May 4, 2023

LTC COVID-19 Update

Presented by:
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Indiana Department of Health Team

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Today's Topics

- Updates and COVID-19 relief with PHE ending May 11, 2023
- The Question of the Week
- Vaccination Update for Immunocompromised
- Q&A

RAC-CT Certification course *(in-person), May 9-11, details HERE*

Designs for Well-rounded Dietary Departments, *a webinar on May 23, details HERE*

Mastering the Art & Science of Dementia Care*, an in-person workshop on May 25, details HERE*

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Good Things Do Come To Those Who Wait

PHE Ends May 11th, 2023

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COVID19 Regulatory Relief

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Guidance for PHE End

- CMS QSO -23-13-ALL -memo

  https://www.cms.gov/files/document/qso-23-13-all.pdf

Read the memo!

You can ask question next week and in the coming weeks.

Remember a few weeks back – Brenda shared some dates in 2024 that would end some of the COVID mandates that we have and are currently under.

Immediate changes are being discussed today.

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Community Transmission Levels

- COVID Community Transmission Levels will be sunset on May 11, 2023, and be removed from the COVID Data Tracker
- The CDC will be updating the COVID guidance for health care settings in the coming weeks
- IHCA/INCAL will update you as that is released on Thursday call

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All Providers/Suppliers

- Emergency Preparedness – Training and Testing Program Exemption
- https://www.cms.gov/files/document/qso-20-41-all-revised-05262022.pdf
- The PHE if used and applied as exemption (PHE – emergency event) – This is your notice to return to normal operating status and comply with the Regualtory requirements for emergency preparedness with the conclusion of the PHE.

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LONG Term Care Facilities
SNFs NFs

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3-Day Prior Hospitalization

- All new SNF stays beginning on or after May 12th will require a qualifying hospital stay before Medicare coverage.
- Additionally, for any new benefit period that begins on or after May 12th, the beneficiary will need to have completed a 60-day wellness period.

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Alcohol-based Hand-Rub Dispenser

- CMS waived the requirement for ABHR dispensers for SNF/NFs at 42CFR 483.90(a) during the PHE because of the need for the sudden increase use by the staff and others of ABHR in infection control.
- This ends May 11, 2023

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Preadmission Screening and Annual Resident Review (PASARR)

- CMS allowed nursing homes to admit new residents who were not screened for Level I or Level II Preadmission Screening. This will now be required at the conclusion of the PHE.
- CMS expects all providers to be in compliance with the requirements for PASARR with all admissions taking place after May 11, 2023

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PASARR continued

- The medical record for residents with a mental illness (MI) or intellectual disability (ID) must include evidence that PASARR Level I pre-screening is completed prior to admission and if the Level I pre-screening is positive, Level II screening is conducted prior to admission to the facility.
- If the state program permits the use of exceptions and the residents remains in the facility longer than 30 days, the medical record must include evidence of Level I pre-screening and a referral to the appropriate state-designated authority for Level II screening if the Level I prescreening is positive on or before the 30th day of admission.

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F885 – Resident and Family Notification

- §483.80(g)(3) Resident and Family Notification and their representatives about COVID-19 cases – Ended May 1, 2023, when QSO memo was issues
- **Facilities are no longer required to notify all residents and their representatives when there is a positive case in the facility, or if there have been three or more residents with new onset of respiratory symptoms occurring within 72 hours of each other.**
- You will need to continue with notification of changes in condition for residents as referenced in F580 at §483.10(g)(14).

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F888 – Staff Vaccination Requirements

- Staff Vaccination Requirements
  - Note: CMS will soon end the requirement that covered providers and suppliers establish policies and procedures for staff vaccination. CMS will share more details soon and IHCA will then share that with you in detail.

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NHSN Reporting Relief

- June 2023
- Key Changes
  - Resident Impact and Facility Capacity Pathway
    - Removal of influenza and PPE supply shortages data fields
    - Reducing vaccination elements to include only up to date status and “not vaccinated” for residents with a positive COVID-19 test
    - Addition of a new data field, hospitalization, assess relevant outcome data on residents with a positive COVID-19 test
  - Staff and Personnel Pathway
    - Removal of COVID-19 deaths, influenzas, and staffing shortages

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Training for the NHSN Changes

- Has not been published
- Tentative webinar trainings June 1 and June 7
- IHCA will announce as soon as we know
- IHCA will offer support with subject matter experts for our Qsource friends

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Questions of the week

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Enhanced Barrier Precautions

- Has IDOH mandated Enhanced Barrier Precautions, and do they expect them to be implemented and if so, when?

IDOH Answer:

No guidance from CMS to implement the additional EBP and we have no plans currently to implement until we receive direction from CMS. EBP are required to be used for the five novel infections as previously discussed and covered by CDC.

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Enhanced Barrier Precautions

- CMS and CDC documents and resources
- This will be a Thursday call agenda item - soon

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Vaccination Update

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CDC New release

- Clinical Guidance for COVID-19 Vaccination | CDC
- Updated guidance for immunocompromised
- First footnote: option of an additional bivalent dose (two months after the last dose)
- See chart next slide

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Ages 12 years and older

COVID-19 vaccination history	Bivalent vaccine	Number of bivalent doses indicated*	Dosage (mL/ug)	Vaccine vial cap and label colors	Interval between doses
Unvaccinated	Moderna† ___or___ Pfizer BioNTech‡	3	0.5 mL/50 ug	Blue cap; gray label border	Dose 1 and Dose 2: 4 weeks Dose 2 and Dose 3: At least 4 weeks
		3	0.3 mL/30 ug	Gray	Dose 1 and Dose 2: 3 weeks Dose 2 and dose 3: At least 4 weeks
1 dose monovalent Moderna	Moderna†	2	0.5 mL/50 ug	Blue cap; gray label border	Dose 1: 4 weeks after monovalent dose Dose 1 and Dose 2: At least 4 weeks
2 doses monovalent Moderna	Moderna†	1	0.5 mL/50 ug	Blue cap; gray label border	At least 4 weeks after last monovalent dose
3 doses monovalent Moderna	Moderna ___or___ Pfizer-BioNTech	1	0.5 mL/50 ug	Blue cap; gray label border	At least 8 weeks after last monovalent dose
		1	0.3 mL/30 ug	Gray	At least 8 weeks after last monovalent dose
3 doses monovalent Moderna and 1 dose bivalent mRNA	—	See footnote	—	—	—
1 dose monovalent Pfizer-BioNTech	Pfizer-BioNTech‡	2	0.3 mL/30 ug	Gray	Dose 1: 3 weeks after monovalent dose Dose 1 and Dose 2: At least 4 weeks
2 doses monovalent Pfizer	Pfizer-BioNTech‡	1	0.3 mL/30 ug	Gray	At least 4 weeks after last monovalent dose
3 doses monovalent Pfizer-BioNTech	Moderna ___or___ Pfizer-BioNTech	1	0.5 mL/50 ug	Blue cap; gray label border	At least 8 weeks after last monovalent dose
		1	0.3 mL/30 ug	Gray	At least 8 weeks after last monovalent dose
3 doses monovalent Pfizer-BioNTech and 1 dose bivalent mRNA	—	See footnote	—	—	—

*People ages 12 years and older who are moderately or severely immunocompromised have the option to receive 1 additional dose of Moderna COVID-19 Vaccine (0.5 mL/50 ug; dark blue cap and label with a gray border) or Pfizer-BioNTech COVID-19 Vaccine (0.3 mL/30 ug; gray cap and label with a gray border) at least 2 months following the last recommended bivalent COVID-19 vaccine dose. Further additional dose(s) may be administered, informed by the clinical judgement of a healthcare provider and personal preference and circumstances. Any further additional doses should be administered at least 2 months after the last COVID-19 vaccine dose.

†Pfizer-BioNTech COVID-19 Vaccine is also authorized in this age group with this vaccination history (0.3 mL/30 ug; gray cap and label with a gray border).

‡Moderna COVID-19 Vaccine is also authorized in this age group with this vaccination history (0.5 ml/50 ug; dark blue cap and label with a gray border).

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THANK YOU!

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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-03-NH

DATE: **November 22, 2019**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Updates and Initiatives to Ensure Safety and Quality in Nursing Homes

Memorandum Summary

The Centers for Medicare & Medicaid Services (CMS) is announcing updates and initiatives aligning with the CMS strategic initiative to Ensure Safety and Quality in Nursing Homes. These updates and initiatives include:

- **Phase 3 Interpretive Guidance:** CMS will be releasing updated Interpretive Guidance and training for the Requirements for Participation for Long-Term Care (LTC) Facilities. However, this guidance will not be released by the November 28, 2019 implementation date of the regulations. We will be releasing the guidance in the second quarter of calendar year 2020, along with information on training and implementing related changes to The Long Term Care Survey Process (LTCSP). While the regulations will be effective, our ability to survey for compliance with these requirements will be limited until the Interpretive Guidance is released.

- **Medicare and Medicaid Programs; Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements:** On July 18, 2019, the Department of Health and Human Services (HHS) published a final rule establishing requirements related to the use of binding arbitration agreements. This final rule amends the requirements that Long-Term Care (LTC) facilities must meet to participate with Medicare and Medicaid. The final rule can be found at: https://www.govinfo.gov/content/pkg/FR-2019-07-18/pdf/2019-14945.pdf

- **Actions to Improve Infection Prevention and Control in LTC Facilities:** CMS has created a nursing home antibiotic stewardship program training; updated the Nursing Home Infection Control Worksheet as a self-assessment tool for facilities; and is reminding facilities of available infection control resources.

- **Release of Toolkit 3, "Guide to Improving Nursing Home Employee Satisfaction":** CMS has created a toolkit that helps facilities improve employee satisfaction.

CMS continues to take action to improve and protect the health and safety of nursing home residents. This memo provides updates on these efforts.

Phase 3 Interpretive Guidance

While the Phase 3 requirements will be effective November 28, 2019, and facilities are required to comply with these and all requirements, our ability to survey for compliance with these requirements will be limited until the Interpretive Guidance is released. We will be releasing the guidance in the second calendar quarter of calendar year 2020, along with information on training and implementing related changes to The Long Term Care Survey Process (LTCSP).

Arbitration Agreements:

On July 18, 2019, CMS published a final rule establishing new requirements related to the use of arbitration agreements by LTC facilities (https://www.govinfo.gov/content/pkg/FR-2019-07-18/pdf/2019-14945.pdf). This revises the Requirements for Participation for LTC facilities at 42 CFR 483.70(n). This final rule aligns with CMS' strategic initiative to increase transparency in nursing homes, by empowering consumers and their families to make informed decisions and choices that are best for them.

The requirements for arbitration agreements are effective on September 16, 2019 and facilities are required to comply with this and all requirements. CMS intends to publish interpretive guidance for surveyors in the upcoming weeks as we do further research, obtain stakeholder feedback, and update the surveyor software to ensure the final guidance and process is comprehensive and effective.

Actions to Improve Infection Prevention and Control

In light of recent reports of healthcare-associated infections in nursing homes, such as adenovirus and *Candida auris*, facilities are reminded of their responsibility for an effective infection prevention and control program to mitigate the onset and spread of infections. Basic practices include:

- Appropriate hand hygiene. As a reminder, alcohol-based handrub (ABHR) should be used instead of soap and water in all clinical situations except when hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected *C. difficile* or norovirus infection during an outbreak; in these circumstances, soap and water should be used. Facilities should ensure adequate access to ABHR since a main reason for inadequate hand hygiene adherence results from poor access;
- Appropriate use of personal protective equipment (PPE). Facilities need to ensure sufficient access and use of PPE, such as gowns and gloves in resident care areas/near the entrance to resident rooms, and appropriate education about the importance of PPE;
- Environmental cleaning and disinfection. Clean and disinfect the resident's care environment and shared equipment with agents effective against the identified organism or products on an EPA-registered antimicrobial list recommended by public health authorities. It is important to follow all manufacturer's directions for use for a surface disinfectant including applying the product for the correct contact time. Facilities need to ensure adequate access to supplies and proper instruction for staff (nursing or housekeeping/environmental services) responsible for cleaning pieces of equipment;
- Implementation of transmission-based precautions when indicated;
- Providing adequate surveillance and identification of resident diagnoses of infections or multidrug-resistant organism (MDRO) colonization status admitted to your facility to understand the types of infections and causative agents present; and
- Identifying and communicating at the time of transfer into and out of a facility the infection and/or MDRO colonization status of residents so appropriate measures can be implemented.

Additionally, we strongly encourage the use of available technical resources, especially when novel organisms appear or there is an outbreak in your area. In many cases the Centers for Disease Control and Prevention is the first entity to release information on novel organisms. Your local and state health department may also be a resource on information specific to the prevalence of a specific organism in your area and actions to take. All facilities must comply with state and local public health authority requirements for identification, reporting, and containing communicable diseases and outbreaks. Many infection prevention and control resources are available to you to prevent and control infections in your facility. These include, but are not limited to:

- Centers for Disease Control and Prevention. For example, infection prevention and control information for *C. auris* is currently located at: https://www.cdc.gov/fungal/candida-auris/c-auris-infection-control.html, and resources for nursing homes, including information about the "Nursing Home Infection Preventionist Training Course" is available at: https://www.cdc.gov/longtermcare/index.html;
- Healthcare-associated infection and antibiotic resistance (HAI/AR) programs in local and state health departments. These programs offer numerous resources directed at improving infection prevention practices and preventing the spread of antibiotic resistant organisms, including performing on-site infection prevention assessments at nursing homes. Nursing homes should develop a relationship with their state and/or local health department as a resource for providing assistance in the implementation of infection prevention practices to increase resident safety. Contact information for state-based HAI/AR programs is available at: https://www.cdc.gov/hai/state-based/index.html; and
- CMS infection control requirements for nursing homes is available at 42 CFR §483.80: https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

In addition to preventing the spread of infectious organisms through basic infection prevention and control practices, establishing an effective antibiotic stewardship program (ASP) is essential for reducing the development of MDROs. To support this, CMS has created a training titled, "Development of an Antibiotic Stewardship Program for Nursing Home Providers" to support compliance with the requirements for an ASP and to improve appropriate antibiotic usage. The training and a supplemental 2-page listing of ASP resources for nursing homes are available and can be accessed by providers and surveyors at the Integrated Surveyor Training website: https://surveyortraining.cms.hhs.gov. This training will be available starting December 2nd, 2019. Completion of the training does not automatically deem a provider compliant. This training supports compliance, but providers must still meet all components of the antibiotic stewardship requirements.

Lastly, through our collaboration with the Centers for Disease Control and Prevention, we have updated the "Nursing Home Infection Control Worksheet" (ICWS). The nursing home ICWS is a voluntary self-assessment tool for facilities to use to improve infection control and prevention. This most recent revision includes questions about facility water management efforts to reduce the risks to residents of *Legionella* infections. This tool will be available on December 2nd, 2019 on the CMS Integrated Surveyor Training Website: https://surveyortraining.cms.hhs.gov.

Civil Money Penalty Reinvestment Program (CMPRP) Toolkit 3: Guide to Improving Nursing Home Employee Satisfaction

CMS has developed optional toolkits to aid nursing home teams with improving staff competency and employee satisfaction:

- Toolkit 1 - Nursing Home Staff Competency Assessment helps nursing homes identify areas where staff competency may need to be improved.
- Toolkit 2 - Nursing Home Employee Satisfaction Survey was designed to help nursing homes recruit, motivate and retain staff. This free, anonymous survey offers facility employees an opportunity to share their perceptions about the nursing home workplace.

Today, CMS is announcing the release of Toolkit 3 - Guide to Improving Nursing Home Employee Satisfaction. This Guide is a repository of evidence-based approaches, solutions and interventions to address challenging areas discovered through the Nursing Home Employee Satisfaction Survey (Toolkit 2). We believe these toolkits will help facilities improve their staff's competency and reduce turnover, which support improved resident health and safety. Toolkits 1, 2, and 3 are available for free at the CMPRP website at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment.html.

Contact: DNH_TriageTeam@cms.hhs.gov for questions regarding any topics on this memo.

Effective Date: Immediately. This information should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David Wright

Attachments:

A. Infection Control Worksheet

cc: Survey and Certification Regional Office Management

ATTACHMENT A

Centers for Medicare and Medicaid Services
Long Term Care (LTC) Infection Control Worksheet

LTC Facility Self-Assessment Tool

This 2019 Nursing Home Infection Control Worksheet (ICWS) is a collaborative effort by CMS and CDC and meant to be used by facilities as a self-assessment tool. It comprises both regulatory requirements and best practices in infection prevention and control. A facility that uses this ICWS will identify gaps in practice and have a "roadmap" that can lead to an improved infection prevention and control program.

The assessment reviews the following domains:

1. Infection Control program infrastructure and Infection Preventionist
2. Infection Preventionist relationship to Quality Assurance Committee
3. Infection surveillance and outbreak response.
4. Influenza and pneumococcal Immunization
5. Linen management
6. Infection prevention during transitions of care
7. Water Management Program

ATTACHMENT A

Section A	Infection Preventionand Control Program (IPCP) Infrastructure	Assessments	Comments
A.1.	The facility has written infection preventionand control policies and procedures which arebased on current nationallyrecognized evidence-based guidelines (e.g., CDC/HICPAC), regulations or standards for its Infection Prevention and Control Program(IPCP).	□ Yes □ No	
A.2.	The facility has evidenceof mandatory personnel infection prevention and control training which includes the IPCP written standards, policies, and procedures.	□ Yes □ No	
A.3.	The facility has documentation of a facility infection control risk assessment conducted according to infection control professional organizations (e.g., APIC, SHEA) guidelines.	□ Yes □ No	
A.4.	Facility has documentation of an **annual** review of the IPCPusing a risk assessment of both facility andcommunity risks, andupdates theprogram as necessary.	□ Yes □ No	
Section B	**Infection Preventionist**	**Assessments**	**Comments**
B.1.	The facility has designated one or more individuals with initial and maintain ongoing specialized training ininfection prevention and control as the Infection Preventionist (IP). This individual works at least part-timein the facility. ***Examples of specialized training may include: Participationin infection control courses organized by thestateor recognized professional societies (e.g., APIC, SHEA, state/local healthdepartment, CDC).*** A free onlineand on-demand infection preventionandcontrol training titled"NursingHome Infection Preventionist Training Course" is availableon CDC's TRAIN website (https://www.train.org/cdctrain/training_plan/3814).	□ Yes □ No	
B.2.	Thereis written evidencethat the IP is a member of thefacility's quality assessment and assurancecommitteeand reports to thecommitteeon a regularbasis.	□ Yes □ No	
Section C	**Quality Assessmentand Assurance (QAA) Committee**	**Assessment**	**Comments**
C.1.	The IP has provided documentation of incidents of communicabledisease and infections identifiedunderthefacility's IPCPto the QAACommittee.	□ Yes □ No	
C.2.	The facility's written QAACommittee plan includes monitoring and evaluationof theactivities of the IPCP.	□ Yes □ No	
C.3.	Thereis evidencethat the QAA Committee develops plans of actionto address incidents of communicablediseaseidentified during review of infection surveillance, staff adherenceto infection prevention practices, and antibioticstewardship data provided by the IP.	□ Yes □ No	
C.4.	Adverseevents related to breaches in infection preventionpractices are analyzed usingroot causeanalysis (RCA) in order to promotesustainable practiceimprovements throughout the facility.	□ Yes □ No	
Section D	**Infection Surveillance** http://www.cdc.gov/nhsn/ltc/	**Assessment**	**Comments**

D.1.	The facility has a written surveillanceplan, based on therisk assessment, outlining activities for monitoring/tracking infections occurring in residents of the facility.	□ Yes □ No	
D.2.	The facility has systeminplace for early detectionandmanagement of potentially infectious symptomaticresidents at thetimeof admission, including implementation of precautions as appropriate ***Examples: Documenting recent antibiotic use, and history of infectionsor colonization with C. difficile or antibiotic-resistantorganisms.***	□ Yes □ No	
D.3.	The facility has a system inplace(e.g., notification of IP by clinical laboratory) for earlydetection and management of potentially infectious symptomaticresidents, including implementationof precautions as appropriate.	□ Yes □ No	
D.4.	The facility surveillancepractices include: a. Useof published surveillancecriteria (e.g., CDC National Healthcare Safety Network (NHSN) Long Term Care Criteria)to define infections. b. Useof a data collection tool. c. Report to QAA (e.g., quarterly). d. Follow-up activity inresponseto surveillancedata (e.g., outbreaks). e. Reportsummarizingsurveillancedataannually.	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No	
D.5.	The facility has a current list of communicablediseases which arereportable to local/statepublichealthauthorities.	□ Yes □ No	
D.6.	The facility staff candemonstrateknowledge of when and to whomto reportcommunicablediseases, healthcareassociated infections(as appropriate), andpotential outbreaks.	□ Yes □ No	
Section E	**Antibiotic Stewardship Programs** http://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html	**Assessments**	**Comments**
E.1.	The facility has an antibiotic stewardship program that has been approved by the governingbody (e.g., facility administrator and facility leadership)to improveantibioticuse.	□ Yes □ No	
E.2.	The facility IP is responsible for ensuring theantibiotic stewardshipprogram is implemented, and the facility has identified oneor moreclinical leaders accountable for antibiotic stewardship-related duties as per theirposition description (e.g., nursing director, medical director, or consultant pharmacist).	□ Yes □ No	
E.3.	The facility has written protocolson antibioticprescribing. ***Note: Theintent is to verify appropriateness based on clinical indications and laboratory findings, duration of use, and national standards.***	□ Yes □ No	

E.4.	The facility uses infection assessment tools or management algorithms for antibioticuse for oneor moreinfections. *Examples: Useof an SBAR tool for UTIassessment, application of the Loeb minimumcriteria forinitiation of antibiotics.*	□ Yes □ No	
E.5.	The facility has a report summarizing antibioticuse from pharmacydata created within last 3 months. *Note: Reportcould include numberof newstarts, types of drugs prescribed, or numberof days of antibiotic treatmentper 1,000 residentdays.*	□ Yes □ No	
E.6.	The facility has a report summarizing antibioticresistance(i.e. antibiogram) based on laboratorydata created withinthepast 18 months.	□ Yes □ No	
E.7.	The facility clinical leadership (e.g., medical director, directorof nursing, infection preventionist, or consulting pharmacist) provides clinical prescribers with feedback about theirantibiotic prescribing practices.	□ Yes □ No	
E.8.	The facility clinical leadership (e.g., medical director, directorof nursing, infection preventionist, or consulting pharmacist) has providedtrainingon antibioticuse(stewardship) to all nursing staff andclinical providers with prescribingprivileges withinthelast 12 months.	□ Yes □ No	
E.9.	The facility has educational materials on antibioticstewardship for residents and families.	□ Yes □ No	
Section F	**Hand Hygiene**	**Assessments**	**Comments**
F.1.	***The facility hand hygiene policies promote preferential use of alcohol-basedhand rub (ABHR) over soap and water in most clinical situations.*** ***Note: Soap and watershould beused when hands arevisibly soiled (e.g., blood, body fluids) and is also preferred aftercaring fora patientwith known or suspected C. difficile or norovirus during an outbreak, or if rates of C. difficile infection in thefacility arepersistently high.***	□ Yes □ No	
F.2.	All personnel receivetraining**and competency** validationon HH at thetime ofemployment.	□ Yes □ No	
F.3.	All personnel receivetrainingand **competency validation** on HH at least every 12 months.	□ Yes □ No	
F.4.	The facility audits (monitors and documents) HH adherenceandprovides feedback among the following: a. Nursing staff including RNs, LPN, and CNAs b. Therapy staff (e.g., PT, OT, speech) c. Clinical staffincluding physicians, NPs, PAs d. Dietary and nutrition including food-preparers e. Environmental services personnel f. Contract staff(e.g., dialysis staff, physical therapy, respiratory therapy, phlebotomy, woundcarephysician, podiatrist)		

F.5.	Facility has written and implemented a resident HH policy (e.g., HH performed immediately before meals).	□ Yes □ No	
	Hand Hygiene Tracer Hand hygieneis performed ina mannerconsistent with the LTC facility infection control practices, policies, and procedures to maximizethe prevention of infection and communicablediseaseincluding the following: ***Note: Observations for compliancewith hand hygieneelements should be assessed throughoutthefacility.***		
F.6.	Soap, water, and a sinkarereadily accessibleinappropriatelocations including, but not limited to, resident careareas, food and medication preparationareas. ***Note: Resident caresupplies shouldbeprotected fromsplashing waterif located closeto sinks.***	□ Yes □ No	
F.7.	Alcohol-based hand rub is readily accessibleand placed inappropriate locations. Some examples may include: - Entranceto thefacility - Entrances to resident rooms - At the bedside(as appropriate for resident population) - In individual pocket-sized containers carriedby healthcare personnel - Staff work station, and/or - Other convenient locations	□ Yes □ No	
F.8.	Personnel perform hand hygiene(even if gloves areused): - Before contact withtheresident - Before performing anaseptictask (e.g., insertion of an invasive device(e.g., urinary catheter)	□ Yes □ No	
F.9.	Personnel perform hand hygiene: - After contact with theresident - After contact with blood, bodyfluids, or visibly contaminated surfaces - After contact with objects and surfaces in theresident's environment - After removing personal protectiveequipment (e.g., gloves, gown, facemask)	□ Yes □ No	
F.10.	When being assisted by healthcarepersonnel, resident hand hygieneis performed: - Prior to resident leaving roomif on transmission-based precautions - After toileting - Beforemeals	□ Yes □ No	
F.11.	The facility does not addsoapto a partially empty soapdispenser(topping off). **Note: Topping off can lead to bacterial contaminationof the soap.**	□ Yes □ No	
Section G	**Standard Precautions Tracer**	**Assessments**	**Comments**

G.1.	Supplies necessary for adherenceto proper personal protectiveequipment (PPE) use(e.g., gloves, gowns, masks) arereadily accessibleinresident care areas (i.e., nursing units, therapyrooms, and resident rooms).	□ Yes □ No	
G.2.	Gloves are worn if thereis contact with blood orbody fluid, mucous membranes, or non-intact skin.	□ Yes □ No	
G.3.	Gloves are removed after contact with blood orbody fluids, mucous membranes, or non-intact skin.	□ Yes □ No	
G.4.	Gloves are changedandhand hygieneperformed before moving from a contaminated-bodysiteto a clean-body siteduring resident care.	□ Yes □ No	
G.5.	Gown is worn for direct resident contact if theresident has uncontained secretions or excretions.	□ Yes □ No	
G.6.	Facemask is worn if contact withresident with new acutecough or respiratorysymptoms(e.g.,influenza-likeillness).	□ Yes □ No	
G.7.	Appropriatemouth, noseandeyeprotection (e.g., facemasks, face shield) is worn for performing aerosol-generating and/or procedures that arelikelyto generatesplashes or sprays of blood orbody fluids.	□ Yes □ No	
G.8.	PPEis appropriatelydiscardedafter residentcareprior toleaving room, followedbyhand hygiene.	□ Yes □ No	
Section H	**Transmission-Based Precautions**	**Assessments**	**Comments**
H.1.	The facility has policies andprocedures for transmission-based precautions (TBP) (i.e., Contact Precautions, Droplet Precautions, Airborne Isolation Precautions) to be followed to prevent spread of infections; whichincludes selection and useof PPE (e.g., indications, donning/doffing procedures) and specifies theclinical conditions for whichspecific PPE should beused(e.g., *C. difficile,* influenza).	□ Yes □ No	
H.2.	Residents with known or suspected infections, or with evidenceof symptoms that represent anincreased risk fortransmission, areplaced on the appropriateTBP. Note: Resident placement (e.g., single/private room orcohorted)is madeon an individual casebasis based on presenceof risk factors for increased likelihood of transmission(e.g., uncontaineddrainage, stool incontinence). Note: Facility should havea process tomanageresidents on TBP when no single/privateroomisavailable.	□ Yes □ No	
H.3.	The facility limits themovement of residents (in accordancewith policies) on TBP with activesymptoms [diarrhea, nausea and vomiting, draining wounds that cannot becontained for highly infectious diseases (e.g., norovirus, C. difficile, MDRO)] outsideoftheirroom formedicallynecessary purposes only.	□ Yes □ No	

H.4.	Facility has written policies and procedures to ensurethat a fter resident discharge, all visiblyor potentially contaminatedsurfaces arethoroughly cleaned and disinfected, and all linens and towels (e.g., textiles) are replaced. Note: Privacycurtains should bechangedor cleaned with an EPA-registered disinfectantafterdischarge.	□ Yes □ No	
	Transmission-Based Precautions Tracer	**Assessments**	**Comments**
H.5.	Signs indicatinga resident is on TBP and required PPE areclearand visible on the door or next to thedoor.	□ Yes □ No	
H.6.	Staff areableto successfully verbalizethe PPE requiredbefore entering a resident's room.	□ Yes □ No	
H.7.	Hand hygieneis performed before entering resident careenvironment.	□ Yes □ No	
H.8.	Gloves and gowns aredonned uponentry into the environment (e.g., room or cubicle) of resident on Contact Precautions.	□ Yes □ No	
H.9.	Dedicated ordisposablenoncriticalresident-careequipment (e.g., blood pressurecuffs) is used, or if not available, then equipment is cleanedand disinfected according to manufacturers' instructions prior to useon another resident.	□ Yes □ No	
H.10.	Gloves and gowns areremoved andproperly discarded, and handhygieneis performed before leaving theresident careenvironment. ***Note: Althoughpreferred for most clinical circumstances, ABHRis not appropriatewhenhands arevisibly soiled (e.g., blood, body fluids) or after caring for a resident with known orsuspected C. difficile or norovirus during an outbreakor if endemicrates of C. difficile infection (CDI) are high. In thesecircumstances, soap and water should beused.***	□ Yes □ No	
H.11.	In rooms withresidents on Contact Precaution, objects and environmental surfaces that aretouched frequently (e.g., bed rails, over-bed table, bedside commode, lavatorysurfaces in resident bathrooms) arecleaned and disinfected withan EPA-registered disinfectant for healthcareuseat least daily and when visiblysoiled.	□ Yes □ No	
Section I	**Injection Practices and Sharps Safety (Medications and Infusates) Tracer**	**Assessments**	**Comments**
I.1.	Appropriatepersonnel receivetraining **and competency validation** on injectionsafety procedures at timeof employment.	□ Yes □ No	
I.2.	Appropriatepersonnel receivetraining **and competency validation** on injectionsafety procedures at least every 12 months.	□ Yes □ No	
I.3.	The facility audits (monitors and documents) andprovides feedback to personnel regarding theiradherenceto injection safety practices ***Note: If yes, facility should providedocumentationof audits.***	□ Yes □ No	

I.4.	The facility has policies andprocedures to monitor andtrack personnel with access to injectablecontrolled substances to prevent potential transmission of infections secondary to contamination of syringes and medication vials. Note: this question highlights therelationshipbetween narcotics theft/drug diversion and contaminated syringes andmedicationvials.	□ Yes □ No	
I.5.	Injections arepreparedusing clean (aseptic) techniqueinan area that has been cleaned and is free of contamination(e.g., visible bloodor body fluids). ***Note: Clean techniqueincludes performing hand hygienebeforeinjection ormedicationpreparation.***	□ Yes □ No	
I.6.	Needles areused for only oneresident.	□ Yes □ No	
I.7.	Syringes areused for only oneresident (this includes manufactured prefilled syringes).	□ Yes □ No	
I.8.	Insulinpens areused for only oneresident.	□ Yes □ No	
I.9.	The rubber septum on any mediationvial, whether unopened or previously accessed, are disinfected with alcohol priorto piercing.	□ Yes □ No	
I.10.	Medication vials areentered with a new needle. ***Note: Reuseof syringes and/orneedles to enter a medicationvial contaminates thecontents of thevial, making thevial unsafefor useon additional residents.***	□ Yes □ No	
I.11.	Medication vials areentered with a new syringe. ***Note: Reuseof syringes and/orneedles to enter a medicationvial contaminates thecontents of thevial, making thevialunsafefor useon additional residents.***	□ Yes □ No	
I.12.	Medication vial labeled for singledose is only used only onceand for only oneresident.	□ Yes □ No	
I.13.	Bags of IV solutions areused for onlyoneresident (and not as a sourceof flush solution for multipleresidents).	□ Yes □ No	
I.14.	Medication administrationtubing and connectors areused for onlyone resident.	□ Yes □ No	
I.15.	Multi-dosemedicationvials aredated when they are first opened and discardedwithin 28 days unless themanufacturer specifies a different (shorter or longer) date for that opened vial. ***Note: Thebeyond-usedateis differentfromtheexpiration dateforthe vial. The multi-dosevial can bedated with either thedateopenedor the discard dateas per facility policy, as long as it is clear what thedate represents and thesamepolicy is used consistently throughoutthefacility.***	□ Yes □ No	

I.16.	Multi-dosemedicationvials used for morethanoneresident arestored appropriately and do not enter theimmediateresident carearea (e.g. procedurerooms, resident room). ***NOTE: If multi-dosevials enter theimmediateresident carearea, they must be dedicated for single resident useand discarded immediately after use***.	□ Yes □ No	
I.17.	All sharps aredisposedof in puncture-resistant sharps containers.	□ Yes □ No	
I.18.	Sharps containers arereplaced when the fill line is reached.	□ Yes □ No	
I.19.	Sharps containers aredisposed of appropriately as medical waste.	□ Yes □ No	
Section J	**Point-of-Care Devices (e.g., Blood Glucose Meter, INR Monitor) Tracer**	**Assessment**	**Comments**
J.1	Appropriatepersonnel receivetraining **and competency validation** on point of caretesting procedures (e.g., during assisted bloodglucosemonitoring) at timeofemployment.	□ Yes □ No	
J.2.	Appropriatepersonnel receivetraining **and competency validation** on point of caretesting procedures (e.g., during assisted bloodglucosemonitoring) at least every 12 months.	□ Yes □ No	
J.3.	Supplies necessaryfor adherenceto safe point-of-caretesting (e.g., single-use, auto-disabling lancets, sharps containers) arereadily accessiblein resident careareas.	□ Yes □ No	
J.4.	Hand hygieneis performed before andafter theprocedure for each resident.	□ Yes □ No	
J.5.	Gloves areworn by healthcarepersonnel when performing the fingerstick procedureto obtain thesampleof blood, andare removed after the procedure(followed by handhygiene).	□ Yes □ No	
J.6.	Fingerstick devices arenot used for morethanoneresident. ***Note: This includes both thelancet andthelancet holding device.***	□ Yes □ No	
J.7.	If used for morethan oneresident, thepoint-of-caretesting device(e.g., blood glucosemeter, INR monitor) is cleaned and disinfected after every use accordingto deviceand disinfectant manufacturer's instructions. ***Note: if manufacturer does notprovideinstructions for cleaning and disinfection, then thedeviceshould not beused for >1 resident.***	□ Yes □ No	
J.8.	The facility has protocols for performing fingersticks andpoint-of-care testing (e.g., assisted bloodglucosemonitoring).	□ Yes □ No	
J.9.	The facility audits (monitors and documents) andprovides feedback to personnel regarding theiradherenceto point-of-caretesting practices.	□ Yes □ No	

Section K	Central Venous Line/Catheters: Accessing and Maintenance Tracer	Assessment	Comments
K.1.	Only properlytrained personnel who demonstratecompetence for access and maintenanceof central venous catheters aregiventhis responsibility.	□ Yes □ No	
K.2.	Central venous line/catheter insertiondateand indicationaredocumented.	□ Yes □ No	
K.3.	Hand hygieneis performed before andafter manipulatingcatheter.	□ Yes □ No	
K.4.	Central linedressings areobservedto beclean, dry, and intact.	□ Yes □ No	
K.5.	Dressing is changed with clean (aseptic)technique using clean gloves or sterilegloves.	□ Yes □ No	
K.6.	Access port is scrubbed with an appropriateantiseptic(chlorhexidine, povidoneiodine, iodophor, or 70% alcohol)priorto accessing.	□ Yes □ No	
K.7.	Catheter is accessed only with sterile devices.	□ Yes □ No	
K.8.	Residents with central venous catheters areassessed regularly to determine continuedneed for thecatheter and this assessment is documented inthe medical record. (Thecentral line is promptlyremoved when no longer needed.)	□ Yes □ No	
Section L	**Indwelling Urinary Catheter Tracer**	**Assessment**	**Comments**
L.1.	The attending physician/practitioner has provided a written rationale for the useof a urinary catheter consistent with evidence-based guidelines (e.g., acuteurinaryretention, bladderoutlet obstruction, neurogenicbladderor terminally ill for comfort measures).	□ Yes □ No	
L.2.	Only trained personnel who havedemonstrated competencyaregiven the responsibility of insertingurinary catheters.	□ Yes □ No	
L.3.	Catheter is secured properly.	□ Yes □ No	
L.4.	Catheter insertiondateandindicationaredocumented.	□ Yes □ No	
Section M	**Urinary Catheter Access and Maintenance Tracer:**	**Assessment**	**Comments**
M.1.	Only trained personnel who havedemonstrated competencyaregiven the responsibility of maintaining andremoving urinarycatheters.	□ Yes □ No	

M.2.	Hand hygieneis performed before andafter manipulatingthe urinary catheter and gloves areworn.	□ Yes □ No	
M.3.	Urinecollectionbagis kept below thelevel of thebladder and off the floor at all times.	□ Yes □ No	
M.4.	Urinary catheter tubing is unobstructed and free of kinking.	□ Yes □ No	
M.5.	Urinebag is emptiedusing a separate, clean collection container for each resident; drainagespigot does not touch collecting container.	□ Yes □ No	
M.6.	Urinesamples areobtained via needleless port and not obtained from the collectionbag.	□ Yes □ No	
M.7.	Residents with indwelling urinary catheters areassessedregularly for continuedneed for thecatheter, andtheneed is documented. The attending physician/practitioner has documented a validclinical indication for theuseof thecatheter andongoing assessment andorders for the removal when theclinical condition demonstrates that catheterization is no longer necessary. Thewritten rationale for theuseof a urinary catheter is consistent with evidence-based guidelines (e.g. acuteurinaryretention, bladderoutlet obstruction, neurogenicbladderor terminallyill for comfort measures).	□ Yes □ No □ Yes □ No	
Section N	**Respiratory Therapy Tracer**	**Assessment**	**Comments**
N.1.	Hand hygieneis performed before andafter contact with a resident or any respiratory equipment used on theresident.	□ Yes □ No	
N.2.	Gloves areworn when incontact withrespiratorysecretions andchanged before contact with anotherresident, object, or environmental surface.	□ Yes □ No	
N.3.	Only sterile solutions (e.g. water or saline) areused for nebulization.	□ Yes □ No	
N.4.	Single-dose vials for aerosolized medications arenot used for morethan one resident.	□ Yes □ No	
N.5.	If multi-dosevialsfor aerosolized medications areused, manufacturers' instructions for handling, storing, anddispensing themedications are followed.	□ Yes □ No	
N.6.	If multi-dosevialsfor aerosolized medications areused for morethan one resident, they arestoredappropriately and do not enter the immediate resident treatment area.	□ Yes □ No	

N.7.	Jet nebulizers are for singleresident useand arecleaned andstored as per facility policy, rinsed with sterilewater, and air-driedbetween treatments on the sameresident. ***Note: Mesh nebulizers which remain in theventilator circuitand arenot cleaned or disinfected arechanged at an interval recommendedby manufacturer's instructions. Nebulizers/drug combination systems are cleaned and disinfected according to themanufacturer's instructions.***	□ Yes □ No	
N.8.	The head of the bed is elevated at an angleof 30-45°, intheabsenceof medical contraindications, for residents at high riskfor aspiration (e.g. resident withan enteral tubein place).	□ Yes □ No	
Section O	**Wound Management Tracer**	**Assessment**	**Comments**
O.1.	Hand hygiene is performed before a woundprocedure.	□ Yes □ No	
O.2.	Gloves areworn duringthe wound dressing procedure.	□ Yes □ No	
O.3.	Face protection(e.g., goggles and facemask, or a face shield) is worn during wound careprocedures that may generatesplashes or aerosols such as irrigation, pulselavage, andhandling of equipment such as vacuum-assisted closuredevices.	□ Yes □ No	
O.4.	A gown is worn ifhealthcare personnel contamination is anticipated during the dressing procedure(e.g. largeor excessively draining wounds).	□ Yes □ No	
O.5.	Reusabledressing careequipment (e.g., bandagescissors)must becleaned and reprocessed (i.e., disinfected or sterilized according to manufacturer's instructions) if shared between residents. Refer to current CDC guidelines. CDC Guideline for Disinfectionand Sterilizationin Healthcare Facilities,2008 https://www.cdc.gov/hicpac/Disinfection_Sterilization/6_0disinfection.html	□ Yes □ No	
O.6.	Clean wounddressingsupplies (e.g. gauze, measuretape) arehandledin a way to prevent cross contamination between residents (e.g., wound care supply cart which remains outsideof resident careareas; unused supplies arenot returned to theclean supply cart but either discarded or remain dedicated to resident; supplies on thecart should onlybehandled by individuals with cleanhands).	□ Yes □ No	
O.7.	The dressing changeis conducted per physician/practitioner orders.	□ Yes □ No	

O.8.	Multi-dosewoundcaremedications (e.g., ointments, creams)shouldbe dedicated to oneresident whenever possible. Dedicated containers should be properly labeled and stored. ***NOTE: If multi-dosewound caremedications (e.g., ointments, creams) are used for morethan oneresident, then themedications should bestoredin a centralmedication area and should notenter theresident treatment area. For example, a small aliquot of medication shouldbedispensed into a clean container for single-residentuse. Any medication container entering a resident's carearea shouldbededicated for thatsingle-resident use.***	□ Yes □ No	
O.9.	Gloves areremoved and handhygieneis performed immediately after the procedure.	□ Yes □ No	
O.10.	Wound caredocumentationinresident's medical record reflects the conditionof thewound andincludes the following: a. Typeof dressing b. Frequency ofdressingchange c. Wound description(e.g., measurement, characteristics)	□ Yes □ No □ Yes □ No □ Yes □ No	
Section P	**Cleaning and Disinfection of Environmental Surfaces and Reusable Equipment**	**Assessment**	**Comments**
P.1.	The facility has cleaning/disinfection policies which includeroutineand terminal cleaning and disinfectionof resident rooms, andhigh-touch surfaces incommonareas. ***Note: Privacy curtains should bechangedwhen visibly soiled.***	□ Yes □ No	
P.2.	The facility cleaning/disinfection policies includehandling of equipment shared amongresidents (e.g., bloodpressurecuffs, rehab therapy equipment, etc.) Note: Personnel can verbalizewho is responsible for cleaning and disinfection of shared equipment	□ Yes □ No	
P.3.	Facility has policies and procedures to ensurethat reusablemedical devices (e.g., wound careequipment, podiatryequipment, and dental equipment) arecleaned and reprocessed appropriately priorto useon another resident. ***Note: If external consultants (e.g., wound carenurses, dentists or podiatrists) provideservices, verify theseproviders haveadequate supplies and spaceto follow appropriatecleaning/disinfection (reprocessing) procedures topreventtransmissionof infectious agents.***	□ Yes □ No	
P.4.	Appropriatepersonnel receivejob-specifictraining andcompetency validationon cleaning anddisinfection procedures at thetimeof employment and within thepast 12 months. ***Note: If environmentalservices areperformed by contractpersonnel, verify that training is providedby contracting company.***	□ Yes □ No	

P.5.	The facility audits (monitors and documents) andprovides feedback to personnel regarding the quality of cleaning and disinfectionprocedures.	□ Yes □ No	
P.6.	Supplies necessary for appropriatecleaning and disinfection procedures (e.g., EPA-registered for usein healthcare facilities, including products labelled as effective against *C. difficile* andnorovirus) areavailableandused accordingto manufacturer instructions for use. ***Note: If environmental services areperformed by contractpersonnel, verify that appropriate EPA-registeredproducts areprovided by contracting company.***	□ Yes □ No	

Section Q	**Healthcare Personnel Safety**	**Assessment**	**Comments**
Q.1.	The facility has policies prohibiting contact with residents or their food when personnel havepotentially communicablediseases orinfected skin lesions.	□ Yes □ No	
Q.2.	The employeehealthpolicies address the following: a. Work-exclusion policies that encouragereporting of illnesses. b. Education of personnel on prompt reporting of illness to supervisorand/or employeehealth.	□ Yes □ No □ Yes □ No	
Q.3.	The facility basedon federal guidelines andapplicable statelaw, has a written policy to providepersonnel TB screening.	□ Yes □ No	
Q.4.	The facility has a protocol for monitoring and evaluating clusters or outbreaks of illness among healthcarepersonnel.	□ Yes □ No	
Q.5.	The facility has an exposurecontrol plan which address potential hazards posed by specific services provided by the facility (i.e., OSHA requirement for bloodbornepathogens).	□ Yes □ No	
Q.6.	All personnel receive trainingandcompetency validation on managing a bloodbornepathogen exposureat thetimeof employment andat least every 12 months.	□ Yes □ No	
Section R	**Respiratory Disease Prevention [(e.g. Pneumococcal, Influenza and Tuberculosis (TB)]**	**Assessment**	**Comments**
R.1.	The facility has a written policy to assess risk for TB (based on local health department data) andprovidescreeningto residents on admission.	□ Yes □ No	
R.2.	The resident's medical recordincludes documentation of TB screening on admission.	□ Yes □ No	

R.3.	The facility has a written policy that requires family and visitors take appropriateprecautions if they arehaving symptoms of respiratory infection during their visit.	□ Yes □ No	
R.4.	Signs areposted at theentrances withinstructions to individuals with symptoms of respiratory infection to: cover their mouth/nose when coughing or sneezing, useand disposeof tissues, and performhand hygiene after contact with respiratory secretions. ***Note: See CDC websitefor examples of signage.***	□ Yes □ No	
R.5	The facility provides resources for performing handhygiene(i.e., alcohol-based handrub) neartheentranceand incommon areas.	□ Yes □ No	
R.6	The facility has policyto provide facemasks to residents with a new cough and other symptomaticpersons upon entry to the facility.	□ Yes □ No	
R.7.	All personnel receiveeducation theat thetimeof employment andat least every 12 months on theimportanceof infection preventionmeasures to contain respiratory secretions to prevent thespreadof respiratory pathogens.	□ Yes □ No	
R.8.	The facility documents resident immunizationstatus for pneumococcal and influenza vaccinationat timeof admission(or as required by per statelaw). ***Note: Theprocess by which a facility determines residentimmunization status may includeinformation providedby theresident/orfamily member healthcaredesignated powerof attorney.***	□ Yes □ No	
R.9.	The resident's medical recordincludes documentation that indicates (at a minimum) either theresident received thepneumococcal immunizations, or the resident refused or had a contraindication to oneor both pneumococcal vaccinations.	□ Yes □ No	
R.10.	The resident's medical recordincludes documentation that aninfluenza immunization is offered annually. ***Note: Theresident or the resident's representativehas theopportunity to refuse influenza immunization.***	□ Yes □ No	
R.11	Facilityhas policyandprocedures to ensure theresident or resident's representativereceives education regarding benefits andpotential side effects of each immunization.	□ Yes □ No	
Section S	**Linen Management**	**Assessment**	**Comments**
S.1.	Personnel handlesoiled linens withminimum agitation to avoid contaminationof theenvironment.	□ Yes □ No	

S.2.	Soiled linens arebagged or otherwise contained at thepoint of collection in leak-proof containers or bags, and arenot sorted or rinsed inthelocation of use. ***Note: Covers arenotneeded on contaminated textile hampers in resident careareas.***	□ Yes □ No	
S.3.	The receiving area for contaminated/soiled linen is clearly separated from clean laundryareas. ***Note: Workflow should preventcross contamination (i.e., If fans areused theventilation shouldnot flowfromdirty to clean laundry areas).***	□ Yes □ No	
S.4.	If facility laundry services arecontracted out and performed offsite, the contractormust show evidencethat thelaundry servicemeets healthcare industry laundry standards.	□ Yes □ No	
S.5.	Clean linen arepackaged, transported, andstored in a mannerthat ensures cleanliness andprotectionfrom contamination(e.g., dust andsoil).	□ Yes □ No	
S.6.	The facility shouldbeusing thefabricmanufacturer's recommended laundry cycles, water temperatures, and chemical/detergent products.	□ Yes □ No	
S.7.	The facility has handwashing stations and PPE (e.g., gloves, gowns, and aprons) in areas wherenon-bagged, soiled linen is handled.	□ Yes □ No	
S.8.	The facility has a policy for cleaning and disinfecting linen carts on the premises or for cart exchangeoff thepremises.	□ Yes □ No	

Section T	**Infection Prevention, Antibiotic Stewardship, and Responsibility of Care During Care Transitions**	**Assessment**	**Comments**
T.1.	When transferring a resident to another facility, the LTC facility has a process that resident documentationis sent to thereceiving facility providers includes direct contact information [name, phonenumber, email] for the resident's treating clinician(MD, APN, PA), transferringnursing unit and casemanager(ifapplicable) before or at thetimeof transfer . CDC sampletransfer forms: https://www.cdc.gov/hai/prevent/prevention_tools.html	□ **Yes** □ **No**	

T.2.	The LTC facility has a process and ensures that documentation of resident infection, colonization or known history of positiveculturewith multidrug-resistant organism, *C. difficile,* or other epidemiologically important organism (e.g. scabies)is sent to receiving provider (e.g., hospital)before or at the timeof transfer.	□ **Yes** □ **No**	
T.3.	The LTC facility has a process and ensures that documentation of the presenceof clinical signs or symptoms of potentially communicable diseases (e.g., vomiting, diarrhea, cough) is sent to receiving provider before or at thetimeof transfer.	□ **Yes** □ **No**	
T.4.	The LTC facility has a process and ensures that communicationof critical information regarding central lines andurinary catheters (i.e., insertion date, rationale), or other medical devices, is sent to receiving provider before or at thetimeof transfer.	□ **Yes** □ **No**	
T.5.	The LTC facility has a process and ensures that communicationof the rationale and useof transmission-based precautions/PPE is sent to receiving provider before or at thetimeof transfer (e.g., C. difficile with diarrhea).	□ **Yes** □ **No**	
T.6.	The LTC facility has a process and ensures that communicationof current or recent (i.e., within past 7 days) antibioticuse, which includes dose, route, indication, start date/stop date, and dateandtimeof last antibiotic administered is sent to receiving provider before or at thetimeof transfer.	□ **Yes** □ **No**	
T.7.	The LTC facility verifies that critical medications and equipment are availableat thereceiving facility (e.g., critical access hospital) at thetimeof transfer to prevent disruptions in thecontinuity of care(e.g., IV antibiotics and administrationequipment).	□ **Yes** □ **No**	
T.8.	The LTC facility has a process to sendadditional information about potentially transmissibleinfections, resistant organisms, andantibioticuse if missingor unavailableat thetimeof resident transfer to thehospital.	□ **Yes** □ **No**	
T.9.	The LTC facility ensures that essential resident information about potentially transmissibleinfections, resistant organisms, andantibioticuse is reviewed and addressed (e.g., TBP) at thetimeof arrival from a hospital.	□ **Yes** □ **No**	
Section U	**Water Management Program**	**Assessment**	**Comments**

U.1.	The facility has a water management program based on national guidelines and toolkits [e.g., The American Society of Heating, Refrigerating and Air-Conditioning Engineers (ASHRAE), The Centers for Disease Control and Prevention (CDC), and United States Environmental Protection Agency (EPA)] including control measures such as physical controls, temperature management, disinfectant level control, and visual inspections for biofilm, slime, scale, and sediment.	□ **Yes** □ **No**	
U.2.	The facility conducts, as a part of the water management program, a risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system.	□ **Yes** □ **No**	
U.3.	The facility's water management program specifies testing protocols and acceptable rangesfor control measures and documents the results of testing and corrective actions taken when control limits are not maintained.	□ **Yes** □ **No**	