturer guidelines. What is dwell/wet time?

- Thermometer
- BP cuff
- Stethoscope
- Pulse Ox
- Bandage scissors
- BGM/INR
- Scales
- Mechanical lifts
- Gait belt
- HME used by therapists - Wheelchairs, walkers
- Telehealth equipment

Medical Record Review

- Vaccine status, consents and education.
- COVID test results.
- Antibiotics – what are they treating and does the resident's symptoms match the facility's definition?
- Resident diagnosed with COVID any prior missed symptoms? Were COVID screenings completed?

Surveillance

- Determine type of surveillance.
- Based on infection control risk assessment, population served, and type of treatment and procedures performed.
- Use standardized surveillance definitions – APIC, McGeer, CDC HICPAC Surveillance Definitions.
- Common surveillance - Central Line-associated Blood Stream Infection-lab confirmed BSI (CLABSI-LCBI), Catheter-associated Symptomatic Urinary Tract Infection (CA-SUTI), Skin and Soft Tissue (SST) Infection, COVID, Lower Respiratory Infections (LRI) (i.e., Bronchitis, Pneumonia), Surgical Site Infections (SSI).

Collecting Surveillance Data

- Make sure staff understand what the facility is monitoring and definitions.
- Staff reports infections to ICP.
- Review lab reports.
- Use EMR – antibiotic report.
- Review providers' orders.
- Chart review.

Antibiotic Usage

- Have antibiotic stewardship P&P.
- Have evidence-based infection definitions and when to use antibiotics. If antibiotic prescribed should be based on definitions.
- McGeer definitions
  - Skin, soft tissue mucosal
  - UTI with or without catheter
  - Respiratory
  - GI tract includes c-diff, norovirus

Table 3: Gastrointestinal Tract Infection (GITI) Surveillance Definitions		
Infection Type	**Signs and Symptoms**	**Comments**
☐ ***C. difficile***	Must have both 1 AND 2 1. MUST HAVE at least 1 of the following criteria: ☐ Diarrhea: ≥ 3 liquid or water stools above what is normal for the resident within a 24-hour period ☐ Vomiting: ≤ 2 episodes in a 24-hour period 2. MUST HAVE at least 1 of the following criteria: ☐ Stool sample yields a positive laboratory test result for *C. difficile* toxin A or B, OR detection of toxin-producing *C. difficile* by culture or PCR in stool sample ☐ Pseudomembranous colitis identified in endoscopic exam, surgery, or histopathologic exam of biopsy specimen	"Primary episode" of *C. difficile* infection is an infection that occurs without any previous history of *C. difficile* infection or that has occurred >8 weeks after the onset of a previous episode of *C. difficile* infection. "Recurrent episode" of *C. difficile* infection is an episode that occurs 8 weeks or soon after the onset of a previous episode, provided that the symptoms of the earlier (previous) episode have resolved. Individuals previously infected with C. diff may continue to remain colonized after symptoms resolve. In the setting of an outbreak of GI infection, individuals could have positive test results for C. diff toxin because of ongoing colonization and be co-infected with another pathogen. It is important to use other surveillance criteria to differentiate infections in this situation.

Table 2. Urinary Tract Infection (UTI) Surveillance Definitions		
Syndrome	**Criteria**	**Selected Comments***
UTI without indwelling catheter	***Must fulfill both 1 AND 2.*** □ 1. At least one of the following sign or symptom □ Acute dysuria or pain, swelling, or tenderness of testes, epididymis, or prostate □ Fever or leukocytosis, and ≥ 1 of the following: □ Acute costovertebral angle pain or tenderness □ Suprapubic pain □ Gross hematuria □ New or marked increase in incontinence □ New or marked increase in urgency □ New or marked increase in frequency □ If no fever or leukocytosis, then ≥ 2 of the following: □ Suprapubic pain □ Gross hematuria □ New or marked increase in incontinence □ New or marked increase in urgency □ New or marked increase in frequency □ 2. At least one of the following microbiologic criteria □ ≥ 10^5 cfu/mL of no more than 2 species of organisms in a voided urine sample □ ≥ 10^2 cfu/mL of any organism(s) in a specimen collected by an in-and-out catheter	The following 2 comments apply to both UTI with or without catheter: • UTI can be diagnosed without localizing symptoms if a blood isolate is the same as the organism isolated from urine and there is no alternate site of infection • In the absence of a clear alternate source of infection, fever or rigors with a positive urine culture result in the non-catheterized resident or acute confusion in the catheterized resident will often be treated as UTI. However, evidence suggests that most of these episodes are likely not due to infection of a urinary source. • Urine specimens for culture should be processed as soon as possible, preferably within 1-2 h • If urine specimens cannot be processed within 30 min of collection, they should be refrigerated and used for culture within 24 h

Infection Control Logs

- Audit infection control logs
  - Are all infections beyond those treated with antibiotics documented?
  - Have all infections been included based on EMR reports, morning meetings, MDS assessments?
  - Are antibiotics prescribed based on P&P and defined evidence-based definitions?
  - Was an analysis performed to determine if there are clusters?
  - Were there any increases in the rate or type of infection?
  - Is there a change in the prevalent organisms?
  - What are the trends and what actions were taken and were they successful?

Competency

- A competency is the capability to apply or use a set of related knowledge, skills, and abilities required to successfully perform "critical work functions" or tasks in a defined work setting. Competencies often serve as the basis for skill standards that specify the level of knowledge, skills, and abilities required for success in the workplace as well as potential measurement criteria for assessing competency attainment. Different from training or education.
- IC competencies include
  - Hand Hygiene
  - Donning and doffing PPE
  - Wound care
  - Medication administering – injections, IV
  - CVL care
  - Trach Care/suctioning
  - Catheter insertion and care

Competencies

- New Hire
- Annual Review
- PRN New Skill or Piece of Equipment
- Changes in scope of services
- Changes in polices and procedures
- Quarterly QAPI reports
- New regulations

Hand Hygiene Competency Validation

Soap & Water

Alcohol Based Hand Rub (ABHR) (60% - 95% alcohol content)

Type of validation: Return demonstration	☐ Orientation ☐ Annual ☐ Other

Employee Name: _____ Job Title: _____

Hand Hygiene with Soap & Water	Competent	
	YES	NO
1. Checks that sink areas are supplied with soap and paper towels		
2. Turns on faucet and regulates water temperature		
3. Wets hands and applies enough soap to cover all surfaces of hands		
4. Vigorously rubs hands for at least ***20 seconds*** including palms, back of hands, between fingers, and wrists		
5. Rinses thoroughly keeping fingertips pointed down		
6. Dries hands and wrists thoroughly with paper towels		
7. Discards paper towel in wastebasket		
8. Uses paper towel to turn off faucet to prevent contamination to clean hands		
Hand Hygiene with ABHR		
9. Applies enough product to adequately cover all surfaces of hands		
10. Rubs hands including palms, back of hands, between fingers until all surfaces dry		
General Observations		
11. Direct care providers—no artificial nails or enhancements		
12. Natural nails are clean, well groomed, and tips less than ¼ inch long		
13. Skin is intact without open wounds or rashes		

Comments or follow up actions:

Personal Protective Equipment (PPE) Competency Validation

Donning and Doffing

Standard Precautions and Transmission Based Precautions

Type of validation: Return demonstration	☐ Orientation ☐ Annual ☐ Other

Employee Name: _____ Job Title: _____

Donning PPE	Competent YES	Competent NO
1. Perform Hand Hygiene		
2. **Don Gown:** Fully covering torso from neck to knees, arms to end of wrists		
3. Tie/fasten in back of neck and waist		
4. **Don Mask/Respirator:** Secure ties/elastic bands at middle of head & neck		
5. Fit flexible band to nose bridge		
6. Fit snug to face and below chin (Fit-check respirator if applicable)		
7. **Don Goggles or Face Shield:** Place over face and eyes; adjust to fit		
8. **Don Gloves:** Extend to cover wrist of gown		
Doffing PPE		
9. **Remove Gloves:** Grasp outside of glove with opposite gloved hand; peel off		
10. Hold removed glove in gloved hand		
11. Slide fingers of ungloved hand under remaining glove at wrist		
12. Peel glove off over first glove		
13. Discard gloves in waste container		
14. **Remove Goggles or Face Shield:** Handle by head band or ear pieces		
15. Discard in designated receptacle if re-processed or in waste container		
16. **Remove Gown:** Unfasten ties/fastener		
17. Pull away from neck and shoulders, touching inside of gown only		
18. Turn gown inside out		
19. Fold or roll into bundle and discard		
20. **Remove Mask/Respirator** (respirator removed after exit room/closed door): Grasp bottom, then top ties or elastics and remove		
21. Discard in waste container		
22. Perform Hand Hygiene		

INJECTION SAFETY CHECKLIST

The following Injection Safety checklist items are a subset of items that can be found in the *CDC Infection Prevention Checklist for Outpatient Settings: Minimum Expectations for Safe Care*.

The checklist, which is appropriate for both inpatient and outpatient settings, should be used to systematically assess adherence of healthcare providers to safe injection practices. Assessment of adherence should be conducted by direct observation of healthcare personnel during the performance of their duties.

Injection Safety	Practice Performed?	If answer is No, document plan for remediation
Proper hand hygiene, using alcohol-based hand rub or soap and water, is performed prior to preparing and administering medications.	Yes No	
Injections are prepared using aseptic technique in a clean area free from contamination or contact with blood, body fluids, or contaminated equipment.	Yes No	
Needles and syringes are used for only one patient (this includes manufactured prefilled syringes and cartridge devices such as insulin pens).	Yes No	
The rubber septum on a medication vial is disinfected with alcohol prior to piercing.	Yes No	
Medication vials are entered with a new needle and a new syringe, even when obtaining additional doses for the same patient.	Yes No	
Single-dose or single-use medication vials, ampules, and bags or bottles of intravenous solution are used for only one patient.	Yes No	

Medication administration tubing and connectors are used for only one patient.	Yes No	
Multi-dose vials are dated by healthcare when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. Note: This is different from the expiration date printed on the vial.	Yes No	
Multi-dose vials are dedicated to individual patients whenever possible.	Yes No	
Multi-dose vials to be used for more than one patient are kept in a centralized medication area and do not enter the immediate patient treatment area (e.g., operating room, patient room/cubicle). Note: If multi-dose vials enter the immediate patient treatment area, they should be dedicated for single-patient use and discarded immediately after use.	Yes No	

The *One & Only Campaign* is a public health effort to eliminate unsafe medical injections. To learn more about safe injection practices, please visit www.cdc.gov/injectionsafety/1anonly.html.

CDC

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Immunization

- Process in place to screen residents and staff eligible for immunizations.
- Administering vaccines.
- Document patient’s and staff immunization status including declinations.
- Provide education regarding benefits and risks and document.

Resident and Family Education

- General Infection Control materials
  - Hand Hygiene
  - Immunizations
  - Cough and respiratory hygiene
  - Are signs posted?

Policies and Procedures

- Keep up-to-date with CMS, CDC, State directives.
- Revise policies as needed.
- Educate staff on P&P.
- Document education to include who attend, education material, handouts, tests etc.
- Observe staff to ensure compliance with P&P.

Summary

- Know the SNF infection control federal regulations and interpretive guidelines.
- Understand the DOH survey process for infection control.
- Analyze the national and state data related to infection control deficiencies.
- Implement strategies to ensure compliance with the regulations.

References

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf
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- https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/fsqrs
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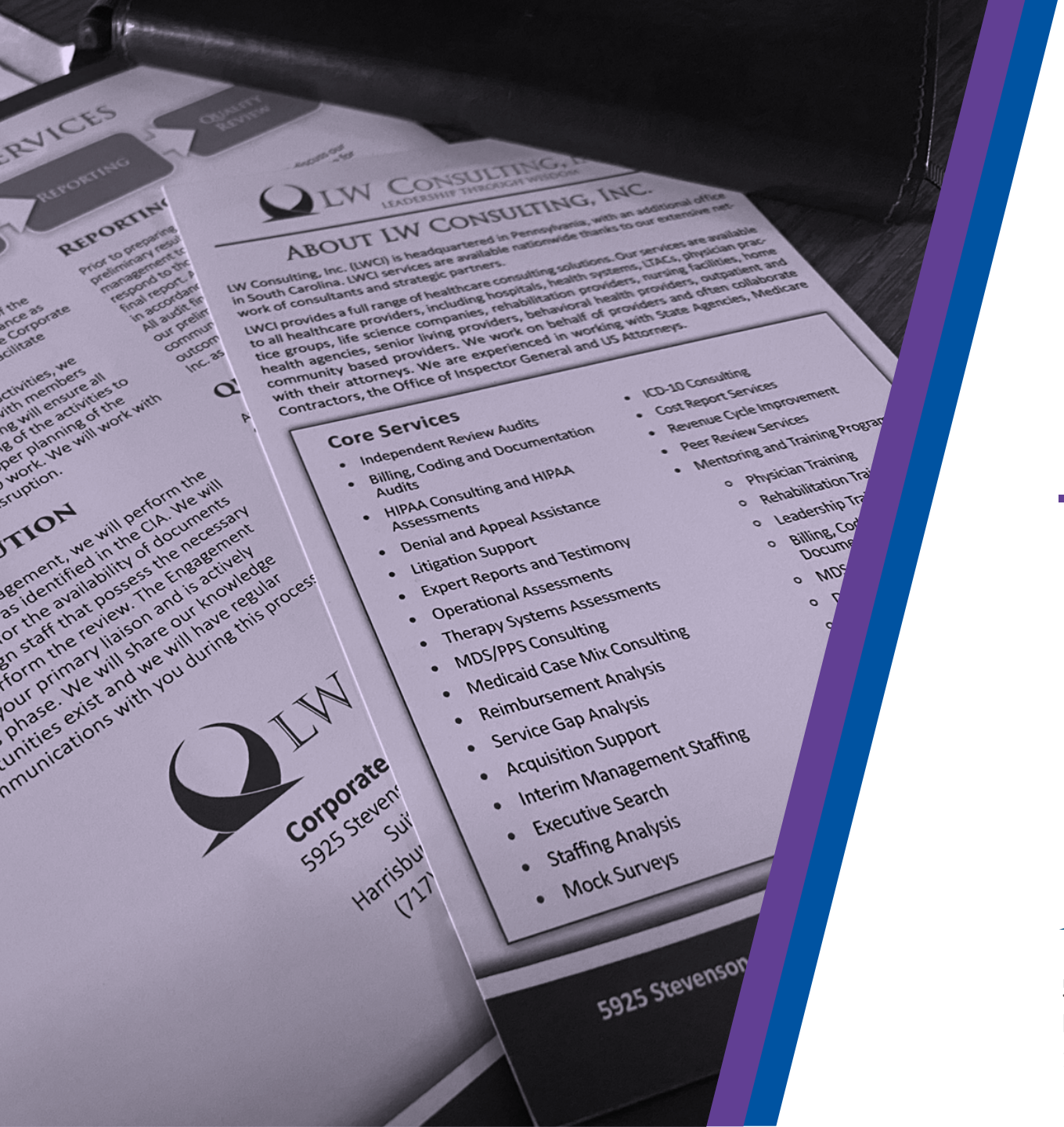

Questions

Patty Klinefelter MBA, BSN, BC, ICP
Pklinefelter@LW-Consult.com
(540) 660-9152

LW Consulting, inc

5925 Stevenson Avenue, Suite G
Harrisburg, PA 17112
1.800.320.5401 | www.LW-Consult.com