

March 17, 2022

LTC COVID-19 Update

Presented by:

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Today's Topics

- COVID-19 update – Dr. Vuppalanchi
- NHSN reporting update – Kara Dawson
- HHS laboratory updates & guidance, waiver updates & newsletter – Lori Davenport
- Q&A

Life Safety Code Workshop, an in-person workshop on Mar. 24, details [HERE](#)

Restorative Nursing Excellence, a webinar series that starts Apr. 7, details [HERE](#)



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Lab Advisory – HHS Updates

- 3/10/2022 – HHS Updated COVID-19 Laboratory Reporting Guidance
- Beginning April 4, 2022 – COVID-19 testing facilities are no longer required to report NEGATIVE results for tests authorized for use under a CLIA certificate of waiver.



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Lab Advisory – HHS Updates

- Includes rapid and antigen testing performed for screening testing at schools, correctional facilities, employee testing programs and **long-term care facilities**, and rapid testing performed in pharmacies, medical provider offices, drive through and pop-up testing sites.
- Also, **no longer** required to report POSITIVE or NEGATIVE antibody tests results.
- **Required** – laboratories to report both POSITIVE and NEGATIVE results for **Laboratory-based nucleic acid amplification tests (NAATs) that are performed in a facility that is certified under CLIA to perform moderate-or high-complexity tests.**



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LAB Advisory

- This updated guidance will replace a blanket requirement to report all SARS-COV-2 test results and tailors reporting requirements that are specific to entity and test type.
- Review [handout](#) – COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115



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Start Date For Change
APRIL 4, 2022



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COVID-19 F888 Survey Matrix

- See handout
- Directions have not changed



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CDC COVID DATA TRACKER

- Question:

The CDC Covid Data Tracker, COVID-19 Integrated County View to monitor “COVID-19 pandemic in the US” is not providing complete data for some counties in Indiana.

Please clarify at what point in the case rate per 100K does the data become “suppressed”?

- Look at the level of transmission, instead of the two parameters for now. – will get further guidance



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Waivers – SNF/NF and Residential

- Executive orders for COVID blanket waivers for both SNF /NF and Residential have a new expiration date.
- July 1, 2022
- Will be published and posted later this week.



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Newsletter
Updates –
soon - IDOH

Defining Community
Transmission of COVID

Updates on can and can-
nots – HCP and residents

AGP Aerosol Generating
Procedures

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Q&A

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THANK YOU!

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COVID-19 Pandemic Response, Laboratory Data Reporting: CARES Act Section 18115

March 8, 2022

Effective date: April 4, 2022

Introductory Information

Public Law 116-136, § 18115(a), the Coronavirus Aid, Relief, and Economic Security (CARES) Act, requires “[e]very laboratory that performs or analyzes a test that is intended to detect SARS-CoV-2 or to diagnose a possible case of COVID-19” to report the results from each such test to the Secretary of the Department of Health and Human Services (HHS). The statute authorizes the Secretary to prescribe the form and manner, and timing and frequency, of such reporting. This updated guidance outlines requirements for data submission to HHS as authorized under this law.

In an effort to receive these data in the most efficient and effective manner, the Secretary is requiring that data elements be reported through existing public health data reporting methods, namely through reporting to state, territorial, local, and Tribal (STLT) public health departments as described in this guidance. As a guiding principle, data must be sent to STLT health departments using existing reporting channels to ensure rapid public health response by those departments (in accordance with STLT law, policies, and procedures). This reporting should be conducted concurrent to test results being shared with an ordering provider or patient, as applicable. HHS acknowledges that reporting laboratories rely on information they receive from ordering health care providers with patient specimens, as laboratories do not typically interact with patients. To enable and effectuate the purpose of § 18115(a), HHS strongly encourages ordering providers to collect and transmit the required data elements to laboratories with test orders.

This guidance outlines federal HHS laboratory reporting requirements under Section 18115 of the CARES Act; STLT jurisdictions may have additional laboratory reporting requirements applicable to testing entities subject to their jurisdiction. Part A, Section 2 of this guidance requires laboratories and testing entities to comply with applicable STLT test reporting requirements. Nothing in this guidance limits or prohibits STLT health departments from requesting or requiring additional SARS-CoV-2 result and/or data element reporting.

Part A of this guidance specifies:

- Laboratory reporting requirements, including reporting requirements by entity and type of testing (Section 1);
- Reporting results required by STLT health departments (Section 2);
- Timing, frequency, and methods of submission (Section 3);
- Minimum required data elements (Section 4);
- Data reporting and transmission requirements (Section 5); and
- Guidance on laboratory reporting and electronic health records (Section 6).

Part B of this guidance provides recommendations for developers and manufacturers of SARS-CoV-2 self-administered tests to facilitate improved capture and reporting of high quality testing data and inform national efforts at the prevention and control of COVID-19.

Note on viral genomic sequencing and variant surveillance

Viral genomic sequencing and variant surveillance are outside the scope of this guidance but are recognized as vital parts of the COVID-19 response and have become increasingly important as the response evolves. While deidentified viral genomic sequencing data has additional complexities compared with other laboratory test result reporting, laboratories that perform sequencing should engage with STLT health departments to identify means of variant surveillance reporting to effectively facilitate public health action by STLT health departments, including responding to specific outbreaks. Timelines and processes for reporting lineages determined through viral genomic sequencing to STLT health departments should be established in accordance with relevant STLT laws or regulations. Additional information on reporting SARS-CoV-2 sequencing results can be found at [Guidance for Reporting SARS-CoV-2 Sequencing Results](#).

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A. Reporting Requirements

The sections below outline HHS SARS-CoV-2 laboratory reporting requirements.

Section 1: Reporting Requirements by Entity and Type of Testing

Federal HHS SARS-CoV-2 laboratory reporting requirements are based on (1) the entity that performs the testing and (2) the type of test being performed.

Guidance for tests that are entirely self-administered are addressed in Part B of this guidance.

- i. **SARS-CoV-2 Nucleic Acid Amplification Test (NAAT) testing conducted in a facility certified under CLIA to perform moderate- or high-complexity tests**
Clinical Laboratory Improvement Amendments (CLIA)-certified laboratories that are certified to perform moderate- or high-complexity testing *must report all test results (i.e., positive, negative, inconclusive) from NAAT testing (e.g., RT-PCR).*

This includes, but is not limited to, NAAT testing performed for SARS-CoV-2 by clinical laboratories, including public health, commercial, healthcare system, and academic laboratories.

- ii. **All other SARS-CoV-2 testing (except antibody and self-administered testing)**
Entities conducting all other SARS-COV-2 testing (e.g., testing conducted in a setting operating under a CLIA certificate of waiver, non-NAAT testing conducted in a facility certified under CLIA to perform moderate- or high-complexity tests) except antibody and self-administered testing, ***must report positive test results***. Reporting of negative results, either individual test results or in aggregate, is optional. This includes rapid testing conducted in many settings (e.g., screening testing at schools, correctional facilities, employee testing programs, long-term care facilities, and point-of-care testing performed in pharmacies, medical provider offices, and drive-through testing sites). Negative result reporting may still be required by applicable state or local law, and entities should check with the applicable STLT jurisdiction for specific reporting requirements.

Note, entities that are using digitally enabled diagnostic tests or automated devices are encouraged to identify potential avenues for reporting aggregate negative totals and/or individual negative test results in collaboration with STLT jurisdictions and public health authorities.

- iii. **SARS-CoV-2 antibody testing**
This guidance does not require entities to report SARS-CoV-2 antibody test results unless required by applicable STLT law or regulation.

Table 1. Reporting Requirements by Entity and Type of Testing

	Is Reporting Required Under this Guidance?		Examples
	Positive Results	Negative & Inconclusive Results	
NAAT-testing conducted in a facility certified under CLIA to perform moderate- or high-complexity tests	Required	Required	<ul style="list-style-type: none"> Laboratory-based Nucleic Acid Amplification Test (NAAT) testing, including RT-PCR, TMA, LAMP, and SDA tests See https://www.cdc.gov/coronavirus/2019-ncov/lab/naats.html for more information
All other testing (except antibody)	Required	Optional*	<ul style="list-style-type: none"> Testing conducted in a setting operating under a CLIA certificate of waiver such as rapid tests used in many settings (e.g., screening testing at schools, correctional facilities, employee testing programs, long-term care facilities, and point-of-care testing performed in pharmacies, medical provider offices, and drive-through and pop-up testing sites) Non-NAAT (e.g., high throughput antigen) testing conducted in a facility certified under CLIA to perform moderate or high-complexity tests
Antibody testing	Optional*	Optional*	<ul style="list-style-type: none"> Tests used to determine previous infection with SARS-CoV-2 in any setting

* State, local, territorial, and Tribal jurisdictions may have additional laboratory reporting requirements applicable to testing entities subject to their jurisdiction. Refer to the applicable jurisdiction’s reporting requirements.

Section 2: Reporting Results Required by STLT Health Departments

Generally, this guidance is intended to provide minimum test result and diagnostic data reporting requirements as set by HHS consistent with the CARES Act. **However, testing entities must follow all SARS-CoV-2 test-result reporting requirements issued by STLT health departments in addition to the minimum reporting requirements in Section 1.**

Section 3. Timing, Frequency, and Methods of Submission

For test results that are required to be reported under Section 1, entities must report:

- (1) information for each individual test,
- (2) within 24 hours of results being known or determined,
- (3) at least on a daily basis, and
- (4) to the appropriate STLT health department based on the individual's residence.

Entities required to report results under Section 1 of this guidance must submit test results to STLT health departments using one of the existing reporting channels below:

- i. Submission directly to a STLT health department:** Submission of laboratory testing data as set forth in this guidance directly to STLT health departments. These health departments will then submit deidentified data to the Centers for Disease Control and Prevention (CDC) on a daily basis using either Health Level 7 (HL7[®]) messaging or the CDC-provided CSV format.
- ii. Submission to STLT health agency via a centralized platform:** Submission of laboratory testing data to STLT health departments through a centralized platform, for example through APHL Informatics Messaging Services (AIMS) or the CDC-provided ReportStream tool. These health departments will then submit deidentified data to the CDC on at least a daily basis using either Health Level 7 (HL7[®]) messaging or the CDC-provided CSV format.
- iii. Submission through state or regional health information exchange:** Submission of laboratory testing data through a state or regional health information exchange (HIE) to the appropriate STLT health department and to the CDC, as directed by the state.
- iv. Submission through the National Healthcare Safety Network (long-term care facilities only):** Centers for Medicare & Medicaid Services (CMS)-certified long-term care (LTC) facilities may submit point-of-care SARS-CoV-2 testing data, including antigen testing data, to CDC's National Healthcare Safety Network (NHSN). This CDC- and CMS-preferred pathway to submit data to CDC's NHSN applies only to CMS-certified LTC facilities. Test data submitted to NHSN will be reported to appropriate STLT health departments using standard electronic laboratory messages. Other types of LTC facilities may also report testing data in NHSN for self-tracking or to fulfill STLT reporting requirements, if any.

Section 4. Minimum Required Data Elements

Required Data Elements and Data Harmonization

The following data elements must be collected and reported for SARS-CoV-2 laboratory tests (as required under Section 1) for the transmission of complete laboratory testing data to the appropriate STLT health departments. STLT health departments may vary in their reporting requirements. Technical Specifications for Implementation for COVID-19 Data Reporting for Laboratory-Based Testing are available to support stakeholder adoption of standardized and harmonized coding for diagnostic data elements. STLT health departments will send deidentified data to CDC or the Secretary's designee. (Note: Additional data elements may be requested at a future date).

1. Patient name (last name, first name, middle initial)*
2. Patient street address*
3. Patient phone number with area code*
4. Patient date of birth*
5. Patient age
6. Patient race
7. Patient ethnicity
8. Patient sex
9. Patient residence zip code
10. Patient residence county
11. a) Test ordered and b) test resulted– use appropriate LOINC codes, as defined by the [Laboratory In Vitro Diagnostics \(LIVD\) Test Code Mapping for SARS-CoV-2 Tests](#) provided by CDC
12. Device identifier
13. Test result (values) – use appropriate SNOMED-CT codes, as defined by the [Laboratory In Vitro Diagnostics \(LIVD\) Test Code Mapping for SARS-CoV-2 Tests](#) provided by CDC
14. Test result date (date format)
15. Date specimen collected (date format)
16. Accession #/Specimen ID
17. Ordering organization or ordering provider name and NPI (as applicable), address, phone number, zip code along with affiliated organization (specific facility)
18. Performing facility name and CLIA number, address, phone number, code
19. Specimen Source - use appropriate SNOMED-CT, LOINC, or SPM4 codes, or equivalently detailed alternative codes
20. Reporting entity name and CLIA number (or appropriate ID), and address.

*Personally identifiable information (PII) is suppressed before data transmission to CDC.

In order for all of these data elements to be available for laboratories to report, it is critical that these data be collected at the time the test is ordered and provided by the submitter to the laboratory performing the test. **Any person or entity ordering a test, registering an individual to be tested, collecting a specimen, or performing a test subject to the guidance and these reporting**

requirements should make every reasonable effort to collect complete demographic information and should include such data when ordering a laboratory test to enable the entities performing the test to report these data to STLT health departments and to comply with this guidance.

To protect patient privacy, any data that STLT health departments send to CDC will not include some patient-level information. The data shared with CDC will contribute to understanding COVID-19's impact, positivity trends for NAAT testing, testing coverage, and will help identify supply chain issues for reagents and other materials. Additional data elements, including “ask on entry” questions, are no longer requested, given the volume of COVID-19 testing in the United States.

Section 5. Data Reporting and Transmission Requirements

When possible, all information and elements set out above should be collected using health information technology certified to the [Office of the National Coordinator for Health Information Technology \(ONC\) 2015 Edition certification criteria](#), and all information and elements set out above should be structured in accordance with the US Core Data for Interoperability (USCDI) when available or when possible. All data transmission in furtherance of the reporting set out above should occur electronically using Health Level 7 (HL7[®]) electronic laboratory reporting (ELR) implementation guides when possible, but a pre-defined flat file format may also be acceptable. In addition, clinical/point-of-care testing facilities using electronic health records (EHRs) are encouraged to use electronic case reporting (eCR) standards to report laboratory testing data, at the receiver's discretion, provided the above data elements and timeliness requirements can be met.

For home-based collection of specimens that are sent to a laboratory for testing, the laboratory must be able to collect the required information to comply with required reporting. To accommodate this required reporting, the process for specimen collection should include collection and submission of all the data elements above (along with the specimen) to the laboratory performing the test, which will then report to the STLT health department consistent with this guidance. For point-of-care testing, the laboratory (including a facility or setting with a CLIA certificate of waiver) must ensure the test is set up and operational to deliver timely and complete electronic results (with identifiers) per the methods of submission.

Links to the relevant applicable standards:

- [Guidance for mapping to SARS-CoV-2 LOINC terms – LOINC](#)
- [LOINC In Vitro Diagnostic \(LIVD\) Test Code Mapping for SARS-CoV-2 Tests | CDC](#)
- [PHIN VADS - Search All Vocabulary \(cdc.gov\)](#)
- [Transmission to public health agencies — reportable laboratory tests and value/results | HealthIT.gov](#)
- [HL7 Standards Product Brief - HL7 Version 2.5.1 Implementation Guide: Electronic Laboratory Reporting to Public Health, Release 1 \(US Realm\) | HL7 International](#)
- [ELR Validation Tool @ NIST](#)
- [COVID-19 Novel Coronavirus Pandemic | Interoperability Standards Advisory \(ISA\) \(healthit.gov\)](#)

Additional Resources provided by CDC and FDA:

- In vitro diagnostic commercial test developers with questions about coding can send questions to: [SHIELD- LabCodes@fda.hhs.gov](mailto:SHIELD-LabCodes@fda.hhs.gov).
- Test users (e.g., laboratories/healthcare providers) can send questions to: dlsinquiries@cdc.gov.

Section 6. Guidance on Laboratory Data Reporting and Electronic Health Records

To ensure that data are captured in the EHR, HHS also recommends, but does not require, that the transmission of laboratory results back to the ordering provider (whenever possible) include the following information:

1. Test result – use appropriate SNOMED codes, as defined by the [Laboratory In Vitro Diagnostics \(LIVD\) Test Code Mapping for SARS-CoV-2 Tests provided by CDC](#)
2. Test result date (date format)
3. Unique patient identifier
4. Test ordered – use appropriate LOINC codes
5. Device Identifier
6. Accession #/Specimen ID

These data fields represent the minimum information, and any data transmission should be in accordance with the [HL7 Lab Results Interface \(LRI\) implementation guide](#) and standard. To ensure that patients receive timely and critical information regarding their own health condition and status, HHS also recommends, but does not require, the transmission of laboratory results be sent directly to the patient (or parent/guardian), either by mail (in writing), email (electronically), and/or via a patient portal or secure standard-based application programming interface (electronically), using commonly available standards such as FHIR[®] (Fast Healthcare Interoperability Resources) (for instance, the [Argonaut Data Query Implementation Guide](#)).

LOINC and SNOMED-CT codes, as defined by the [Laboratory In Vitro Diagnostics \(LIVD\) Test Code Mapping for SARS-CoV-2 Tests](#) provided by CDC, should be used to help ensure normalization and harmonization of data elements related to laboratory test and results.

Laboratories that meet the definition of a covered entity under the HHS Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations are permitted to disclose this protected health information (i.e., laboratory results and other data elements described above) as provided in this guidance under the [HIPAA Privacy Rule](#). A laboratory’s business associate also is permitted to disclose this protected health information if their business associate agreement allows the disclosure, or if the disclosure is pursuant to HHS Office of Civil Rights’ (OCR) [Notification of Enforcement Discretion for Business Associates](#). Nothing in this guidance changes the existing requirements for HIPAA-covered entities and business associates to comply with the applicable HIPAA Privacy, Security, and Breach Notification Rules.

B. Self-Administered Tests

Self-administered SARS-CoV-2 home use tests (not including self-collected specimens where the test is performed at a laboratory)

Home use tests that are entirely self-administered (i.e., a test that allows for self-collection and testing at home, also known as home use or over the counter tests) have been authorized for emergency use by the federal Food and Drug Administration (FDA), and tests from additional test developers may be authorized in the future. While self-administered tests are outside the reporting requirements for laboratories in Section 18115 of the CARES Act as articulated in this guidance, these tests are of enormous potential public health and clinical value and utility.

Developers of self-administered tests are strongly encouraged to consider ways in which the data elements and information described in this guidance could be enabled to be collected and reported to public health authorities given their importance to current and future public health efforts. This might be accomplished through applications on a personal smartphone or tablet, a patient portal, direct transmission from the test platform itself, or other innovative technologies. Manufacturers working to enable automated, digital and/or wireless reporting from these at home or point-of-care technologies are strongly recommended to ensure the collection of all the data elements in Section 4 is enabled and data systems have the capacity to securely transfer data to a centralized platform as described in Section 3. Technical specifications for implementation for [COVID-19 data reporting for non-laboratory-based testing](#) are available to support stakeholder adoption of standardized and harmonized coding for diagnostic data elements.

COVID-19 STAFF VACCINATION MATRIX INSTRUCTIONS FOR PROVIDERS

The Matrix is used to identify the vaccination status for all staff. The facility completes this form, including section I, staff name, and columns 1–11, which are described in detail below, or provide a list containing the same information required in the matrix.

Unless stated otherwise, for each staff mark an X for all columns that are pertinent.

- 1. Direct facility hire (DH), Contracted hire (C), or Other (O):** Direct facility hires (DH) are employees who are directly hired by the facility. Contracted hires (C) provide care, treatment, or other services for the facility and/or its residents under contract or by other arrangements. Other (O) includes adult students, trainees, and volunteers.
- 2. Title:** Identify the staff's title (e.g., RN, LPN, CNA, PA, RD).
- 3. Position:** Identify the staff's position (e.g., staff nurse, charge nurse, infection preventionist, restorative aide).
- 4. Assigned work area:** The physical location in the facility (e.g., laundry room, kitchen, unit, ward, wing). If the staff is PRN/floater/agency, indicate their assigned work area on the first day of the survey.
- 5. Partially vaccinated:** Staff who have received one dose of a multi-dose vaccine.
- 6. Completely vaccinated:** Staff who have received one dose of a single dose vaccine or all doses of a multi-dose vaccine. (For the purpose of this document, fully vaccinated and completely vaccinated are the same)
- 7. Booster dose:** A dose of vaccine administered when the initial sufficient immune response to the primary vaccination series is likely to have waned over time.
- 8. Pending (P) or Granted (G) medical exemption:** Per CDC certain allergies or recognized medical conditions, which may provide grounds for a medical exemption (Please refer to the [CDC](#)).
- 9. Pending (PN) or Granted (GN) non-medical exemption:** May be a religious exemption in accordance with Title VII.
- 10. Temporary delay per CDC/new hire:** Vaccination that must be temporarily postponed, as recommended by the [CDC](#), due to clinical precautions and considerations. Newly hired staff, who are not completely vaccinated due to timing requirements between doses.
- 11. Not vaccinated without exemption or**

delay: Any staff who have not received any doses of a vaccine and do not qualify for any of the exemptions or delays.

Section I

Total number of staff: All staff that work in the facility. Staff includes facility employees (regardless of clinical responsibilities or resident contact), licensed practitioners, adult students, trainees, and volunteers; and individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

Number partially vaccinated staff (column 5): Number of current staff who received partial vaccination at any time as defined as, current staff who have received at a minimum, the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine.

Number completely vaccinated staff (column 6): Number of current staff who completed vaccination at any time is defined as, current staff with administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine

Number of staff with pending exemption (columns 8 and 9): Number of current staff with a request (pending) a medical or non-medical exemption.

Number of staff with granted exemption (columns 8 and 9): Number of current staff who was granted a qualifying medical or non-medical exemption.

Number of staff with temporary delay (column 11): Number of current staff whose COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations.

Number of staff not vaccinated without exemption or delay: Number of current staff who have not received any doses of a vaccine and do not qualify for an exemption or temporary delay.

Instructions for Surveyors to Determine Compliance at §483.80(i) COVID-19 Vaccination of Facility Staff

Note: A Staff Formula spreadsheet is available in the Survey Resources folder that can be used to calculate the formulas listed below. **Please attach the completed spreadsheet to the LTCSP software or the survey shell.**

Section II – Verification of National Health Care Safety Network (NHSN) data

- Please fill in the blanks with data directly from [this link](#).
- NHSN as reported for week ending on (report header):
- Recent Percentage of Staff who are Fully Vaccinated: If there is no data present in NHSN, please ask the facility staff the rationale while onsite. (For the purpose of this document, fully vaccinated and completely vaccinated are the same)
- Review the staff matrix or the facility’s list of all staff and their vaccination status, which is obtained on the first day of the survey. Calculate the percentage of the current staff who have completed vaccinations using the formula listed in Figure 1 (do not round). Compare the facility’s data with the above NHSN data.

Figure 1: Formula to calculate percentage of current vaccinated staff to compare with NHSN data

$$\begin{array}{c} \% \text{ current staff} \\ \text{received completed} \\ \text{vaccination} \end{array} = \frac{\begin{array}{c} \# \text{ Completely} \\ \text{vaccinated (6)} \end{array}}{\begin{array}{c} \# \text{ of total staff} \end{array}} \times 100$$

- If there is a 10% or less difference between the facility documentation and the NHSN data, no further investigation is required.
- If there is a greater than 10% difference, ask the facility to verify and explain why there is a significant variation.
- If the information presented to the surveyor is incorrect (and NHSN is correct), or if both sources are incorrect, this likely demonstrates the facility’s failure to have a process for tracking and securely documenting the COVID-19 vaccination status for all staff [per §483.80(i)(3)(iv)], consider citing F888.
- If the information reported to NHSN is incorrect (and the information reviewed onsite is correct) or data is not present, inform the facility to immediately correct the information in the NHSN system.

Section III – Determine when to cite F888

Determine the percentage of staff vaccinated: (Follow the data in Section I provided on the facility matrix)

- When surveying between 30 - 59 days following issuance of the [QSO-22-07-ALL](#) (effective 1/27/2022–2/27/2022) / [QSO-22-09-ALL](#) (effective 2/14/2022-3/14/2022) / [QSO-22-11-ALL](#) (effective 02/22/2022-03/20/2022) : Use the formula below (or in the Staff Formula spreadsheet) to calculate the percentage (round to the whole number) of staff that received a COVID-19 vaccination using the information the facility completed in Section I above.

Formula for surveys conducted between 30 - 59 days following issuance of the QSO memo

$$\%Vaccinated = \frac{\begin{array}{|c|} \hline \# Partially \\ vaccinated \\ (5) \\ \hline \end{array} + \begin{array}{|c|} \hline \# Completely \\ vaccinated \\ (6) \\ \hline \end{array} + \begin{array}{|c|} \hline \# Pending \\ exemption \\ (8 and 9) \\ \hline \end{array} + \begin{array}{|c|} \hline \# Granted \\ exemption \\ (8 and 9) \\ \hline \end{array} + \begin{array}{|c|} \hline \# \\ Temporarily \\ delayed (10) \\ \hline \end{array}}{\begin{array}{|c|} \hline \# of total staff \\ \hline \end{array}} \times 100$$

○ If the percent vaccinated is less than 100%, cite F888.

- **When surveying 60 days following issuance of the [QSO-22-07-ALL \(effective 2/28/22 and thereafter\)](#) / [QSO-22-09-ALL \(effective 3-15-2022 and thereafter\)](#) / [QSO-22-11-ALL \(effective 03/21/2022 and thereafter\)](#):** Use the formula below (or in the Staff Formula spreadsheet) to calculate the percentage (round to the whole number) of staff that received a completed COVID-19 vaccination series.

Formula for surveys conducted 60 following issuance of the QSO memo

$$\%Vaccinated = \frac{\begin{array}{|c|} \hline \# Completely \\ vaccinated (6) \\ \hline \end{array} + \begin{array}{|c|} \hline \# Granted \\ exemption (8 and 9) \\ \hline \end{array} + \begin{array}{|c|} \hline \# Temporarily \\ delayed (10) \\ \hline \end{array}}{\begin{array}{|c|} \hline \# of total staff \\ \hline \end{array}} \times 100$$

- If the percent vaccinated is less than 100%, cite F888.
- Note: If the facility's staff vaccination rate is below 100% because of newly hired staff, who are not yet eligible to receive the second dose in a two-dose series, the facility will be considered compliant with the 100% staff vaccination requirement. The facility would need to be in compliance with §483.80(i)(3)(iii), including adhering to additional precautions that are intended to mitigate the spread of COVID-19.