DISCLAIMER

This manual was prepared by staff of the MU nursing home consultant program. This manual is advisory and does not represent the views of the Department of Health and Senior Services. The purpose of this manual is to serve as a guide to assist administrators, DONs, and infection prevention and control practices unique to long-term care facilities. All information contained in this manual is solely intended as a resource and a guide and assumes no responsibility for any error, omissions, or discrepancies. Refer to the official regulations listed for the most current and accurate information.

If you find information in the manual that needs revision or if you have information you feel should be added to this manual, contact our project coordinator by email at musonqipmo@missouri.edu. Electronic files of this manual can be downloaded at http://www.nursinghomehelp.org. Your QIPMO nurse and/or Long-Term Care Leadership Coach can also provide you with electronic copies during on-site visits.
DEDICATION

This manual is dedicated to the countless long-term staff who worked endless hours, sleepless nights, and through realms of worry to care for our residents and each other through the COVID-19 pandemic. It is with a special honor that the Quality Improvement Program for Missouri team prepares this manual to capture your clinical and managerial capabilities and lend guidance for those who come after you.

Finally, for those heroic nurses, CNAs, social workers, administrators, dietary, housekeeping, maintenance, business office, activities, therapists, and the long list of others in long-term care who lost their lives to COVID-19 - we thank you from the bottom of our hearts and salute you. Thank you and God bless.
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**INTRODUCTION**

When Clara Barton joined the American Civil War, it was as one of the first volunteers at the Washington Infirmary. She did not come armed with guns and sabers but rather with bandages, soap, rags, and donations for hearty and nutritious meals. She opened the windows, gave baths, applied fresh dressings, and literally swept out the stifling environment of infection. She knew that for her patients to heal, they needed fresh air, clean surfaces, sunshine, exercise, and good food. Like Clara, we are fighting a war against infection and it going to take serious measures, ingenuity, compliance, and creativity to win the battles.

Germs have been with us since the beginning of time and that will not change. We need germs, bacteria, fungus, and even viruses to balance out the symmetry of life. However, it is our duty in healthcare to distinguish between the good germs and the bad and to understand those which help us with life versus those that could extinguish it.

In 2017, the Center for Medicare and Medicaid Services pre-empted our attention to the importance of strong infection control practices. We were taught to embody antibiotic stewardship to help fight off the super bugs that while different, are no less deadly than the bacteria and viruses of Clara’s day. No one could ever have suspected that in 2020, we’d fast forward into putting all that into forceful and immediate action.

This infection control manual is designed to help long-term care staff understand the pieces and requirements of the infection control and prevention program. In Part I, you will find the CMS guidance, sample policies and procedures, surveillance systems, data and tracking, reporting, vaccination protocols, and tools for implementing an antibiotic stewardship program. Part II is dedicated to pandemic operations and management. While we sincerely hope to never encounter another pandemic in this century, it is our hope these tools will guide you on how to set up isolation units, inventory and prepare PPE stores, create emergency staffing programs, and understand and document the various financial aspects of dealing with a pandemic response.

At the core of infection control is us—our staff, our daily habits and practices, our education, and our expectations for creating a safe environment for our residents, their families, and our coworkers. When it comes to infection control, Clara Barton said it best with this statement:

“You must never so much think as whether you like it or not, whether it is bearable or not; you must never think of anything except the need, and how to meet it.”
CMS REGULATIONS FOR INFECTION PREVENTION AND CONTROL PROGRAM

§483.80 Infection Control 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.

§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) 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 conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (I) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) 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, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) 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; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility’s IPCP and the corrective actions taken by the facility.

INTENT §483.80(a),(e),(f)

The intent of this regulation is to ensure that the facility:

- Develops and implements an ongoing infection prevention and control program (IPCP) to prevent, recognize, and control the onset and spread of infection to the extent possible and reviews and updates the IPCP annually and as necessary. This would include revision of the IPCP as national standards change;
- Establishes facility-wide systems for the prevention, identification, investigation, and control of infections of residents, staff, and visitors. It must include an ongoing system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility and procedures for reporting possible incidents of communicable disease or infections; NOTE: For purposes of this guidance, “staff” includes employees, consultants, contractors, volunteers, caregivers who provide care and services to residents on behalf of the facility, and students in the facility’s nurse aide training programs or from affiliated academic institutions.
- Develops and implements written policies and procedures for infection control that, at a minimum: Explain how standard precautions and when transmission-based precautions should be utilized, including but not limited to the type and duration of precautions for particular infections or organisms involved and that the precautions should be the least restrictive possible for the resident given the circumstances and the resident’s ability to follow the precautions; o Prohibit staff with a communicable disease or infected skin lesions from direct contact with
residents or their food, if direct contact will transmit the disease; and o Require staff follow hand hygiene practices consistent with accepted standards of practice.

- Requires staff handle, store, process, and transport all linens and laundry in accordance with accepted national standards in order to produce hygienically clean laundry and prevent the spread of infection to the extent possible.

**GUIDANCE §483.80(a),(e),(f) INFECTION PREVENTION AND CONTROL PROGRAM**

Healthcare-associated infections (HAIs) can cause significant pain and discomfort for residents in nursing homes and can have significant adverse consequences. The facility must establish and maintain an IPCP designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This program must include, at a minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors. The IPCP must follow national standards and guidelines.

For purposes of this guidance, we would expect facilities to tailor the emphasis of their IPCP for visitors. We expect facilities to work to prevent transmission of infection to the resident from the visitor using reasonable precautions and national standards. For example, passive screening through the use of signs at the entrances to alert visitors with signs and symptoms of communicable diseases not to enter the facility. If a facility has a visitor exception protocol (e.g., end-of-life care), this would need to be determined by the facility. In this case, if a symptomatic visitor/family member must enter the facility, the visitor must still follow the facility’s policies for prevention of transmission (e.g., following respiratory hygiene/cough etiquette procedures).

The **Infection Prevention and Control Program** must include the following parts:

- A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases that: o Covers all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement; o Is based on the individual facility assessment; o Follows accepted national standards;
- Written standards, policies and procedures in accordance with §483.80(a)(2);
- A system for recording incidents identified under the IPCP and corrective actions taken by the facility; and
- An antibiotic stewardship program (ASP) (F881).

TIPS AND LESSONS LEARNED

**TIP:** Throughout this manual you will find TIP boxes with ideas to help you implement your infection control program. Some of them are resources, others are short cuts. Feel free to utilize these tips to make the process as simple and efficient as possible.

**Lessons Learned:** Lessons learned are adages learned from the frontlines that we are passing on to you from fellow caregivers. As we know, many of these lessons are learned the hard way so they are worth mentioning to hopefully help you prevent the same mistakes.

**GETTING STARTED IN INFECTION CONTROL**

1. Create an Infection Prevention and Control binder (electronic and hard copy). The electronic copy will be helpful to sharing with surveyors and administration who may need to work off-site.
2. Create an interdisciplinary Infection Prevention and Control Team.
3. Plan to include your procedures for infection control practices, return demonstration, and reporting as part of your orientation process.
4. Review your infection control manual annually with your medical director and include the following signatures on the face page:
   a. Medical Director(s)
   b. Administrator
   c. Director of Nursing
   d. Infection Preventionist
PART I: GENERAL INFECTION DISEASE PREVENTION AND CONTROL PROGRAM
CHAPTER 1: INFECTION PREVENTION AND CONTROL TEAM AND THE INFECTION PREVENTIONIST

Infection Prevention and Control Team

Everywhere there is a congregation of people, particularly those at high-risk for viral or bacterial infections, there is a need for infection control. To successfully prevent and control potential outbreaks, as well as normal infections, it takes every staff member. By organizing an infection control and prevention team, or ICP team, surveillance, reporting, and environmental control are more efficient and more helpful to all residents and staff.

Members of the IPC Team should include

- Infection Preventionist
- DON/ADON
- Administrator
- Medical Director
- Maintenance Supervisor
- Housekeeping Supervisor
- Laundry Supervisor
- Dietary Supervisor
- Quality Assurance/Quality Improvement Liaison
- CNA

Each team member plays a vital role in preparing for outbreaks of communicable diseases as well assuring oversight and competency and environmental issues. Keep in mind, the IPC team can also be part of PIP or QAPI projects to improvement infection control processes and infection rates in your building.

Infection Preventionist

In November of 2019, CMS required the implementation of an Infection Preventionist as part of the infection control and prevention program.

“Nursing facilities will be required to have one or more staff members who have been designated as the Infection Preventionist (IP) and who is/are responsible for the facility’s Infection Prevention and Control Plan. The regulatory requirement generally focuses on the qualifications of someone who will be designated as the IP and provides you with a minimum set of requirements for that role, including:

- Must have primary professional training in one of the following: nursing, epidemiology, microbiology, medical technology, or a related field.
- Be qualified for this role through education, training, certification, or experience
- Have completed specialized training in Infection Prevention and Control
- Needs to work at least part-time at the facility.
- Must be a member of the facility’s QAA Committee and routinely report to the QAA Committee on the facility’s IPCP.”
The certification for this position can be obtained through free training at https://www.train.org/cdctrain/training_plan/3814. This training includes 23 modules, a certificate of completion for each section, and a multitude of resources and will be available through September 1, 2021.

Roles of the Infection Preventionist may include:

- Leading the interdisciplinary team.
- Monitoring IPC compliance and record keeping.
- Assisting with the IPC portion of the facility assessment.
- Tracking monthly infections and antibiotic usage.
- Assisting with Quality Assurance/Improvement reporting.
- Leading a QAPI or PIP team for improving the prevalence of infections within the facility.
- Serving as community public health liaison for reporting to the county health department, DHSS regional office, and laboratory. This is especially necessary in an Emergency Communicable Disease outbreak.
- Investigating incidents related to infection control.

Consider starting with the Infection Preventionist Orientation Checklist. This checklist will guide you through the steps and the different areas which you need to focus on in your individual home. [IP_orientation_checklist_FINAL_20200601.pdf](qioprogram.org).
CHAPTER 2: INFECTION PREVENTION AND CONTROL FACILITY ASSESSMENT

The Infection Prevention and Control part of your facility assessment is an important part of your infection control program. Not only is it a required part of the overall facility assessment, but it also allows you to see patterns and potential problems in your infection prevention program. The infection prevention portion of your facility assessment should be completed by the Infection Preventionist and reviewed annually. You can utilize your quarterly QA numbers and lab reports to help you get started. A copy of this assessment is provided in the appendix of this manual.

TIP: Take time to be realistic with this analysis of your infection control program. You can utilize the Long-term Care Tool (full document in The Appendix) to help you analyze elements to be assessed and actions to take.

<table>
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<tr>
<th>Elements to be assessed</th>
<th>Assessment</th>
<th>Notes/Areas for Improvement</th>
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<tbody>
<tr>
<td>A. The facility has specified a person (e.g., staff, consultant) who is responsible for coordinating the IC program.</td>
<td>○ Yes ○ No</td>
<td></td>
</tr>
<tr>
<td>B. The person responsible for coordinating the infection prevention program has received training in IC</td>
<td>○ Yes ○ No</td>
<td></td>
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<tr>
<td>Examples of training may include: Successful completion of Initial and/or recertification exams developed by the Certification Board for Infection Control &amp; Epidemiology; Participation in infection control courses organized by the state or recognized professional societies (e.g., APIC, SHEA).</td>
<td>○ Yes ○ No</td>
<td></td>
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<td>C. The facility has a process for reviewing infection surveillance data and infection prevention activities (e.g., presentation at QA committee).</td>
<td>○ Yes ○ No</td>
<td></td>
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<tr>
<td>D. Written infection control policies and procedures are available and based on evidence-based guidelines (e.g., CDC/HICPAC), regulations (F-411), or standards.</td>
<td>○ Yes ○ No</td>
<td></td>
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<tr>
<td>Note: Policies and procedures should be tailored to the facility and extend beyond OSHA bloodborne pathogen training or the CMS State Operations Manual</td>
<td>○ Yes ○ No</td>
<td></td>
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<tr>
<td>E. Written infection control policies and procedures are reviewed at least annually or according to state or federal requirements, and updated if appropriate.</td>
<td>○ Yes ○ No</td>
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CHAPTER 3: INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES: IDENTIFICATION, INVESTIGATION, AND REPORTING REQUIREMENTS

Summary of Requirements

- Annual review of facility assessment based on facility and community risk (see previous page).
- Ongoing system of surveillance.
- Written occupational health policies.
- Vaccinations and antibiotic stewardship.
- Infection prevented.

In this chapter we will discuss surveillance and occupational health policies.

Surveillance System

The surveillance system is based on two distinct pieces—*process* surveillance and *outcome* surveillance. As you create your surveillance system, it should be based on state and national CDC standards and the individual needs from your facility assessment.

*Process Surveillance*

Process surveillance is the review of practices by staff directly related to resident care. The purpose is to identify whether staff implement and comply with the facility’s IPCP policies and procedures. It is under process surveillance that you see *how* and *if* your infection control practices are working.

CMS highlights the following areas in Appendix PP:

- Hand hygiene
- Appropriate use of personal protective equipment (e.g., gowns, gloves, facemask);
- Injection safety;
- Point-of-care testing (e.g., during assisted blood glucose monitoring);
- Catheter care;
- Wound care;
- Injections and IVs;
- Continence management;
- Skin care;
- Dialysis; and
- Managing blood borne pathogen exposure.

The Long-term Care Infection Control Tool (below) is an excellent checklist that covers everything you need to assess in your surveillance program, including competency check-offs for your staff. Refer to the appendix for the complete document.
Long-term Care Infection Control Tool

**Outcome Surveillance**

Outcome surveillance includes the identification, assessment, handling, and reporting of suspected or confirmed healthcare-acquired infections or other communicable diseases. This process consists of collecting/documenting data on individual resident cases and comparing the collected data to standard written definitions (criteria) of infections.

Examples of outcome surveillance include:

- Monitoring a resident(s) with fever or other signs or symptoms suspicious for infection;
- Laboratory cultures or other diagnostic test results consistent with potential infections to detect clusters, trends, or susceptibility patterns;
- Antibiotic orders;
- Medication regimen review reports;
- Documentation from the clinical record of residents with suspicion of an infection such as physician orders/progress notes; and/or
- Transfer/discharge summaries for new or readmitted residents for infections.

**Surveillance System—Getting Started**

1. **Who and how will identify potentially infectious diseases?** This will generally be your nursing staff—on admission, after community outings such as doctor’s appointments and outpatient hospital visits, and during routine care. Be sure to educate your nursing staff on common signs of potentially contagious diseases such as rashes, vomiting, diarrhea, flu, and respiratory symptoms, etc. Refer to the Missouri Infection Control Guideline for Long-term Care.

2. **Create a “phone” tree notification system.** This should be specific to your facility.

3. **Know when and how isolation should be used for a resident; including the type and duration of the isolation, depending upon the infectious agent or organism involved.** Remember that isolation should be the least restrictive possible for the resident under the circumstances.
Include the CDC Isolation Guidelines in your IPC binder and make it easily accessible to your nursing staff for guidance on whether isolation is necessary, the types of precautions needed, and the duration. The complete list can be found here.

https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html

4. **Who and how will monitor infection control processes and procedures?** It’s up to you if you divide this task or assign one person to monitor all the areas of infection control in your building. Some tasks should be monitored at minimum yearly, others monthly, or more frequently depending on the circumstances. The Long-term Care Tool, as mentioned above, can help with that process.

5. **Decide if the situation requires moving into your Emergency Communicable Disease plan.**

6. **Once confirmed, report the infection to the resident, family, local county health department, and regional DHSS office.** Missouri has a specific list of communicable diseases that must be reported during a designated timeline. See example below. The full form can be found in the appendix.

We expect this to be updated due to the outbreak of COVID-19 and will update the form once available.
COMMON SYMPTOMS OF POSSIBLE INFECTION
- Fever
- Increasing lethargy or confusion
- Dizziness or Weakness
- Generalized pain or complaint of local pain
- Anorexia
- Cloudy, thick, foul smelling urine
- Complaints of painful or difficult urination
- Open or draining sores
- Complaints of sore throats or cough with thick, colored phlegm
- Puffy, red, runny eyes or Stuffy or draining nose
- Labor or difficult respiratory

Communication/reports to license nurses

Nursing assessment
- Vital signs
- Investigate and assess sites/areas of infection

Reporting to physicians for further evaluation (using SBAR)
- Obtain treatment orders
- Notify the pharmacy
- Implement treatment orders

Notify the other professional coordinators internally and outsources (wound care) for additional services

NOTIFYING/REPORTING/COMMUNICATING SYSTEM

Infection control preventionist
- Case investigation
- Surveillance for data
- Provide further info
- Provide staff education

Director of nurses/ADON

Primary Care Physician

Medical Director

MDS coordinator

Administrators

Regional DHSS

Public Health

Medical Director

QAPI program
- Follow-up treatment
- Case evaluation
- System review
- Policy & procedures
- Care planning
- Communication to others

QAPI program
- Investigation
- Guidance
Example of the CDC Guideline for Isolation Precautions

Diseases and Conditions Reportable In Missouri (19 CSR 20-20.020)

Report Diseases and Conditions to your local health agency or to:
Missouri Department of Health and Senior Services during business hours 573-751-6113, after hours and on weekends 800-392-0272 or by fax 573-526-0235

- Outbreaks (including nosocomial) or epidemics of any illness, disease or condition that may be of public health concern, including illness in a food handler that is potentially transmissible through food. (A05)
- Pertussis (A37)
- Poliovirus infection, nonparalytic (A80.4, A80.9, B91)
- Q fever (acute and chronic) (A78)
- Rabies (animal)
- Rubella, including congenital syndrome (B06, P35.0, Z00.4)
- Shiga toxin-producing Escherichia coli (STEC) (A04.3, B96.21-B96.23)
- Shiga toxin positive, unknown organism
- Smallpox (A07)
- Staphylococcal enterotoxin B (A05.0)
- Syphilis, including congenital syphilis (A50-A53, A65, O98.11, O98.12, O98.13)
- T-2 mycotoxins (T64.81-T64.84, Y38.6X)
- Tetanus (A32-A35)
- Tuberculosis disease (A15, A17-A19, B90, 65, O98.0, P17.0)
- Tularemia (all cases other than suspected intentional release) (A21)
- Typhoid fever (Salmonella Typhi) (A01, Z22.0)
- Vancomycin-resistant Staphylococcus aureus (VISA), and Vancomycin-resistant Staphylococcus aureus (VRE)
- Venezuelan equine encephalitis virus neuroinvasive disease (A92.8, A92.9)
- Venezuelan equine encephalitis virus non-neuroinvasive disease (A92.2, A92.8, A92.9)
- Viral hemorrhagic fevers other than suspected intentional, (e.g., Ebola, Marburg, Lassa, Lujo, new world Arenaviruses (Guaranito, Machupo, Junin, and Sabia viruses), or Crimean-Congo virus) (A96, A98, A99)
- Yellow fever (A95)

Example of the Missouri DHSS Reportable Diseases

Created by QIPMO, MU MDS and Quality Research Team, March 2021
1. **What is your process related to investigating incidents related to infection control? For example:**
   - How will you obtain information on incidents from residents, staff, and family?
   - How will you address and investigate these incidents?
   - How will you prevent further infection and maintain control?
   - What corrective actions will you take to stop or fix the problem?
   - How will you monitor the program for effectiveness?
   - What methods for feedback will be used for failed practices?

Many of these answers will fall under your regular facility monitoring. Make sure you address these questions in your IPC policy and procedures.

**TIP:** One easy way to obtain this information is to the INTERACT Stop and Watch tool. Educate your staff and families about how to use the tool and place a box or jar at the nurses’ desk or on your office door where these incidents can easily be followed up on. This tool can be found in the Appendix.
Occupational Health Policies

Protecting the health of your facility, also includes having written policies for your staff and outside visitors. These policies should include:

- Reporting of staff illnesses and following work restrictions. Remember, it is important to follow your own policies, even if you are short-staffed! This will protect you and your employees.
- Prohibiting contact with residents or their food when staff have potentially communicable diseases or infected skin lesions.
- Assessing risks for tuberculosis (TB) based on regional/community data. This can be simply by calling your local health department.
- Monitoring and evaluating for clusters or outbreaks of illness among staff.
  - Implementing an exposure control plan to address potential hazards (i.e., blood-borne pathogen, OSHA, etc.)
  - Education and competency assessment.
  - Signage on the front door for family and visitors.

There are a lot of great resources available for Human Resources related directly to occupational health. It’s a good idea to review your current policies and make sure you have strategies in place to meet the requirements of infection prevention and control.

Additional Resource:

**TIP:** One easy way to educate staff on these potential hazards is to do a yearly employee training day where you include stations for things like handwashing, proper waste disposal of various body fluids, policies on finger-sticks, annual TB assessment, and annual influenza vaccine.
CHAPTER 4: INFECTION PREVENTION AND CONTROL TRACKING AND DOCUMENTATION

The purpose of data tracking is simply to monitor the types of infections in your building, their specific locations, prevalence, reoccurrence, pathogen, and if required, antibiotics used to treat it. This includes anything from urinary tract infections or upper respiratory infections to shingles outbreaks or enterococcus. The goal is that by properly identifying infection trends, you can mitigate further spread and work on decreasing overall infection rates and antibiotic usage in your facility.

Data collected should include:

- infection site (i.e., type of infection)
- pathogen (if available),
- signs and symptoms,
- resident location, and
- unusual or unexpected outcomes (e.g., foodborne outbreak), infection trends and patterns.

The data will be used and shared with appropriate individuals (e.g., staff, medical director, director of nursing, quality assessment and assurance committee- QAA), when applicable, to ensure that staff minimize spread of the infection or disease (e.g., require revision of staff education and competency assessment) and should be kept both electronically (if possible) and via hard copy. It is possible these records may be requested by surveyors who must work off-site.

There are several excellent tracking tools available. The first example is of a general infection tracking form. Track infections monthly so it makes it easier to follow trends. The second example is for antibiotic stewardship and follows the most common healthcare-acquired infections in long-term care. Full forms can be found in the appendix.

TIP: Most laboratories and pharmacies will send monthly reports with the labs that were ordered and the results, often with graphs for common infection categories, and antibiotics ordered, dosage, and duration for each facility. It's helpful to include these in your data tracking.

TIP: Create a separate binder for your data tracking due to the inclusion of resident names and privacy information. Include copies of your general forms and tools in your IPC binder/electronic file. By keeping your data tracking separate you are not compromising private information in the general IPC program needs to be viewed by surveyors or others in the facility.
### Example of general infection tracking form

![INFECTION CONTROL LOG](image)

### Example of antibiotic tracking form for common healthcare-acquired infections

![Nursing Home Antimicrobial Stewardship Guide](image)
CHAPTER 5: VACCINATIONS AND TUBERCULOSIS TESTING

Influenza and Pneumococcal

In accordance with F883, influenza and pneumococcal vaccinations must be offered to every resident entering a skilled nursing facility.

Influenza

The facility must develop policies and procedures to include

- Education for each resident or the resident’s POA regarding the benefits and potential side effects of the immunization.
- Offering each resident an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period;
- The opportunity for resident’s or their POA to refuse immunization; and
- Documentation in the resident’s medical record that indicates, at a minimum, the resident and/or family was provided education and that resident either did or did not receive the influenza immunization due to medical contraindications or refusal.

Pneumococcal

The facility must develop policies and procedures to include

- Education for each resident or the resident’s POA regarding benefits and potential side effects of the immunization.
- Offering each resident, a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized;
- The opportunity for residents or their POA to refuse immunization; and
- Documentation in the resident’s medical record that indicates that the resident or resident’s representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and that the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

Examples of educational pieces can be seen below and printed off the CDC website by following this link People 65 Years and Older Need a Flu Shot (cdc.gov).
Example of flu vaccination education produced by the CDC

Example of pneumonia vaccination education produced by the CDC.
Example of vaccination consent form for influenza and pneumococcal

**SARS-COV2-19**

Vaccinating for SARS-COV2-19 is discussed further in the chapter of Pandemic Clinical Management.

**Tuberculosis Testing**

Tuberculosis, or TB, is a bacterial infection that is highly infectious and kills millions of people worldwide every year. While it usually attacks the lungs, TB can also affect the brain, spinal column, and kidneys. Not every case of TB is considered active (symptomatic and infectious). People can have TB bacteria in the body in a latent stage without ever feeling ill. It is important to detect TB as quickly as possible, particularly in group settings, due to the airborne spread and more susceptible population.

**Staff Testing for TB**

On April 23, 2020 DHSS issued a waiver regarding the compliance of TB skin testing for staff in long-term care. At this time, facilities may employ individuals prior to completing tuberculin testing, however, they must complete an assessment for signs and symptoms of possible TB. Individuals showing signs and symptoms shall be instructed to see their physician or local public health department, prior to working
in the facility. Once the waiver ends, employees or residents who required testing and were not tested, must be tested. SLCR expects the testing to be completed within a reasonable time period, usually within 30 days. This waiver has been extended through May 31, 2021.

The CDC recommends annual screening for all staff, testing upon hire (temporarily waived), and annual TB education. Records should be kept in the employee personnel file.

Source: Testing Health Care Workers | Testing & Diagnosis | TB | CDC

**Resident Testing for TB**

Within one (1) month prior to or one (1) week after admission, all residents new to long-term care are required to have the initial test of a Mantoux PPD two (2)-step tuberculin test. If the initial test is negative, zero to nine millimeters (0–9 mm), the second test, which can be given after admission, should be given one to three (1–3) weeks later. Documentation of chest X ray evidence ruling out tuberculosis disease within one (1) month prior to admission, along with an evaluation to rule out signs and symptoms compatible with infectious tuberculosis, may be accepted by the facility on an interim basis until the Mantoux PPD two (2)-step test is completed. All skin test results are to be documented in millimeters (mm) of induration. Bacillus of Calmette and Guerin (BCG) vaccination shall not prevent residents from receiving a tuberculin test. A reaction of ten millimeters (10 mm) or more shall be considered as infected with Mycobacterium tuberculosis for an individual with a history of BCG vaccination.

Evidence of tuberculosis infection is considered to be a reaction of five millimeters (5 mm) or more for all contacts to infectious tuberculosis or for an individual who is immunosuppressed or has abnormal chest Xray findings consistent with old, healed tuberculosis disease, and ten millimeters (10 mm) or more for all others. Residents with a negative, zero to nine millimeters (0–9 mm), Mantoux PPD two (2)-step test need not be routinely retested unless exposed to infectious tuberculosis or they develop signs and symptoms which are compatible with tuberculosis disease. Residents with a documented history of tuberculosis infection or an adequate course of preventive treatment shall not be required to be retested. Residents with a documented history of tuberculosis disease and adequate chemotherapy shall not be required to be retested. In the absence of documentation, a repeat test shall be required. (All skin test results of five millimeters (5 mm) or more for contacts to infectious tuberculosis or for an individual who is immunocompromised, or ten millimeters (10 mm) or more for all others, shall require a chest X ray within one (1) week, or a review of the results of a chest X ray taken within the month prior to admission along with an evaluation to rule out signs and symptoms compatible with tuberculosis disease to rule out active pulmonary disease.

Individuals with a positive finding presenting evidence of a recent, within one (1) month of the date of admission, chest X ray need not be given a new X ray. However, the results of the X ray must be reviewed in the light of the additional information of the identification of tuberculosis infection as indicated by the Mantoux PPD skin test. An individual who is skin-test positive with a normal chest X ray should be considered for preventive medication. Those who complete a recommended course of preventive treatment and those for whom preventive treatment is not medically indicated need have no further testing for tuberculosis unless signs and symptoms which are compatible with tuberculosis disease are present.

All residents of long-term care facilities who are exposed to a case of infectious tuberculosis or who develop signs and symptoms which are compatible with tuberculosis disease shall be medically evaluated. All long-term care facility residents shall have a documented annual evaluation to rule out signs and symptoms of tuberculosis disease.

The following is an example of a TB screening form you can use on all new hires and new residents. The full document can be found in The Appendix.
Example of TB screening form

**Other Vaccinations**

Residents may have had other vaccinations in their medical history. It is important to obtain as much vaccination information as possible. Common vaccinations include measles, mumps, rubella, tetanus, varicella, HPV, and diphtheria. Although this is not a requirement, it’s always good to know in case there is a community outbreak.
CHAPTER 6: ANTIBIOTIC STEWARDSHIP PROGRAM

What is Antibiotic Stewardship?

Antibiotic stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. This can be accomplished through improving antibiotic prescribing, administration, and management practices thus reducing inappropriate use to ensure that residents receive the right antibiotic for the right indication, dose, and duration. It is part of the infection prevention and control program (IPCP) and includes antibiotic use protocols and a system to monitor antibiotic use.

**Intent of Regulation (F881)**

The intent of the regulation is to ensure that the facility:

- Develops and implements protocols to optimize the treatment of infections by ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic.
- Reduces the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use; and
- Develops, promotes, and implements a facility-wide system to monitor the use of antibiotics.

Nursing home residents are at risk for adverse outcomes associated with the inappropriate use of antibiotics that may include but are not limited to the following:

- Increased adverse drug events and drug interactions (e.g., allergic rash, anaphylaxis, or death).
- Serious diarrheal infections from C. difficile.
- Disruption of normal flora (e.g., this can result in overgrowth of Candida such as oral thrush); and/or
- Colonization and/or infection with antibiotic-resistant organisms such as MRSA, VRE, and multidrug-resistant gram-negative bacteria.

**Core Elements of the Antibiotic Stewardship Program**

1. Facility leadership commitment to safe and appropriate antibiotic use.
2. Appropriate facility staff accountable for promoting and overseeing antibiotic stewardship.
3. Accessing pharmacists and others with experience or training in antibiotic stewardship.
4. Implement policy(ies) or practice to improve antibiotic use.
5. Track measures of antibiotic use in the facility (i.e., one process and one outcome measure).
6. Regular reporting on antibiotic use and resistance to relevant staff such as prescribing clinicians and nursing staff; and
7. Education of staff and residents about antibiotic stewardship.
8. Development of protocols and system to monitor antibiotic use
   - Be incorporated in the overall infection prevention and control program; (UTIs, URIs)
   - Be reviewed on an annual basis and as needed.
   - Contain a system of reports related to monitoring antibiotic usage and resistance data.
9. Providing leadership support and accountability via the participation of
   • the medical director,
   • consulting pharmacist,
   • nursing and administrative leadership, and
   • individual with designated responsibility for the infection control program if different

Reporting Antibiotic Stewardship

Your tracking records of infections and subsequent antibiotic use will be the foundation for your reports. You should plan to include these reports with your QA meetings and discuss the outcomes with your QA team, including your medical director.

For the purposes of survey, these general reports (without resident names or identifiers) should be available to the state and/or federal surveyors and should be kept separately from the resident information.

These general reports should include

1. Summarizing antibiotic use from pharmacy data:
   • rate of new starts,
   • types of antibiotics prescribed, or
   • days of antibiotic treatment per 1,000 resident days
2. Summarizing antibiotic resistance (using laboratory data)
3. Tracking measures of outcome surveillance related to antibiotic use (process and outcomes)
4. Frequency of monitoring/review (new, readmit, monthly review, etc.)
5. Process for assessing residents for any infection using standardized tools and criteria; and,
6. the mode (e.g., verbal, written, online) and frequency (as determined by the facility) of education for prescribing practitioners and nursing staff on antibiotic use (stewardship) and the facility's antibiotic use protocols.

The CDC has a variety of helpful resources, including materials for families and residents. https://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html.

**TIP:** Make sure to follow-up *monthly* with the daily nursing documentation to make sure the nurses are documenting care points associated with the infection and the antibiotic being given. For example, if you were treating a minor skin infection the *daily* documentation should include the site of infection, appearance of skin, temperature (it is warm to touch?), any bleeding or drainage, dressing application, and any improvement or declination of the wound. There should be *weekly* documentation of the size and depth of the wound and documentation of the wound as being healed. There should be documentation on any adverse effects of the antibiotic being given.
Example of literature from the CDC for families and resident; see the following link for the full document - [https://www.cdc.gov/longtermcare/pdfs/factsheet-core-elements-what-you-need-to-know.pdf](https://www.cdc.gov/longtermcare/pdfs/factsheet-core-elements-what-you-need-to-know.pdf)
With a proper antibiotic stewardship program, good peri-care, and clean techniques for wound care, etc., you should start to see a decline in the most common infections found in your home.

**Lessons Learned:** It is helpful to notify families and residents upon admission and once a year that you follow an antibiotic stewardship program, as required by CMS. This may not stop those that want an antibiotic for everything, but it will back you up when your medical director or physician refuses to prescribe one and the families don’t understand. Also, it provides the data and science for educational purposes.
PART II: PANDEMIC MANAGEMENT

Nurses treating patients infected with the Spanish flu (circa 1918); photo credit: Library of Congress

Gearing up for treating patients with SARS-COV-2 COVID-19 (circa 2020); photo credit: Dreamstime
INTRODUCTION TO MANAGING A PANDEMIC

“A pandemic influenza strain is one that humans have not yet been exposed to, so people do not have immunity to it and it spreads rapidly in, and beyond, the community.”

Who would ever thought in the 21st century we would need to prepare for a pandemic? In today’s modern world even the mere thought of “germ warfare” is something from a Hollywood movie—or it was until December 2019. While most of us were thinking about Christmas gifts and New Year’s resolutions, a little-known virus from the SARS family was making its way from China across the Pacific Ocean on cruise liners and airplanes to the United States of America. What had started in Wuhan, China quickly became an international crisis. At the time of this publication, there are over 118 billion cases of SARS-COV-2, otherwise known as coronavirus COVID-19, world-wide and over 29 billion cases in the US alone, with over 2 million fatalities encompassing nearly every country in the world.

As part of the Affordable Care Act, beginning in 2017 skilled nursing facilities were required to implement emergency and disaster preparedness, including a facility assessment of infection control plans. It was only once COVID hit we realized how drastically underprepared we were in skilled nursing to address and combat the problems that come with a pandemic.

Since we are still in this pandemic at the time of publication, this will remain a working tool. We will add to this as information as information and best practices become available. One year into the pandemic in the United States, we are just now beginning to digest and understand the wealth of information coming from other countries and within our own healthcare system to formulate ideas, successes, and failures.

It is our hope that by compiling these sources we can cut out much of the guesswork contrived back in January 2020 and change our attitudes from complacency to combat. Good luck and we’re with you!

PANDEMICS THROUGHOUT HISTORY

165 AD   Antonine Plague, death toll: 5 million, cause: unknown
541-542 AD   Plague of Justinian, death toll: 25 million, cause: Bubonic plague
1356-1353 AD   the Black Death, death toll: 75-200 million, cause: Bubonic plague
1852-1860 AD   Cholera (3rd of 7 major outbreaks), death toll: 1 million, cause: cholera
1889-1890 AD   Flu Pandemic, death toll: 1 million, cause: influenza
1910-1911 AD   Cholera (6th of 7 major outbreaks), death toll >800,000, cause: cholera
1918 AD   Flu Pandemic, death toll: 20-50 million, cause: influenza
1956-1957 AD   Asian Flu, death toll: 2 million, cause: influenza
1968 AD   Flu Pandemic, death toll: 1 million, cause: influenza
2009 AD   H1N1 Swine Flu, death toll: 575,000, cause: H1N1 influenza strain


Although right now it feels like this is a new and monumental problem, history shows us pandemics have occurred time and time again. What is also shows us is that we are resilient! So, hold your head high and keep moving forward and we’ll get through this together.
CHAPTER 7: PANDEMIC PREPAREDNESS

For some of you, pandemic preparedness may seem a bit after the fact. However, you can always plan and the lessons you’re learning now will make that planning more focused for whatever comes next. For the rest of you, take heart—there is nothing obscure or unusual about the planning we’re going to discuss. It’s about mitigating all the known risks and being flexible for the contingencies.

Preparing for a pandemic or even a facility-wide outbreak involves several steps.

1. Essential Response Planning
2. Coordination
3. Resources
4. Legalities and Policies
5. Ethics
6. Communication
7. Surveillance
8. Clinical Management

Many of these steps will be discussed in more detail in the next chapter under Pandemic Operations. However, by taking a snapshot of where you currently stand and knowing your current capabilities, you can more accurately plan for crisis mode.

One place to start is with your facility assessment. There are several pieces from your emergency preparedness plan and facility assessment that will overlap with your pandemic preparedness. This includes

1. Contractual partners
   • Environmental
   • Medical
   • Communications
2. Staffing
3. Resident acuity/special needs
   • High risk vs low risk
   • Cognitive ability
   • Dialysis

As you start putting together the planning puzzle, you need to know what you have and what you need to fill in the gaps, your strengths, and weaknesses, and most of all, how to coordinate those capabilities once you’re in crisis mode.

**Essential Response Planning**

To begin your essential response planning, you need to bring your infection control and prevention team to the table. This includes, at minimum, the...

• Infection Preventionist,
• DON/ADON,
• Administrator,
• Medical Director,
• Maintenance Supervisor,
• Housekeeping Supervisor,
• Laundry Supervisor,
• Dietary Supervisor,
• Quality Assurance/Quality Improvement Liaison, and a
• CNA.

Each of these participants will bring valuable insight to the table about what will work on paper versus what will work in real life. As we’ve seen with COVID-19, just because something looks good in writing, does not necessarily mean it will work in action. Remember, at the end of the day, your biggest stakeholders are your residents and staff. It is literally their lives in your hands, so failure is not an option.

TIP: You also need to keep in mind the context of authority. Skilled nursing facilities that provide Medicare and Medicare services are bound by the rules set forth of CMS. That means, even in a pandemic, unless waivers are provided, SNFs are still legally accountable for those rules and guidelines.

Coordination
Successful coordination of service in a pandemic is only as good as the process for coordination you put in place with the planning. By having an outline of who is going to do what, how, and with what resources provides us with a starting point instead a panic button.

Incident Command System (ICS)
The ICS or incident command system is a standard emergency preparedness tool employed by the Federal Emergency Management Agency (FEMA) and other emergency management operations throughout the world. Because this is a widely adopted system, other agencies can meld into your ICS with understanding and working capability without getting hung up on traditional titles, roles, and expectations in a normal business hierarchy. As we’ve seen in a pandemic, viruses are not picky about who gets sick so your administrator or DON may not be present to lead the charge!

Command: Sets incident objectives and priorities and has overall responsibility at the incident or event.
Operations: Conducts tactical operations to carry out the plan. Develops the tactical assignments and organization and directs all tactical resources.
Planning: Prepares and documents the Incident Action Plan to accomplish the incident objectives, collects and evaluates information, maintains resource status, and maintains documentation for incident records.
Logistics: Provides support, resources, and all other services needed to meet the incident objectives.
**Finance/Administration:** Monitors costs related to the incident. Provides accounting, procurement, time recording, and cost analyses.

Source: [https://www.usda.gov/sites/default/files/documents/ICS100.pdf](https://www.usda.gov/sites/default/files/documents/ICS100.pdf)

**TIP:** However you designate staff to different roles, make sure that more than one person knows where important files and operational procedures are kept. Administrators, DONs, CEOs, and Infection Preventionists get sick too and may not be able to run your building.

**Rules Regulator**

For skilled nursing facilities regulated by CMS, this aspect of coordination is relatively simple in that federal, local, and county government offices will put out regulations and you are expected to follow them. However, the difficult piece is keeping up and sorting out through the latest QSOs, understanding the specifications of each one, and figuring out how they apply to your operations. As we’ve discovered with COVID, rules change quickly and often! Designating one person to monitor the regulations daily and make sure you are complying will help streamline the process and keep everyone from getting bogged down in paperwork. It will also help continuity of interpretation, which can be confusing and frustrating for staff.

**Communications Officer**

Under the incident command system, this would fall under the Public Information Officer (PIO). FEMA offers some wonderful training to help understand and facilitate this role [FEMA - Emergency Management Institute (EMI) | National Preparedness Directorate National Training and Education Division](https://www.fema.gov). This person(s) can serve multiple communication roles. However, the main goal is this: consistent, accurate, timely information. If you have too many talking and everyone is not on the same page, it quickly leads to confusion, frustration, and rumors.

**Lessons Learned:** “We had over 45 people in our building get COVID, 22 staff and 23 residents. The first to get it were our Administrator and DON—I guess because they were always together. Our head of maintenance went out sick on week 2 and some of the dietary and housekeeping staff, along with nurses and CNAs from all shifts. It was a mess. Luckily our ADON was able to keep things running but she didn’t know where some of the papers were when state came in on week 4. It just added to the stress.”

---A.M., August 2020, 67-licensed bed SNF
Resources

Planning for what resources you will need, where to get them, how to store them, and how to continue to get them if you run out is a crucial part of pandemic preparedness. We found this out the hard way with PPE. In looking at your resources consider these categories.

- Staffing (see chapter on Pandemic Staffing)
- Material resources, advance purchase agreements and stockpiling (see chapter on Pandemic Operations)

Legalities and Policies

In the event of a pandemic, certain public health measures may be put into place to decrease the spread with the overall goal of saving lives. In some cases, as we’ve seen with COVID-19, quarantine and temporary suspension of resident rights may be required that are in the best interests of the community as a whole.

As of March 10, 2021, full visitation has been allowed into homes with the exception of those currently positive for COVID. However, it would be naïve to discount future outbreaks or issues of infection control. Therefore, facilities should consider the following areas in terms of legalities and policies in current and future management strategies.

- Risk management,
- Required screening, testing, and vaccination of residents,
- Required screening, testing, and vaccination of staff, and
- Liability related to unforeseen adverse effects.

Leading Age has produced a Pandemic Playbook with a multitude of resources that address these issues. That information can be found at this link, https://playbook.leadingage.org/articles/chapter-2-management-and-crisis-intervention/#Management.

Also, it is worthwhile to consult your legal team as to the extent of which vaccination of employees could be required. A great starting point is this information from the law office of Polsinelli, which discusses information from the Equal Employment Opportunity Commission (“EEOC”), with published guidance outlining employer compliance mandates under the Americans with Disabilities Act (“ADA”), Title VII of the 1964 Civil Rights Act (“Title VII”) and the Genetic Information Nondiscrimination Act (“GINA”). https://www.covid19.polsinelli.com/labor-employment/eeoc-issues-guidance-on-covid-19-vaccine-and-the-workplace.

Lessons Learned: Prevention is ALWAYS better than the cure! As stated by a home in North Carolina, as soon as they heard about the virus’s effects on vulnerable populations, they empowered their staff early on to wear PPE, being socially responsible out of work, and reviewed and re-educated on best practices in infection control. By doing this they were able to keep COVID out their building for 93 days when other buildings around them were starting to fall!
Pandemic Partners

As you prepare your list of resources, consider at which level partnerships will fall and prioritize your planning with that in mind. Communication is critical at all levels in the planning stage. It is a good idea to run a table-top and full-scale exercise at least once a year with all partners involved to make sure you’re still on the same page. Be aware that as personnel change in an organization, it is important to maintain those working relationships.

**Primary Partners**

- Staff—infection control education
- Residents—infection control education
- Medical director—policies, procedures, federal guidelines, facility pandemic capabilities
- Laboratories—screening, testing, documentation
- Durable medical equipment
- Food services
- Pharmaceuticals
- Hospitals & EMTs
- Primary care physicians
- Local public health
- Local DHSS office
- Waste disposal services

**Secondary Partners**

- Families of residents
- Families of staff
- Volunteers
- Nonessential service staff (beauticians, activities)
- Community partners
- Healthcare coalitions
- QIPMO
- Local newspapers, radio, television
Ethics

Major health crises challenge policy and ethics. The balance between keeping people safe and keeping them sane is something we’ve endured with COVID-19. The end goal for long-term care is finding that balance. By becoming familiar with ethical laws and policies before a pandemic occurs can help serve as a guide for your organization. Risk communication, as described by the WHO, is one way to start that discussion. “Risk communication is the real-time exchange of information and advice between authorities and experts, and the people and communities who are at risk. It is an essential part of the public health response to any influenza event or other disease outbreak. Accurate information provided early and often – and in formats, languages and channels that people use and trust – will enable communities to understand the health risks they face and will make it easier to engage them in actions to protect themselves” (WHO, 2018).

There are several articles available to help guide your discussion with ethics in disaster management. Feel free to reach out to the MU School of Medicine as well.

- https://medicine.missouri.edu/centers-institutes-labs/health-ethics/pandemic
- https://medicine.missouri.edu/sites/default/files/health%20ethics/Framing_Issues2.pdf

Communication

The scariest thing about this pandemic has been the unknown. Even though we’ve made it through a lot of the initial outbreaks, there’s a lot of questions we still need answered. Complicating the communication world is social media, lack of facts or simply inaccurate information, and your standard fear mongers whose sole purpose in life is to “sell” fear and its antidote in the form of strange potions and formulas that will fix the problem.

So, it’s clear to see why communication is absolutely key and will be the most essential tool in your toolkit next to your staff. Here are the key factors to keep in mind.

Be transparent. Let your staff, residents, and families know what’s going on. Even though it is a requirement to report cases of COVID, it will behoove your facility to keep all parties informed of good and bad news as we move through this pandemic.

Make information available immediately. With the speed of social media, you probably have about 30 seconds to convey the information you want out there. Get it right quickly, keep it brief, and have a system in place to make sure this happens. We all know the rumor mill is much faster than the memos.

Make it brief and deliverable. Keep it simple, to the facts, and deliver it in multiple ways—signage, emails, texts, via your website, verbally at change of shift, etc. Just be aware that we’re all being inundated with a ton of information and we physically cannot process it all. Get the most important points out there and leave the explanations for individual-need-to-know circumstances.

Acknowledge the uncertainty. Information will change as circumstances change and more knowledge becomes available. Ask everyone to keep an open mind and be flexible. You can reinforce your commitment by get the information out there quickly and briefly from a reliable source.

Address errors. You’re going to make mistakes. You’re human. And things change constantly. If errors are made, acknowledge them immediately along with the remedy and move on.

Source: https://www.who.int/about/communications/credible-and-trusted/being-transparent
TIPS:

1. Assign someone to answer phone calls/make phone calls/keep loved ones up to date
2. Take a FEMA public information office training to learn how to dictate social media
3. Assign a care coordinator liaison for sharing information between EMS/hospitals/med director/local health dept/funeral homes
4. Refer back to the ICS Logistics for communicating with ordering and deliveries
5. Streamline communications with board or corporate

Surveillance

Under the surveillance part of planning, you can begin with your general infection control and prevention program, starting with assessment and education. By recognizing signs and symptoms of potential communicable disease, you can more easily implement the measures necessary to control or even prevent, an outbreak. By ensuring that your nurses have appropriate training and risk assessment, such as the when/how to use PPE during a potential outbreak investigation, can prevent an isolated incident from becoming a facility-wide outbreak. Refer to Part 1 for discussion on surveillance procedures.

Clinical Management

Clinical management in the planning stage means knowing the people involved and the roles they will play. By making these clear in your policies and procedures it will give everyone a guidebook and structure to start with as the pandemic evolves. People will, in most cases, revert to your incident command structure. More information can be found under the chapter on Pandemic Clinical Management.

Adapted from emergency preparedness and response systems from:

The World Health Organization: WHO | Pandemic preparedness

The Center for Disease Control and Prevention: Are We Prepared? | Pandemic Influenza (Flu) | CDC

ASPR-TRACIE: ASPR TRACIE | Healthcare Emergency Preparedness Information Gateway (hhs.gov)

FEMA: Home | FEMA.gov

USDA: Microsoft Word - ICS100.doc (usda.gov)
CHAPTER 8: PANDEMIC OPERATIONS

Running a pandemic response is different than normal day-to-day operations. Some of the hierarchy changes, supplies become a primary factor, and suddenly maintenance and engineering are critical components of immediate care. There is an endless amount of information we are learning about different parts of pandemic operations as this crisis continues. However, there are four core components that need to be analyzed as you prepare for or encounter an outbreak in your home.

- Staffing (discussed more fully in the chapter on Pandemic Staffing)
- Spaces
- Supplies
- Systems

Staffing

The first component to understand is staff hierarchy. In an infectious disease outbreak, your Infection Preventionist should serve as the overseer of operations (or at the minimum share this role with the administrator). This serves two important services: a) the Infection Preventionist is trained in infection control and may be a nurse, and b) if one or the other becomes ill with the disease another person is able to step in. More information on the role of the staff educator/staff coordinator will be shared in the chapter on Pandemic Staffing.

*Example of pandemic operations hierarchy*
Infection Preventionist

The Infection Preventionist should act as the overseer. They will be accountable for infection control operations, including overseeing policies, tracking and documentation, and accountability.

Other considerations/duties:

- Implementing telehealth operations for COVID patients. Telehealth has become a common means of bringing physicians and residents together during the pandemic. The following sources will provide you more information on establishing a telehealth system.
  - Simplifying telemedicine use in long-term care facilities - Marketplace - McKnight’s Long Term Care News

TIP: The Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit is a great resource for getting you started in telehealth. The full document can be found in the Appendix.

- Creating policies/procedures related to outpatient procedures and appointments. Make this a working document that can be altered as contagion requirements may change per disease.
- Setting up the COVID unit (discussed further under Spaces)
- Laboratory testing coordination and reporting with public health department, DHSS, and CDC (see the Appendix for a complete list of MO DHSS contracted laboratories)
- Equipment logistics
  - HEPA filters for Ambu-bags *important for performing CPR and keeping infectious particles from entering the common airspace
PPE type, storage, tracking, assignment, cleaning, fit testing of N95s (see discussion on PPE)

- PPE education (see discussion on PPE)
- “Doff-icers” (staff assigned to monitor donning/doffing of PPE—this can also be a colleague on the floor) (see discussion on PPE)
- Oxygen concentrators, tubing, E-tanks, portability (this will also be part of your contractual partners in your emergency preparedness materials)
- IV poles and equipment
- Disposable vitals equipment
  - Zoning for contagion (red, yellow, green) (discussed further under Spaces)
  - Mapping—see the following website for instructions NHSN Acute Care Location Mapping in Response to the COVID-19 Pandemic (cdc.gov).

Maintenance

The maintenance person will be your go-to man/woman in rebuilding or restructuring your physical building, including the COVID unit.

Other considerations/duties:
- Mapping of beds on units, including routes for egress and staying within fire code (discussed further under Spaces)
- Ventilation systems and negative air spaces
- Adding fans to outside windows (subject, of course, to CMS guidance on room temperature ranges)
- Repurposing non-resident care areas
- Turning off water fountains
- Revisiting your water maintenance plan
- How to utilize privacy curtains as room dividers
- Lockers for staff
- Shower unit for staff working on COVID unit
- Staff entrance designation and security
- Additional storage requirements for PPE, nursing equipment, cots, food
- Repurposing of normally non-resident areas for additional beds/units
- Electrical and technical components/needs for converted units

Life Safety Code Compliance. Currently, CMS has waived certain aspects of the regulations in regard to Life Safety Codes. These include the following and can be found at COVID-LongTermCareFacil11-04.docx (cms.gov) on pages 8 and 9.

Specific Physical Environment Waiver Information:
- 42 CFR §482.41(d) for hospitals, §485.623(b) for CAH, §418.110(c)(2)(iv) for inpatient hospice, §483.470(j) for ICF/IID; and §483.90 for SNFs/NFs all require these facilities and their equipment to be maintained to ensure an acceptable level of safety and quality. CMS is temporarily modifying
these requirements to the extent necessary to permit these facilities to adjust scheduled inspection, testing and maintenance (ITM) frequencies and activities for facility and medical equipment.

✓ 42 CFR §482.41(b)(1)(i) and (c) for hospitals, §485.623(c)(1)(i) and (d) for CAHs, §482.41(d)(1)(i) and (e) for inpatient hospices, §483.470(j)(1)(i) and (5)(v) for ICF/IIDs, and §483.90(a)(1)(i) and (b) for SNFs/NFs require these facilities to be in compliance with the Life Safety Code (LSC) and Health Care Facilities Code (HCFC). CMS is temporarily modifying these provisions to the extent necessary to permit these facilities to adjust scheduled ITM frequencies and activities required by the LSC and HCFC.

The following LSC and HCFC ITM are considered critical are not included in this waiver:

- Sprinkler system monthly electric motor-driven and weekly diesel engine driven fire pump testing. Portable fire extinguisher monthly inspection.
- Elevators with firefighters’ emergency operations monthly testing.
- Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing.
- Means of egress daily inspection in areas that have undergone construction, repair, alterations, or additions to ensure its ability to be used instantly in case of emergency.

✓ 42 CFR §483.470(e)(1)(i) for ICF/IIDs, and §483.90(a)(7) for SNFs/NFs require these facilities to have an outside window or outside door in every sleeping room. CMS will permit a waiver of these outside window and outside door requirements to permit these providers to utilize facility and non-facility space that is not normally used for patient care to be utilized for temporary patient care or quarantine.

CMS is waiving and modifying waivers under 42 CFR §483.470(j) for ICF/IIDs and §483.90(a) for SNF/NFs. Specifically, CMS is modifying these requirements as follows:

- Alcohol-based Hand-Rub (ABHR) Dispensers: We are waiving the prescriptive requirements for the placement of alcohol-based hand rub (ABHR) dispensers for use by staff and others due to the need for the increased use of ABHR in infection control. However, ABHRs contain ethyl alcohol, which is considered a flammable liquid, and there are restrictions on the storage and location of the containers. This includes restricting access by certain patient/resident population to prevent accidental ingestion. Due to the increased fire risk for bulk containers (over five gallons) those will still need to be stored in a protected hazardous materials area. Refer to: 2012 LSC, sections 18/19.3.2.6. In addition, facilities should continue to protect ABHR dispensers against inappropriate use as required by 42 CFR §483.470(j)(5)(ii) for ICF/IIDs and §483.90(a)(4) for SNF/NFs.

- Fire Drills: Due to the inadvisability of quarterly fire drills that move and mass staff together, we will instead permit a documented orientation training program related to the current fire plan, which considers current facility conditions. The training will instruct employees, including existing, new, or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area. Refer to: 2012 LSC, sections 18/19.7.1.6.

- Temporary Construction: CMS is waiving requirements that would otherwise not permit temporary walls and barriers between patients. Refer to: 2012 LSC, sections 18/19.3.3.2.

Housekeeping

The housekeeping infection control team leader should oversee considerations related to the appropriate disinfects, waste management, and biohazard. There are many resources available on cleaning, disinfecting, and housekeeping based on locations. Below are some general guidelines and definitions.
General information. Cleaning refers to the removal of germs, dirt, and impurities from surfaces. Cleaning does not kill germs, but by removing them, it lowers their numbers and the risk of spreading infection.

Disinfecting refers to using chemicals to kill germs on surfaces. Following manufacturer’s instructions thoroughly for the use of disinfectants is important and will help provide the best results possible.

Practice routine cleaning of frequently touched surfaces (for example: tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks, telephones, remote controls) with EPA-registered disinfectants that are appropriate for the surface, following label instructions.

Focus areas. Consider each area and follow the guidelines to properly care for each area.

1. Resident rooms
2. Public areas
3. Food service
4. Restrooms
5. Employee areas
6. Entry/exits
7. COVID units

Examples of High-Touch Surfaces
- Bed rails/ bed surfaces
- Call buttons
- Doorknobs
- Intravenous Pumps
- Light Switches
- Over-bed tables
- Supply carts

Examples of Medium- and Low- Touch Surfaces
- Toilets
- Sinks/sink surrounds
- Control panels and electronic equipment, such as mounted monitors, mobile workstations, and person cell phones

Surfaces can be classified as high, medium, and low touch, but any surface that is touched poses a risk of HAI transmission. Just because a surface is less high touch, does not mean that it does not have a very high contamination level (e.g., toilets, sinks/sink surrounds are less high touch, but VERY high contamination. Risk can exceed that of bed rails.)

An Environmental Checklist for Monitoring Terminal Cleaning from the CDC is available in the Appendix.

<table>
<thead>
<tr>
<th>Date:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unit:</td>
<td></td>
</tr>
<tr>
<td>Room Number:</td>
<td></td>
</tr>
<tr>
<td>Initials of ES staff (optional):</td>
<td></td>
</tr>
</tbody>
</table>

Evaluate the following priority sites for each patient room:

<table>
<thead>
<tr>
<th>High-touch Room Surfaces</th>
<th>Cleaned</th>
<th>Not Cleaned</th>
<th>Not Present in Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed rails / controls</td>
<td></td>
<td></td>
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<tr>
<td>Tray table</td>
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<tr>
<td>IV pole (grab area)</td>
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<tr>
<td>Call box / button</td>
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<tr>
<td>Telephone</td>
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<tr>
<td>Bedside table handle</td>
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<tr>
<td>Chair</td>
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<td>Room sink</td>
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<tr>
<td>Room light switch</td>
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<td></td>
<td></td>
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<tr>
<td>Room inner door knob</td>
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<tr>
<td>Bathroom inner door knob / plate</td>
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<td></td>
<td></td>
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<tr>
<td>Bathroom light switch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom handrails by toilet</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Bathroom sink</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Toilet seat</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Toilet flush handle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet bedpan cleaner</td>
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</tr>
</tbody>
</table>

Example of Environmental Checklist for Monitoring Terminal Cleaning
How to Clean and Disinfect

Hard Surfaces

- Wear disposable gloves when cleaning and disinfecting surfaces. Gloves should be discarded after each cleaning. If reusable gloves are used, those gloves should be dedicated for cleaning and disinfection of surfaces and should not be used for other purposes. Wash hands immediately after gloves are removed.
- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
- Consider using disposable paper towels for cleaning and discard them in a sealed waste container.

Soft/Porous Surfaces

For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present. Clean with appropriate cleaners indicated for use on these surfaces. After cleaning, launder items as appropriate in accordance with the manufacturer’s instructions.

Approved Disinfectants

- Clorox Multi Surface Cleaner + Bleach
- Clorox Disinfecting Wipes
- Clorox Commercial Solutions Clorox Disinfecting Spray
- Lysol Heavy-Duty Cleaner Disinfectant Concentrate
- Lysol Disinfectant Max Cover Mist
- Lysol Clean & Fresh Multi-Surface Cleaner
- Purell Professional Surface Disinfectant Wipes
- Sani-Prime Germicidal Spray

A complete list of EPA registered disinfectants is located here: https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19
In addition to these recommendations, make sure you are reviewing (and following) your home’s infection control policy and adapting as needed for COVID-19. Communication and education are keys to maintaining a safe and effective cleaning and disinfecting program.

Other considerations/duties:

- Refilling hand soap, paper towels
- Hand sanitizer (and batteries if touch sensitive units) (and deployment)
- Disinfectant wipes and sprays
- Toilet paper
- Linen & laundry handling
- PPE for housekeeping staff
- Commodes (including bedside commodes)


**Dietary**

No matter what else is happening, the food must go on! Already in long-term care, a lot of daily routine revolves around meals and snacks. This won’t change just because there’s a pandemic. The expectation for nutritious, good tasting meals and personal preferences will be just as, and even perhaps, more important than usual because the socialization factor of mealtime has changed. Residents may be eating more on their own or in their rooms.

In addition to the normal specialized diets, we need to consider the diets required during certain illnesses. For example, during outbreaks of enterococcus that produce a lot of nausea, vomiting, and diarrhea, a more subtle, liquid diet will be appropriate, while during respiratory illnesses like COVID we need to stay away from things that could create heavy secretions such as dairy products and dry foods that could get caught and making coughing even more difficult.

**TIP:** Many persons who have experienced COVID have become dehydrated and show a loss of appetite and desire to drink. It’s very important that they stay hydrated so get creative in whatever they will drink.

**Lessons Learned:** Several companies have helped mitigate the spread of COVID in/out of their communities by providing staff meals at no cost. This allows staff to stay within the building (or at minimum on campus) for meals and takes the stress off of them to obtain lunches and snacks. In some homes, companies have even gone so far as providing meals for staff families to pick up if their loved one is working late hours or cannot leave the campus due to a COVID outbreak. Both are excellent ways to support staff and reduce the risk of COVID transmission in/out of the building.

QIPMO hosted an excellent webinar on dietary management and snacking during a pandemic. Feel free to access the recording and handouts for your dietary staff by following this link:


Also, there is a great dietary sanitation checklist available in the appendix.
Example of dietary sanitation checklist

Activities

Boredom, isolation, depression—three of the top issues in long-term care. Add isolating for >8 months in their rooms and away from family and friends and it’s a recipe for disaster. While we’re currently working on ways to get residents more active and out of their rooms safely and able to visit with their families, the reality is we are still having to restrict their normal lifestyles. Finding new avenues for interaction and entertainment has been a challenge and our hearts go out to all those activity professionals who’ve reached into the depths for ways to manage in these times.

Luckily, many organizations have created resources to help assist in this quest. The following links are just some ideas to help you implement activity during isolation and social distancing.

- Resident Engagement During Social Isolation | LeadingAge
- 50 Activities for the Elderly in Lockdown and Isolation (goldencarers.com)
- Activities professionals ramp up virtual offerings in response to COVID-19 - Products - McKnight's Long Term Care News
- Activities Directors of Missouri - Home and Pictures (activitydirectorsofmo.org)
Spaces

A core aspect of pandemic operations is space—literally the space required to handle isolation, quarantine, dining, activities, and nursing administration activities. Every facility is unique. The following discussion is based on general ideas and principles of infection control practices and may require altering to fit your facility’s specifications.

Considerations include:

- Repurposing non-patient care areas such as activity rooms or therapy rooms
- Additional storage spaces for PPE
- Areas for donning/doffing PPE
- Separate, closed-off from the interior COVID unit
- Air flow
- Fire safety regulations
- Additional beds, bedside tables, bedside commodes
- Waste storage/disposal sites
- Temporary morgue
- Alternative care site (on site or off site—this would be coordinated with Missouri Hospital Association healthcare coalition, SEMA/FEMA, and DHSS)

Example of room redesign to accommodate a donning/doffing area. Note the new/temporary screen door. Doors pushed out without handles from the inside the room outward. Doffing was done in the bathroom and main door generally kept closed as the secondary barrier. Photo courtesy The Lutheran Home.
1. Start with a blueprint of your building (make several copies so you can practice!)

2. Look at all the logistics including
   - Dining
   - Entrances/exits
   - Purpose
   - # of rooms needed (and whether they will be single or double occupancy)
   - PPE storage
   - Staff storage
   - Supply overflow
   - Waste
   - Donning/doffing
   - Airflow
   - Staff restrooms
   - Nurse’s station
   - Staff breakroom

3. Consider how you can create a COVID unit, step down units, and quarantine spaces.

4. Once you have a working plan, check that you are still able to meet fire safety codes for exiting.

5. Set up barriers as needed, including signage, and if necessary, begin creating your COVID-positive unit.

**GREEN** = COVID (-)/general population

**YELLOW** = COVID (+) > 10 days and/or “recovered”

**RED** = COVID (+) <10 days or still symptomatic
Things you need to include in the quarantine set up:

Barrier wall (this can be a plastic shower curtain floor to ceiling)

*Inside barrier wall:*
  - Trash can
  - Biohazard box
  - Linen can
  - Hand sanitizer
  - Fan for window
  - Extra linens, continence and peri-care supplies, nursing supplies as needed

*Donning/doffing areas and immediately outside of room:*
  - Hand sanitizer
  - Trash cans
Supplies

The supplies required during a pandemic will be certainly be magnified, particularly healthcare supplies. Try to pre-plan as much as possible (see Pandemic Preparedness) and be aware, due to national stockpiles and global supply and shipping issues, there may still be a shortage.

Here is a preliminary list of the supplies you will need to increase during a COVID outbreak.

- Oxygen concentrators, tubing, humidifier bottles
- Bedside commodes
- Cavi-wipes (or other approved cleaning and disinfectant supplies)
- Trash cans and liners
- Biohazard boxes
- Contaminated linen cans and liners
- Toilet paper
- Hand sanitizer
- Hand soap, paper towels
- PPE (discussed in detail later in the chapter)

If you are opening a COVID unit, you should also include the following items in addition to the items listed above:

- Glucometers, lancets, test strips
- Surgical tape, band-aids
- Vitals equipment
- Sharpie markers
- Scratch paper, pens, scissors, duct tape, batteries
- Hand lotion
- Ambu-bag with HEPA filter
- Emergency Code box **designated to the COVID unit only!
- Water pitchers/cups, straws
- Extra linens
- Extra paper products (napkins, toilet paper, paper towels)
- Individually packaged snacks for residents and staff nothing dry or dairy

Basically, make a “grocery list” of the things you normally use, even simple things, and bring them to your COVID unit. The idea is to minimize the number of individuals in/out and the number of times anyone is in/out. You need to be as self-sufficient as possible.
A Word About Trash

There is a lot of confusion and misunderstanding about how to handle medical waste when it comes to infectious disease. Each disease has a spreadibility measure that will be determined by the CDC. Use the following Biohazard Management and Medical Waste guide to help you know what goes where without breaking the bank! The full document can be found in the Appendix.

COVID-19 BIOHAZARD MANAGEMENT AND MEDICAL WASTE

For medical waste with potential or known COVID-19 contamination, manage like any other regulated medical waste. COVID-19 is not a Category A infectious substance. The Centers for Disease Control and Prevention (CDC) has determined that medical waste generated in the treatment of COVID-19 patients and patients under investigation (PUIs) be managed in accordance with routine procedures.

For regulated medical waste information, consult the regulated medical waste information in CDC’s Guidelines for Environmental Infection Control in Health-Care Facilities (2003). This document provides additional information related to the management of waste streams from hospitals and other healthcare facilities.

CDC also provides information on medical waste management as a question and answer page on its coronavirus website.

**Does NOT go in Biohazard**

- Beverage containers
- Ear speculums
- Examining table paper
- Food wrappers
- Paper
- Paper towels
- Patient gowns or drapes
- Tongue depressors

The only reason any of the above items should be placed in the red bags is if they have been soiled with blood or bodily fluid, including fecal material.

**Goes in Biohazard**

- Drapes, gauze, or other absorbent material used to soak up blood or body fluids
- Expired drugs, vaccines, control solutions and medications (excluding controlled prescription drugs)
- Gloves contaminated with blood or body fluids (including fecal material)
- Paper towels used to absorb blood or body fluids
- Swabs used for obtaining specimens of blood or body fluids
- Used fecal occult blood tests
- Used urinary catheters and Foley bags
- Used urine dipsticks
- Used urine pregnancy tests
- Used urine specimen cups after the urine is discarded – preferably in the toilet

**REMEMBER**—ALL DESIGNATED SHARPS CONTAINERS MUST BE CLOSED BEFORE PLACING INTO THE BIOHAZARD BAG!

ONLY GROSSLY CONTAMINATED PPE SHOULD BE PLACED INTO RED BAGS.
**Personal Protective Equipment (PPE)**

Where do we even start?! You need this! A lot of this! During this pandemic we’ve learned a lot of lessons but one of the most prevalent has been the amount and types of PPE we need to keep ourselves and our staff safe. QIPMO has compiled an extensive list of PPE resources to help you know what kind of PPE to use, by whom, and when in your home; where PPE can be obtained; management strategies for reuse; and educational pieces around the proper use of PPE.

**Types of PPE.** PPE involved a variety of pieces. The types and levels of PPE needed depends on the levels of precaution required.

- Respirator masks (N95s are preferred but other types of respirator masks such as K95s are better than nothing) and surgical masks
- Face shields/goggles
- Gowns
- Head covers/shoe covers
- Gloves

*Note: cloth masks are NOT considered PPE, but this section does address the use of cloth masks in long-term care settings.*

**Masks.** Masks come in several sizes, protective materials, and fits. Again, what you need depends on the level of protection required.

- Intended for use by 1 person only. Masks should never be shared.
- Surgical masks are intended for one time (or day if necessary) only.
- Label with name and date.
- Do not use if visibly soiled.
- Do not use N95 or K95 masks for more than 1 week, even if unsoiled.
- N95 and K95 respirator masks must be able to air dry—do not put them in plastic bags where they can breed bacteria.
- Fit testing. Having a properly fitting N95 respirator is imperative to proper protection. More information and resources for fit testing are available in The Appendix.
- Store as shown below.
Example of how to properly store surgical mask or N95 respirator mask

Face shields.

- Full face shields are dedicated to individual direct care staff as foam piece and elastic head band cannot be adequately disinfected between personnel.
- While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe.
- Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution.
- Wipe the outside of face shield or goggles with clean water or alcohol to remove residue.
- Fully dry (air dry or use clean absorbent towels).
- Remove gloves and perform hand hygiene.

Gowns.

- One gown per person. Label with name and date.
- Place on removable wall hook outside bedroom door or at the entry/exit point for staff from unit.
- At end of shift, remove prior to exiting room/apt, bag and secure bag, perform hand hygiene, if reusable put in soiled utility room to have laundered per policy, discard if disposable.
Surgical caps.

*Not required as part of full PPE in long-term care for COVID-19 but using them will help protect against the spread of COVID-19.*

- Store caps in paper bag/bin designated for 1 person. Reuse for 5 shifts and wash (discard if paper).
- If you can't get surgical caps, chemo caps are a good alternative.
- Shoe covers can be stored in the individual bin/locker. Throw away any that are wet or soiled with body fluids. Reuse for 5 shifts.

Gloves.

- Single-use item.
- Dispose of immediately after doffing using proper glove removal.
- Wash hands after removal.

**Donning and Doffing PPE**

PPE won’t do you any good unless you know how to safely put it on and take it off. Follow these two links from the CDC for donning and doffing training videos. Have your staff watch these for great educational tools.

Donning: [Demonstration of Donning (Putting On) Personal Protective Equipment (PPE) - YouTube](https://www.youtube.com/watch?v=example_video_id)

Doffing: [Demonstration of Doffing (Taking Off) Personal Protective Equipment (PPE) - YouTube](https://www.youtube.com/watch?v=example_video_id)

It’s also important to monitor PPE utilization. After months of full PPE or even just wearing N95s, healthcare staff are finding themselves in PPE fatigue. This is a legitimate concept and compromises the safety of your staff and residents with every incidence. It is important to emphasize community-wide compliance.

*Lessons Learned:* Some companies have created a “Dofficer.” This person’s role is to monitor the correct donning and doffing of PPE. If you can’t spare a person strictly for this role, use the buddy system. It’s human nature to take shortcuts especially when we’re tired after working all day. However, even one slip can possibly infect you or others.
When-Where-Who Should Wear What Kind of PPE

QIPMO has created an easy-to-use PPE protocol to show you who needs to wear what kinds of PPE, where, and when. The full document can be found in the Appendix or by following this link

PPE-Protocol-102720.pdf (nursinghomehelp.org)

Obtaining PPE

There are several avenues for obtaining PPE. As we’ve seen throughout the pandemic supplies of certain things wax and wane. The following resources are available either from the state national stockpile, available via donation, or for purchase.

- Missouri Companies Retooled to Make PPE - Missouri-Companies-that-retooled-to-make-PPE-June-25-2020.pdf (nursinghomehelp.org)
- Mask Match.com Mask Match (mask-match.com)
- Get Us PPE.org Get Us PPE - Personal Protective Equipment to those who need it most
• Missouri PPE Marketplace PPE Resource Process and Requests | COVID-19 Outbreak | Health & Senior Services (mo.gov)
• Amazon Business marketplace COVID-19 and PPE supplies for work - Amazon Business

*Businesses must register as healthcare providers to get priority

Re-Using PPE

What happens when PPE runs out? There are strategies up to reuse some kinds of PPE. The following resources give those guidelines and restrictions.

Re-Use, MO DHSS, Dr. Randall Williams 4-10-2020-DHSS-HG-PPE-Sterilzation-R.pdf (nursinghomehelp.org)

Optimizing PPE Use During Shortages, Center for Disease Control and Prevention

Lessons Learned: The National Emerging Special Pathogens Training and Education Center (NETEC) has created a series of webinars since COVID began. These educational sessions are directly from frontline workers and the strategies and struggles they’ve encountered with PPE. Check these out for great tips on obtaining, managing, and using PPE. https://repository.netecweb.org/exhibits/show/ppe-cons/covidwebinars.

Systems

William Fasbender, the Associate Director, Safety Management, NYC Health + Hospitals in Elmhurst (New York) presented on a NETEC webinar regarding the systems element of the New York City COVID-19 response during its peak. His words summed up systems in a pandemic perfectly:

“This is different. Personnel may be treating co-workers – friends. Personnel may get sick. Personnel may die. Personnel may cause their loved ones to become sick or die.”

Trying to run a skilled nursing facility (or any business for that matter) “as usual” during a pandemic is an illusion. Aside from the financial, physical, and operational constraints there will always be the underlying emotional stress to contend with. You can’t operate “as usual,” but you can and must operate.

Lessons Learned:

▪ Subscribe to ASPR, CDC, state and local Department of Health and Emergency Management info sources
▪ Push info to personnel, and encourage them to watch /listen to / read it
▪ Have solid information collection and reporting
▪ Make considerations for mass fatality management
▪ Use video phones for patient/family visits
▪ Offer long-term psychosocial services for existing patients, new patients, and personnel
▪ Have policies for engaging with the news media and utilizing social media accounts
▪ Create procedures for patients without decisional capacity

William Fasbender, the Associate Director, Safety Management, NYC Health + Hospitals in Elmhurst (New York)
CHAPTER 9: PANDEMIC STAFFING

If you’re in healthcare, there is never a time when staffing isn’t an issue of some sort. During a pandemic particularly but always your staff are your GREATEST resource. Let me say that again STAFF ARE YOUR GREATEST RESOURCE. Without them it doesn’t matter how many gloves, patients, or policies you have.

Per CMS Appendix PP, “The facility must have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable level of physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment . . . (see 42 C.F.R. § 483.70(e))”

This chapter is focused on the various facets of staffing needs, regulations, and support during a pandemic.

- Staffing assessment tool and “at-risk” personnel
- Employee rights and regulations
  - OSHA Guidance
  - Families First Coronavirus Response Act
  - Human resources consideration and pandemic staffing
- Managing existing staff and staffing recruitment
  - Existing staff
  - Ancillary staff
  - Non-nursing staff
- Mental health support services

Staffing Assessment Tools and “At-Risk” Personnel

Staffing assessment is comprised of two key areas:

- Staff available without complications
- Staff available with considerations

Available is more than just physically in-person. When considering infection control, you also have to take your staff population into account for being possible “at-risk.” So, we consider staff available without complications as those who are NOT considered clinically to be at risk for obtaining the disease or experiencing extreme complications from it.

Staff available with considerations are those that ARE clinically at-risk and should be considered for positions that will not unnecessarily expose them to possible harm from infection.

Knowing where your staff fit into these categories will also help you know what kinds and how much PPE you will need, scheduling changes, cross-training, and staffing shortfalls in quarantine units. The Minnesota Department of Health has created a fantastic full-scale Long-term Care Contingency Staffing Plan (TEMPLATE) which helps plan for and evaluate normal staffing needs versus crisis staffing needs and how to create a contingency staffing plan that will be documented.
<table>
<thead>
<tr>
<th>Department</th>
<th># of Personnel per Department</th>
<th># identified as “at-risk” based on CDC recommendations</th>
<th># of total hours worked by those “at-risk” individuals</th>
<th>Names of employees who can potentially be relocated within the facility or temporarily change duties to decrease risk</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Activities</td>
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</tbody>
</table>

For those staff considered at-risk, you need to consider and plan for multiple contingencies.

1. Do an individualized, confidential assessment of any employee’s request for accommodations.
2. Consider having a leave request form to be signed by a physician that discusses
   a. How the disability/age creates a limitation
   b. how the requested accommodation will effectively address the limitation
   c. whether another form of accommodation could effectively address the issue
   d. how a proposed accommodation will enable the employee to continue performing the “essential functions” of his/her position.
3. The letter should include a copy of the employee’s job duties and a list of the measures currently being taken to protect the employee from exposure to COVID-19.
4. Alternative mitigation strategies for these employees may include remote working, physical barriers (glass or plastic), modified work schedules, PPE, and possible temporary transfers. The key is to be flexible in determining accommodations as much as possible.
5. Update your policy on accommodation to ensure consistency.
6. Educate your employees on these policies and procedures.
7. Be thoughtful of requirements under the Americans with Disabilities Act (ADA), Title VII of the Civil Rights Act (Title VII), the Pregnancy Non-Discrimination Act (PDA), the Age Discrimination and Employment Act (ADEA), the Genetic Information Nondiscrimination Act (GINA), the National Labor Relations Act, Occupational Safety and Health Act (OSHA), Family Medical Leave Act (FMLA) and Health Insurance Portability and Accountability Act (HIPAA); and
8. Seek further legal guidance when necessary.

Employee Rights and Regulations

People panic. It’s a human response and factor in a new, deadly, highly contagious disease and you can bet your bottom dollar that employers will quickly have their hands full with frightened employees. The best way to subdue these fears and mitigate a staffing crisis is to communicate clearly and often and make sure your employees know that you have their backs. The next section will address OSHA guidance, sick leave, and the Families First Coronavirus Response Act.

OSHA Guidance


The Department of Labor and OSHA have created a Guidance on Preparing Workplaces for COVID-19. The following guidelines are excerpted from that document and provide ideas for further assessment and practice that should be part of your employee protection program.

GENERAL WORKPLACE PRACTICE AND PPE PROTOCOL

- Employers should explore whether they can establish policies and practices, such as flexible worksites (e.g., telecommuting) and flexible work hours (e.g., staggered shifts), to increase the physical distance among employees and between employees and others if state and local health authorities recommend the use of social distancing strategies.
- Discourage workers from using other workers’ phones, desks, offices, or other work tools and equipment, when possible.
- Maintain regular housekeeping practices, including routine cleaning and disinfecting of surfaces, equipment, and other elements of the work environment. When choosing cleaning chemicals, employers should consult information on Environmental Protection Agency (EPA)-approved disinfectant labels with claims against emerging viral pathogens. Products with EPA-approved emerging viral pathogens claims are expected to be effective against SARS-CoV-2 based on data for harder to kill viruses. Follow the manufacturer’s instructions for use of all cleaning and disinfection products (e.g., concentration, application method and contact time, PPE).
- Promote frequent and thorough hand washing, including by providing workers, customers, and worksite visitors with a place to wash their hands. If soap and running water are not immediately available, provide alcohol-based hand rubs containing at least 60% alcohol.
- Minimize contact among workers, clients, and customers by replacing face-to-face meetings with virtual communications and implementing telework if feasible.
- Establish alternating days or extra shifts that reduce the total number of employees in a facility at a given time, allowing them to maintain distance from one another while maintaining a full onsite work week.
- Develop emergency communications plans, including a forum for answering workers’ concerns and internet-based communications, if feasible.
- Provide workers with up-to-date education and training on COVID-19 risk factors and protective behaviors (e.g., cough etiquette and care of PPE).
• Train workers who need to use protecting clothing and equipment how to put it on, use/wear it, and take it off correctly, including in the context of their current and potential duties. Training material should be easy to understand and available in the appropriate language and literacy level for all workers. **Employers are obligated to provide their workers with PPE needed to keep them safe while performing their jobs. The types of PPE required during a COVID-19 outbreak will be based on the risk of being infected with SARS-CoV-2 while working and job tasks that may lead to exposure.** Workers, including those who work within 6 feet of patients known to be, or suspected of being, infected with SARS-CoV-2 and those performing aerosol-generating procedures, need to use respirators:

  o National Institute for Occupational Safety and Health (NIOSH)-approved, N95 filtering face piece respirators or better must be used in the context of a comprehensive, written respiratory protection program that includes fit-testing, training, and medical exams. See OSHA’s Respiratory Protection standard, 29 CFR 1910.134 at www.osha.gov/laws-reg/standard number/1910/1910.134.

  o When disposable N95 filtering face piece respirators are not available, consider using other respirators that provide greater protection and improve worker comfort. Other types of acceptable respirators include: a R/P95, N/R/P99, or N/R/P100 filtering face piece respirator; an air-purifying elastomeric (e.g., half-face or full-face) respirator with appropriate filters or cartridges; powered air purifying respirator (PAPR) with high-efficiency particulate arrestance (HEPA) filter; or supplied air respirator (SAR). See CDC/NIOSH guidance for optimizing respirator supplies at: www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy.

  o Respirator training should address selection, use (including donning and doffing), proper disposal or disinfection, inspection for damage, maintenance, and the limitations of respiratory protection equipment. Learn more at: www.osha.gov/SLTC/respiratory-protection.

  o The appropriate form of respirator will depend on the type of exposure and on the transmission pattern of COVID-19. See the NIOSH “Respirator Selection Logic” at: www.cdc.gov/niosh/docs/2005-100/default.html or the OSHA “Respiratory Protection e-Tool” at www.osha.gov/SLTC/e-Tools/respiratory.

OSHA’s On-Site Consultation Program offers no-cost and confidential advice to small and medium-sized businesses in all states, with priority given to high-hazard worksites. On-Site consultation services are separate from enforcement and do not result in penalties or citations. For more information or to find the local On-Site Consultation office in your state, visit www.osha.gov/consultation, or call 1-800-321-OSHA (6742).

**WORKPLACE FLEXIBILITIES AND PROTECTIONS**

• Actively encourage sick employees to stay home.

• Ensure that sick leave policies are flexible and consistent with public health guidance and that employees are aware of these policies.

• Talk with companies that provide your business with contract or temporary employees about the importance of sick employees staying home and encourage them to develop non-punitive leave policies.

• Do not require a healthcare provider’s note for employees who are sick with acute respiratory illness to validate their illness or to return to work, as healthcare provider offices
and medical facilities may be extremely busy and not able to provide such documentation in a timely way.

- Maintain flexible policies that permit employees to stay home to care for a sick family member. Employers should be aware that more employees may need to stay at home to care for sick children or other sick family members than is usual.
- Be aware of workers’ concerns about pay, leave, safety, health, and other issues that may arise during infectious disease outbreaks. Provide adequate, usable, and appropriate training, education, and informational material about business-essential job functions and worker health and safety, including proper hygiene practices and the use of any workplace controls (including PPE). Informed workers who feel safe at work are less likely to be unnecessarily absent.

ENVIRONMENTAL WORKPLACE PROTECTION

As employers we are also obligated to reduce exposure to potential hazards within the working environment without relying on worker behavior. Per the OSHA guidelines, engineering controls for SARS-CoV-2 include:

- Installing high-efficiency air filters.
- Increasing ventilation rates in the work environment.
- Installing physical barriers, such as clear plastic sneeze guards.
- Installing a drive-through window for customer service.
- Specialized negative pressure ventilation in some settings, such as for aerosol generating procedures (e.g., airborne infection isolation rooms in healthcare settings and specialized autopsy suites in mortuary settings).

TIP: For more information on OSHA guidelines, visit:

OSHA Regional Office for Region 7
Kansas City Regional Office
Two Pershing Square Building
2300 Main Street, Suite 1010
Kansas City, MO 64108-2416
(816) 283-8745
(816) 283-0547 Fax

Families First Coronavirus Response Act: Employee Paid Leave Rights

The Families First Coronavirus Response Act (FFCRA or Act) requires certain employers to provide employees with paid sick leave or expanded family and medical leave for specified reasons related
to COVID-19. The Department of Labor’s (Department) Wage and Hour Division (WHD) administers and enforces the new law’s paid leave requirements. These provisions will apply from the effective date through December 31, 2020.

Generally, the Act provides that employees of covered employers are eligible for:

- 2 weeks (up to 80 hours) of paid sick leave at the employee’s regular rate of pay due to quarantine, person under investigation (PUI) for symptoms of COVID-19, or COVID-19 diagnosis
- 2 weeks (up to 80 hours) of paid sick leave at 2/3 the employee’s regular rate of pay because the employee is unable to work in order to care for a child (under 18 years of age) whose school or child care provider is closed or unavailable for reasons related to COVID-19, and/or the employee is experiencing a substantially similar condition as specified by the Secretary of Health and Human Services, in consultation with the Secretaries of the Treasury and Labor; and
- up to an additional 10 weeks of paid expanded family and medical leave at 2/3 the employee’s regular rate of pay where an employee, who has been employed for at least 30 calendar days, is unable to work due to a bona fide need for leave to care for a child whose school or childcare provider is closed or unavailable for reasons related to COVID-19.

Additional information on calculating pay, covered employees, and duration can be found at the link above. **This mandate has currently been extended through March 31, 2021.**

https://www.jdsupra.com/legalnews/ffcra-in-2021-extended-mandates-no-6705798/#:~:text=Both%20laws%20were%20set%20to%20expire%20December%2031%2C%202020.&text=Each%20individual%20is%20entitled%20to%20March%2031%2C%202021.


**Human Resource Considerations for Pandemic Staffing**

It is a vital that Human Resources take a look at insurance policies and sick leave, including insurance. The NETEC webinar entitled “The Use of HICS for COVID-19 Resilience and Recovery” discusses some practical and financially stable ideas for managing pay, staffing, and a changing financial scene for hospitals and health care institutions as the pandemic continues. In addition, there are lots of good ideas here on how to utilize and retain staff during pandemic operations. You can find that webinar at this link **NETEC COVID-19 Webinar Series (4/6/20): Resilience and Care of the Caregiver Webinar · NETEC Resource Library (netecweb.org)**

**Managing Existing Staff and Staff Recruiting**

As was mentioned previously, **STAFFING IS YOUR GREATEST RESOURCE!** And often in a pandemic that comes at a high price. There are two ways to look at this: existing staff and ancillary staff. It is also worth mentioning that nursing staff may not be the only ones to become ill. The final point will discuss options for recruiting other necessary staff in your homes.

**Existing Staff**

There are several things you can do for your existing staff.

1. **Take care of those you have.** To get some great advice ways to debunk COVID myths, provide a Staff Caregiver in your home, and discuss community support for staff outside your home, tune into the November 3, 2020 QIPMO DON support group meeting

   [Information/Helpful Links on Coronavirus (COVID-19) | Nursing Home Help](https://www.jdsupra.com/legalnews/ffcra-in-2021-extended-mandates-no-6705798/#:~:text=Both%20laws%20were%20set%20to%20expire%20December%2031%2C%202020.&text=Each%20individual%20is%20entitled%20to%20March%2031%2C%202021.)
Here are some of the vital points:

- Check on the various staff in the building. Do 1:1 visits, really talk to people. See how they’re coping. If they have any needs and make notes. Give them a quiet “safe” place and person to vent to, laugh with, and cry on. WE ALL NEED THIS!!

- If they get sent home with COVID or to care for a loved one with COVID, ask these questions:
  
  - Do they live alone? Are there caregivers available to stay with them or can you schedule a daily check in?
  - Is there a bedroom where they can recover without sharing immediate space with others?
  - Is there a separate bathroom for them to use? Or at least a person/resources available to disinfect after the infected persons use?
  - Is there someone to bring in groceries, etc.?

**Lessons Learned:** “Most of us were staying in the hotel rather than going home. Over 80% of our residents had COVID and many of them really bad. We were doing 12-hour shifts and it was working out pretty well until we started getting sick too. We didn’t want to take it to our families so we just stayed at the hotel, but the problem was that those of us who had gotten sick were scared. We wouldn’t admit it at the time. If you’re home there are people to check on you but in a hotel room, you’re all alone. And we didn’t know if all the sudden we wouldn’t be able to breathe and nobody would know until we were dead. After the first few days of going through that, and one of us ending up in the hospital, we started buddy checks...every 4 hours we’d call or text and whenever somebody left the hotel or came back, they’d physically go to the room to check on that person. It means a lot when someone checks on you. COVID isn’t just physical.”

*J.I., May 2020*

The following NETEC webinar also offers some great resources for community management for staff that get sent home to quarantine from COVID exposure or who are actively ill with the disease.

[NETEC COVID-19 Webinar Series (10/28/20)/Online Course: Community Health Considerations: Infection Prevention · NETEC Resource Library (netecweb.org)]

2. **Investigate ways to change your practices and utilize staff that test positive but are asymptomatic.** The CDC has created a resource called Strategies to Mitigate Healthcare Personnel Staffing Shortages. We know this has been in use in several homes during the pandemic was finding staff was simply nonexistent. Check out this resource for the rules according to whom you can allow to work and how/where: [https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html](https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html).

3. **Consider giving “hazard pay.”**

4. **Look for nurses out-of-state (if allowed).** During the COVID pandemic, many states issued emergency authorization waivers for nurses licensed in other states to practice in Missouri. Make sure you check with the MO Division of Professional Regulation to see if this is currently in effect as waivers expire.
5. **Train new CNAs.** Changes were made to the CNA exam, allowing for quicker, more accessible testing and turnaround for new CNAs. Information can be found through Headmaster at the following website: [D&S - Missouri Nurse Aide (hdmaster.com)](http://hdmaster.com). The waiver for the shortened training hours, etc. can be found in Appendix.

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### Ancillary Nursing Staffing

When too many of your staff are ill or you are literally out of people, you may need to consider calling in help. One avenue is to look for volunteers within the state.

1. **Consider calling on Show Me Response or Medical Reserve Corp volunteers.** These medically trained staff have active licenses workable under the state of Missouri. Check with the organizations for logistics and availability. Medical Reserve Corp volunteers can be found all over the state.
   - [Show-Me Response](http://mo.gov)
   - [Volunteer | Emergency Preparedness & Response | Health & Senior Services (mo.gov)](http://mo.gov)

2. **Submit a request through the Missouri Disaster Assistance Team (DMAT) team.** This is the best done through your healthcare coalition. If available, they can provide nurses and other medically trained personnel for a short-term basis for a few days until you can get staff back into your building.

   Additional staffing resources can be found through the Missouri Hospital Association at [COVID-19 Surge Staffing Solutions Fact Sheet - MHA (mhanet.com)](http://mhanet.com) and the CDC’s [Reopen America Staffing Resources | CDC](https://www.cdc.gov).

### Non-Nursing Staffing

Nurses and CNAs won’t be the only ones to get sick if you have an outbreak. You will still need kitchen aids, housekeepers, and maintenance staff. Make it easy on yourself and look within your own community first!

**Dining services.** As restaurants close, many kitchen staff are displaced and needing jobs. Reach out to local restaurants, hotels, and catering centers for additional staff already trained in dining services. For some good ideas on cross-training staff to assist with dining, check out the QIPMO webinar.

[Microsoft PowerPoint - Cross Training & Dining.pptx (nursinghomehelp.org)](http://nursinghomehelp.org)

**Housekeeping.** As people stay closed into their homes and businesses shut down or worked on minimal staffing, many housekeeping services have also been displaced. Reach out to local services for temporary staff to get you through.

**Maintenance.** There are lots of ways to recruit maintenance workers, including Facebook, Indeed, and the traditional employment paths. However, you might also consider talking to construction workers, secondary vocational schools, and of course, simply asking those within your own organization.
Mental health services/Caring for the Caregiver

Nurses don’t like to ask for help. We give help, not receive it. But this is different. The COVID-19 pandemic has changed not only our work life but our daily lives. It’s a lot to cope with and it’s okay to need someone to talk to. Battling through the exhaustion, sadness, anger, frustration, and fear on your own is an incredibly difficult thing. Reach out. Don’t bottle it up. We’ll get through this together.

There are 3 main aspects of mental health that must be addressed as a caregiver during a pandemic: stress, fear, and grief. QIPMO has some excellent materials on these subjects from past webinars that will help you recognize and cope with these elements. Feel free to access them here as often as you need.

Microsoft PowerPoint - crisis on crisis ppt [Read-Only] (nursinghomehelp.org)
Microsoft PowerPoint - Statewide support 7.28.20 (nursinghomehelp.org)
PowerPoint Presentation (nursinghomehelp.org)

Other resources available include

- Show Me Hope: Mo Show Me Hope – Mo Show Me Hope
- Missouri Coalition for Community Healthcare: First Responder Provider Network Info.pdf
- Healthcare Personnel and First Responders: How to Cope with Stress and Build Resilience During the COVID-19 Pandemic | CDC
- National Suicide Prevention: toll-free - 800-273-TALK (800-273-8255) - the online Lifeline Crisis Chat is free and confidential. You’ll be connected to a skilled, trained counselor in your area.
- National Domestic Violence Hotline Call 800-799-7233 and TTY 800-787-3224
- Disaster Distress Helpline Call 800-985-5990 or text TalkWithUs to 66746

CHAPTER 10: CLINICAL MANAGEMENT OF COVID-19

This chapter will focus specifically on management of COVID-19. However, every strategy, tool, and guideline here could potentially be replicated for another type of community outbreak situation.

TIP: Take some time for your own emotional well-being.
- Practice meditation or breathing exercises
- Read a book
- Dance
- Listen to music
- Walk in the woods
- Reconnect with old friends
- Take a yoga class
- Clear the clutter
- Learn a new recipe
- Keep a gratitude journal
This chapter has a lot of moving parts located under 3 main headings: Before, During, and After COVID. The simplest way to guide you is to present an outline so you can get what you efficiently and quickly and some overlap into other timelines of the clinical management process.

A. Before COVID hits
   a. Facility assessment reevaluation
      i. High-risk residents
      ii. Residents with special needs
      iii. Infection control practices
      iv. Staffing availability and roles
   b. Family, staff, resident education
   c. Advanced care planning & CPR
   d. Visitation

B. During COVID outbreak
   a. Symptoms, assessment surveillance, SBAR, and documentation
   b. Isolation vs cohorting
   c. Communal dining
   d. Vitamins, ventilators, proning
   e. Testing
   f. Reporting
   g. COVID & influenza
   h. Mortality

C. After COVID outbreak
   a. Clinical manifestations
   b. Post-COVID rehabilitation
   c. Vaccinations
   d. Reopening

Before COVID Hits

Most long-term care facilities in Missouri have already been hit with COVID but just in case your home is one of the few that has not, this section will provide invaluable insights in how to prepare, what to look for, what to be aware of. If COVID has already been in your building, refer to the guidance laid out in this section through best practices, DHSS, CMS, and the CDC. The QIPMO webinar from 4.14.20, particularly slides 10-17, will give you tons of great ideas on what to think about, who to talk to, and how to plan before COVID hits. Microsoft PowerPoint - crisis on crisis ppt [Read-Only] (nursinghomehelp.org)

Facility Assessment and Reevaluation

It’s easier to fight a battle when you know who the players are, what capabilities and resources you have and can obtain, and where your strongest and weakest links come in. You should already have a good handle on this based on your facility assessment. The chapter on Pandemic Staffing addresses some of the at-risk population in your staff while this chapter focuses on COVID-19 and your residents.
High-risk residents. COVID isn’t picky about who it hits but there are some underlying medical conditions and special populations that are more vulnerable to the acute and chronic effects of COVID than others. The CDC published these conditions as placing someone at high-risk for COVID-19.

- Cancer
- Chronic kidney disease
- COPD (chronic obstructive pulmonary disease)
- Down Syndrome
- Heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies
- Immunocompromised state (weakened immune system) from solid organ transplant
- Obesity (body mass index [BMI] of 30 kg/m² or higher but < 40 kg/m²)
- Severe Obesity (BMI ≥ 40 kg/m²)
- Pregnancy
- Sickle cell disease
- Smoking
- Type 2 diabetes mellitus

Certain Medical Conditions and Risk for Severe COVID-19 Illness | CDC

Keep in mind that those on dialysis are at even higher risk for COVID due to frequent potential exposure. While preparing for COVID to enter your building, it is important to consider relocating residents requiring dialysis away from a COVID unit or highly trafficked area.

Residents with special needs. Residents with developmental and cognitive special needs, including those with intellectual developmental disabilities and those with dementia are at an increased risk for contracting COVID. Aside from changes in the physical environment such as relocation, creation of COVID units, and staff and residents now being required to wear face masks, the mental processing for residents during this time is difficult and frustrating for them at best. QIPMO did a special seminar especially for those residents with a variety of tips and management strategies. Check it out. PowerPoint Presentation (nursinghomehelp.org)

Infection control practices. What are your current problem areas when it comes to infection control? Do you have a lot of upper respiratory issues? UTIs? If so, this is a great time to do some education and some cleaning! COVID is primarily airborne. However, it can be found in body fluids such as urine and feces as well. Some questions to consider:

- Who uses a nebulizer machine on a regular basis? This person may need to change to an inhaler-type device instead.
- Are nebulizers, inhaler spacers, and oxygen machines being cleaned regularly?
- Is tubing being changed regularly?
- Who has trouble with the humidified oxygen? This is a potential concern. Watch for oxygen concentrators where water backs up into the tubing. With the thick secretions and inflammation of COVID, this could potentially be a life-threatening aspiration situation.
- How are you handling residents with trachs?
TIP: Start thinking through a “What If” staffing scenario before COVID ever gets in your building.

- What if the DON, Administrator, or Infection Preventionist gets sick and is out of the building?
- What if 25, 40, or even 60% of my staff are out ill over a 3-week period?
- What are my ancillary staffing plans?
- Who can I cross-train to cover dining, housekeeping, etc.?
- How can I physically accommodate staff either on-site or off-site to keep them able to work without risking taking COVID home to their families?
- Can I tap into any community support for staff in terms of meals, lodging, spiritual support?

- What is your process for disposal of peri care products? Hint, they should not be tossed into the garbage but “placed” in the garbage, reducing any possible liquid air-borne infectious particles.

- Do you have hand sanitizer available throughout the home, in resident rooms, and in all high-traffic areas?

Staffing availability and roles. Staffing is discussed in detail in the chapter on Pandemic Staffing. However, it is important to recognize now through your facility assessment if you have the staff already available to designate to a specific COVID unit and begin contingency plans for a COVID surge.

Family, Staff, and Resident Education

COVID is rampant, just like the amount of misinformation being tossed out there. The best way to get a handle on it is right out of the gate. In the Appendix A you will find signage created by the CDC and other organizations you may use and display in your home and pass out to your residents, staff, and family members.

As discussed in the chapter on Pandemic Preparedness, it is vital to have persons designated to act as your communications officer. While the Infection Preventionist can do the clinical training to staff, if or when an outbreak occurs, that person will be tied up in clinical management to man the phones, relay information, and assist family members in daily communications.

Frequent, transparent education and communication with staff, residents, and family members is KEY to getting through a COVID outbreak.
**Advanced Care Planning and CPR**

One of the scarier issues with COVID has been that someone can go from “doing fine” to completely crashing within a matter of hours with few to none of the normal, obvious clinical signs. Because of this and the multitude of other factors affecting the pandemic, it is important to discuss medical goals and wishes **before** that scenario comes to fruition.

Having that discussion is never easy and can be especially difficult during this time when accompanied by fear and the idea that family members may not be able to be with loved ones if something should happen. Here are a couple of resources that can assist with that.

- QIPMO webinar COVID-19 Infection 4.7.20, slides 37-47. [PowerPoint Presentation](nursinghomehelp.org)
- Specific Phrases & Word Choices that Can Be Helpful When Dealing with COVID-19 [Microsoft Word - SIC COVID Guidelines.docx](memberclicks.net)

Should your resident decide to be resuscitated in the event that they would code, and they are positive for COVID-19, you need to educate your staff on the algorithm provided for COVID-19 CPR precautions. An enlarged, full version of the algorithm is available in Appendix A.

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**BLS Healthcare Provider Adult Cardiac Arrest Algorithm for Suspected or Confirmed COVID-19 Patients**

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*[Image of the BLS Healthcare Provider Adult CPR Algorithm]*

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*BLS Healthcare Provider Adult CPR Algorithm for suspected or confirmed positive COVID-19 patients*
Visitation

The ability to allow visitors in have fluctuated from the beginning of pandemic to complete shutdowns to now allowing essential caregivers. To say this experience has been an opportunity for learning and discussion about quality of life is putting it lightly. Going forward we must learn to balance regulations, guidance, and common sense.

CMS updated the visiting guideline on March 10, 2021 to include the following guidance:

**Ombudsman.** Ombudsman must be allowed immediate access to residents within the guidelines of indoor visitation and provided they have passed the infection control screening. If in-person access is deemed inadvisable (e.g., the Ombudsman has signs or symptoms of COVID-19), facilities must, at a minimum, facilitate alternative resident communication with the ombudsman, such as by phone or through use of other technology. Nursing homes are also required under 42 CFR § 483.10(h)(3)(ii) to allow the Ombudsman to examine the resident’s medical, social, and administrative records as otherwise authorized by State law.

**Outdoor Visits.** While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred even when the resident and visitor are fully vaccinated* against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. Therefore, visits should be held outdoors whenever practicable. However, weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality) or an individual resident’s health status (e.g., medical condition(s), COVID-19 status) may hinder outdoor visits. For outdoor visits, facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When conducting outdoor visitation, all appropriate infection control and prevention practices should be adhered to.

**Indoor Visits** Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times). These scenarios include limiting indoor visitation for:

- Unvaccinated residents, if the nursing home’s COVID-19 county positivity rate is >10% and 70% of residents in the facility are fully vaccinated.
- Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue transmission-based precautions.
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

Other considerations:

- Consider # of visitors allowed at one time in order to maintain infection control guidelines
- Length of visit in order to ensure all residents are allowed to receive visits
- Limit movement of visitors by ensuring visitors go directly to residents’ room or meet in the designated visiting area without trespassing the various hallways and patient care areas
- If a resident has a roommate, try to conduct visit outside of the room in a designated visiting area. If the resident being visited is unable to leave the room, try to adhere to infection control principles for the in-room visitation.

**Visits During an Outbreak.** An outbreak exists when a new nursing home onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:
• If the first round of outbreak testing reveals no additional COVID-19 cases in other areas (e.g., units) of the facility, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing.

For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.

If the first round of outbreak testing reveals one or more additional COVID-19 cases in other areas/units of the facility (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

If subsequent rounds of outbreak testing identify one or more additional COVID-19 cases in other areas/units of the facility, then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing. NOTE: In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.

Compassionate care visits. While end-of-life situations have been used as examples of compassionate care situations, the term “compassionate care situations” does not exclusively refer to end-of-life situations. Examples of other types of compassionate care situations include, but are not limited to:

• A resident, who was living with their family before recently being admitted to a nursing home, is struggling with the change in environment and lack of physical family support.
• A resident who is grieving after a friend or family member recently passed away.
• A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
• A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).

Allowing a visit in these situations would be consistent with the intent of, “compassionate care situations.” Also, in addition to family members, compassionate care visits can be conducted by any individual that can meet the resident’s needs, such as clergy or lay persons offering religious and spiritual support. Furthermore, the above list is not an exhaustive list as there may be other compassionate care situations not included. Compassionate care visits, and visits required under federal disability rights law, should be allowed at all times, regardless of a resident’s vaccination status, the county’s COVID-19 positivity rate, or an outbreak.

Lastly, visits should be conducted using social distancing; however, if during a compassionate care visit, a visitor and facility identify a way to allow for personal contact, it should only be done following appropriate infection prevention guidelines, and for a limited amount of time.

Other Healthcare Service Providers. Health care workers who are not employees of the facility but provide direct care to the facility’s residents, such as hospice workers, Emergency Medical Services (EMS) personnel, dialysis technicians, laboratory technicians, radiology technicians, social workers, clergy, etc., must be permitted to come into the facility as long as they are not subject to a work exclusion due to an exposure to COVID-19 or showing signs or symptoms of COVID-19 after being screened. We note that EMS personnel do not need to be screened, so they can attend to an emergency without delay.
Admissions, Discharges, and Transfers

Before accepting the resident from the hospital, follow these steps:

1. Review the medical record
2. Confirm the resident’s status COVID status. If they are positive, are they recovered and how long?
3. What is hospital discharge plan of care and instructions?
4. Does your facility have the isolation room or unit/rooms reserved for residents with Covid-19?
5. Do you have enough PPE? Oxygen?

Other considerations:
- What is their skill-able need/what services will you be providing if they are to be on Medicare Part A?
- Have they been on blood thinners?
- What is their past medical history related to strokes or DVTs?

There are a lot of clinical considerations, so it is important to consider the whole picture before accepting a patient.

When transporting a resident via ambulance, it is important to share with the crew whether is positive for COVID so additional practices can be put into place.

During a COVID Outbreak

And it’s happened! You’ve officially got COVID in your home. This section will take you through handling a COVID outbreak from the first positive test to (hopefully) the last positive test. Guidance found here comes from a variety of sources, not the least the TIPS and Lessons Learned from those of you who had and lived to share advice. Thank-you for that!

One very resourceful tool you may find helpful is the MO Interim Guidance for Long-term Care Facilities with Confirmed COVID-19. Parts of that guidance is discussed in the upcoming sections. [Itcf-guidance.pdf](mo.gov)

As COVID has evolved so have the symptoms. What started as a tenuous respiratory condition has evolved to include every organ system in the body. While every case of COVID is unique to that individual, there is a basic list of symptoms and timeline that COVID infections tend to follow.
SYMPTOMS ASSESSMENT SURVEILLANCE

The key to containing COVID in your home is rapid response.

1. Recognize symptoms and/or exposure.
2. Quarantine from other residents and set up PPE protocols for staff (see chapter on Pandemic Operations, PPE).
3. Verify positive infection.
4. Follow-up in-house, family, and regulatory reporting protocols.
5. Manage from symptom expression and/or exposure until “recovered” status or quarantine complete. The last section of this chapter will discuss Post-Covid. “Recovered” is a variant term and only expresses the safe return of residents to their pre-COVID infection or exposure living conditions.

Symptoms may appear 2-14 days after exposure to the virus. These are what you need to look out for.

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

Source: Symptoms of Coronavirus | CDC

Another “unofficial” symptom includes COVID “toes” (a red-purple tender, itchy rash that appears on the toes, hands, and sometimes heels).
ASPR-TRACIE created an illustration that explains how COVID symptoms often present and resolve.

Figure 5. Timeline of COVID-19 Disease Progression

This timeline shows an approximation of disease progression for COVID-19 patients who admitted to the hospital between day 5 and 7. Patients with milder symptom presentation follow a similar path in terms of length of illness, but obviously do not progress to critical illness. COVID-19 patients can rapidly progress to death over several days versus weeks when placed on a ventilator.

https://asprtracie.hhs.gov/
SBAR and documentation. The modified QIPMO INTERACT SBAR (Situation, Background, Appearance, Review) tool is an excellent resource for assessing residents with potential COVID-19 infections. The accompanying Documentation Guidelines for Residents with Positive or Suspected Cases of COVID-19 help staff know what to document and how often. The full SBAR and documentation tools can be found in the Appendix. It is a good idea to do chart audits to make sure you are capturing all services and assessments being given to the resident.

QIPMO SBAR tool
Isolation vs. Cohorting

If possible, contain all positive COVID residents in one area or COVID unit. However, as more people become infected, it may be more practical to quarantine residents where they are rather than increase the risk of moving them and a few of their necessary items. Also, it may become necessary to do reverse isolation.

**How long do asymptomatic positive residents need to stay in quarantine?**

10 days after positive PCR test

**How long do symptomatic positive residents need to stay in quarantine?**

- 10 days after symptom onset, AND
- 24-hours fever-free without the use of NSAIDs, AND
- Symptoms have improved

**What if the resident has COVID with severe illness?**

You may need to extend quarantine to up to 20 days since symptom onset. The 24-hour fever-free rule also applies.


Residents with a positive COVID test should be cohorted based on symptoms (i.e., keep asymptomatic residents away from those who are showing symptoms). Ensure at least 6 feet between beds and provide a physical barrier between beds. For examples of plans for COVID units and set-up, see the chapter on Pandemic Operations.

Communal Dining and Activities

Sharing a meal and participating in group entertainment has always been an integral part of the human culture. For several months residents have not been able to share the time or camaraderie as they did in the past. While COVID is still circulating in our buildings, this will remain an issue. However, here are the guidelines for communal dining and activities in homes without a current COVID outbreak (updated 3/10/21). **If you are currently in an outbreak, you should suspend communal dining.** Activities should be limited to those done in private rooms.

1. Limiting communal dining and group activities to only residents who are:
   - COVID-19 negative or asymptomatic and not suspected to have COVID-19, or in isolation, OR
   - Previously COVID-19 positive but have been released from isolation based on either the symptom based or test based strategy.

2. Resident should remain socially distanced by spacing tables 6-feet apart and minimizing the number of people at table. Staff should assist residents with hand hygiene before and after eating and encourage the use of a face mask during transport and/or they stay seated at the table before/after the meal.

3. Allowing activities where residents can remain socially distanced, with masks, and hand hygiene practices.

*Source: DHSS June 15, 2020 Guidance Considerations for Communal Dining and Group Activities*

Vitamins, Ventilators, and Proning

The medical field has been busy since this outbreak trying to find the best, safest ways to manage COVID infections in patients of all ages and health statuses. While there is currently no scientific evidence to
back it up, vitamins C, D, and zinc have been given to boost the body’s immune system. Before giving any supplements, be sure to check with the resident’s primary care physician.

As residents return from the hospital, we are finding out that many of them have been put on ventilators. There are many physiological consequences to being on the vent and they require long periods for recovery. Some of these issues include:

1. Impairment of cognitive function resulting from delirium or sedation use.
2. Associated issues include anxiety, insomnia, paranoia, difficulty reading and/or writing, inability to think clearly or memory loss.
3. Impaired physical function due to Immobility which can lead to muscle wasting, including respiratory muscles which may increase the risk for aspiration and pneumonia, skin breakdown with pressure ulcer/injury development, and blood clots, e.g., DVTs or pulmonary emboli.
4. Prolonged intubation may cause vocal cord issues with subsequent hoarseness, raspy voice or soreness or a swallow dysfunction. It is suggested to have a SLP evaluation to identify any swallow dysfunction, e.g., post-extubation dysphagia and treat accordingly.
5. Mental health issues such as PTSD due to a prolonged ICU length of stay and hospitalization, extended intubation and ventilation or sleep pattern disturbances. (Refer to F 699 Trauma Informed Care)

The second concern that should be addressed is proning. Because it eases the strain on the lungs to inhale and exhale, many patients have been placed in a prone position. **Proning should not be done in a long-term care setting without a doctor’s order and specific direction.** If physicians do give orders for proning be sure to carefully monitor for skin breakdown, comfort, and place on a consistent turning schedule. Therapists are ideal personnel to assist with these tasks.

A final concern comes in monitoring for blood clots, heart attacks, stroke, and gastrointestinal bleeding. The nature of the COVID-19 virus causes a thrombotic storm—meaning your immune system as it relates to your cardiovascular system goes into hyperdrive. Clots are thrown easily throughout the body and can impair veins and arteries in the extremities, heart, lungs, and brain. To counteract this many hospitalists have prescribed anticoagulant therapy. However, it is worth noting that in some patients, even 3-4 weeks post-hospital stay, have had significant GI bleeds, causing readmission to the hospital and in a few cases even death. Assessing residents carefully can help mitigate potential problems.

Common symptoms of GI bleed seen in post-COVID patients:

- Hemataemesis
- Bleeding from the mouth and gums
- Coffee-ground emesis *think about the smell
- Melena
- Blood in the ears, nose
- Unusual fatigue
- Pallor
- Shortness of breath

*Testing and Reporting*

Testing and reporting have also been an ever-evolving process. The following information is the most recent guidance we have available as of March 10, 2021. Lots of resources of available are available on our website under the COVID tab on the front page [www.nursinghomehelp.org](http://www.nursinghomehelp.org).
**Required routing testing of staff.** Starting in September of 2020, CMS began requiring routine testing of staff based on the county positivity rates. For communities in counties with

- **low** COVID activity (<5%), test 1x/month
- **medium** COVID activity (5-10%), test once a week
- **high** COVID activity (>10%), test twice a week

County positivity rates are updated every 2 weeks, usually on Mondays and can be found at [https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg](https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg)

With the availability of point-of-care tests, test results should be available within 15 minutes or within 24-48 hours for PCR tests. If you have trouble with turnaround time in tests, contact DHSS and make sure you document your correspondence, etc.

- If the county positive rate **increases** to a higher level of activity, the facility should begin testing staff at the frequency described above.
- If the county positivity rate **decreases** to a lower level of activity, the facility should continue testing at the higher frequency level until the county positivity rate has remained at lower level for at least 2 weeks.

Facilities should also consider positivity rates of neighboring counties. Anyone (staff or residents) who have previously tested positive within 90 days of the current test, do **not** need to be tested. After 90 days, testing should resume for those cases.

*For staff who refuse to be tested*, the facility must have a policy in place to restrict staff from entering the building or working until the return-to-work criteria have been met. For residents who refuse to be tested, if they are symptomatic, they should be placed in quarantine on transmission-based precautions until at minimum 10 days has passed with an additional 24-hours fever-free. If they are not symptomatic, the facility should attempt to remain hypervigilant in regard to helping the resident wear a mask and social distance. Make sure your policy is clear on how residents and staff who refuse testing will be treated.

Testing for COVID-19 can be done 3 ways.

1. **Point-of-care test.** A point-of-care test is swab of the nares that can test for an acute viral SARS-CoV-2 infection. The results usually take up to 15 minutes and should be followed by a laboratory-confirmed PCR test.
2. **PCR test.** This is also a viral test but tends to be more accurate in diagnosing a positive acute COVID-19 infection.
3. **Serology test.** This is a test for antibodies that shows you have had COVID in the past.

For specific information on the Quidel and BD Veritor point-of-care tests, check out these links.

[https://togetheragain.quidel.com/](https://togetheragain.quidel.com/)
Positive COVID tests for residents or staff must be reported to DHSS within 24 hours.

TIP: Before testing

- Obtain physician order.
- Make sure you have your supplies and are well-educated on the point-of-care machines.
- Obtain your SAMS id and reporting login for the NHSN reporting system.
- Have a documentation system in place for those with previously positive COVID tests.

COVID-19 reporting algorithm

**Documentation of testing.** Facilities must demonstrate compliance with the testing requirements. To do so, facilities should do the following:

- For symptomatic residents and staff, document the date(s) and time(s) of the identification of signs or symptoms, when testing was conducted, when results were obtained, and the actions the facility took based on the results.
- Upon identification of a new COVID-19 case in the facility (i.e., outbreak), document the date the case was identified, the date that all other residents and staff are tested, the dates that staff and residents who tested negative are retested, and the results of all tests. All residents and staff that tested negative are expected to be retested until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result (see section Testing of Staff and Residents in response to an outbreak above).
- For staff routine testing, document the facility’s county positivity rate, the corresponding testing frequency indicated (e.g., every other week), and the date each positivity rate was collected. Also, document the date(s) that testing was performed for all staff, and the results of each test.
- Document the facility’s procedures for addressing residents and staff that refuse testing or are unable to be tested and document any staff or residents who refused or were unable to be tested and how the facility addressed those cases.
- When necessary, such as in emergencies due to testing supply shortages, document that the facility contacted state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.

Refer to the Documentation Guidelines earlier in this chapter on how to document signs/symptoms in the resident’s chart for those who test positive for COVID-19.


**Reporting Tools**

- [NHSN LTCF COVID-19 Module Facility Dashboard (cdc.gov)](https://www.cdc.gov/nhsn/ltcf/)
- [NHSN LTCF COVID-19 Module Facility Dashboard (cdc.gov)](https://www.cdc.gov/nhsn/ltcf/)
- [COVID-19 Module | LTCF | NHSN | CDC](https://www.cdc.gov/nhsn/ltcf/)

**COVID-19 and Influenza**

It is unfortunate the signs and symptoms of COVID-19 are very similar to that of seasonal influenza, which brings up a myriad of questions. Similarities include

- Fever or feeling feverish/chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue (tiredness)
- Sore throat
- Runny or stuffy nose
- Muscle pain or body aches
- Headache
- Some people may have vomiting and diarrhea
QUESTION: Should you give the annual flu vaccine?

ANSWER: Yes. Screen resident for symptoms, use PPE as appropriate.

QUESTION: What is the difference between incubation and symptom time for COVID and influenza?

ANSWER: Flu symptoms develop anywhere from 1 to 4 days after infection. COVID-19 symptoms develop 5 days after being infected, but symptoms can appear as early as 2 days after infection or as late as 14 days after infection, and the time range can vary. Flu is contagious for about 1 day before they show symptoms. Adults are most contagious during the initial 3-4 days of their illness but may continue to be contagious as long as 7 days. People with weakened immune systems can be contagious for even longer. Persons with COVID-19 are contagious 2 days before experiencing signs or symptoms and remain contagious for at least 10 days after signs or symptoms first appeared.

QUESTION: Are flu and COVID spread the same way?

ANSWER: COVID-19 and flu are spread person-to-person, between people who are in close contact with one another (within about 6 feet). Spread mainly by droplets, via physical human contact, touching a surface or object that has virus on it and then touching his or her own mouth, nose, or possibly their eyes. Both are spread to others by people before they begin showing symptoms, with very mild symptoms or who never developed symptoms (asymptomatic). The difference is that COVID-19 is more contagious among certain populations and age groups than flu. COVID-19 has been observed to have more superspreading events than flu.

Source: Similarities and Differences between Flu and COVID-19 / CDC

Mortality

None of us want to think about our residents passing but it happens. During an outbreak, you may be faced with more than one fatality in a short span of time. In the event we have multiple cases in multiple homes and/or the hospitals, funeral homes may be overwhelmed and may have a longer than usual pick-up time for the decedents. Every county may do things a bit differently so it’s best to ask in your jurisdiction. The following page has some general tips for caretaking from the Cape Girardeau County Deputy Coroner.
Deaths in Facility During a Pandemic

How to Care for a Body if Asked to Hold for >3-4 Hours...

- Make sure the body is kept separate from any other resident (aka, no roommate). Homes may need to consider a “morgue room.”
- Turn the air conditioning in the room as low as possible.
- Place a large bag of ice on the chest and a small bag of ice over the face. This will preserve the body as well as possible and prevent contamination to allow embalming later on.

Paperwork and Procedures for Positive and Suspected Positive COVID cases...

- Nothing should change IF the death in considered a NATURAL death or something clearly OTHER than COVID (non-symptomatic, heart attack, stroke, etc.) Homes should follow their usual procedures.
- If COVID suspected (symptomatic OR confirmed cases) 1. Follow steps above (minus the ice unless you are told by the funeral home that there will be a delay in pick-up). 2. Call the county coroner and funeral home and tell them the resident is suspected and/or confirmed COVID. The county coroners are considering positive COVID cases a “natural” death from that specific disease. **It is up to each municipality/county if those bodies will be autopsied.** We should convey to the homes to NOT mention that aspect to the families.
- Provide the following PPE to the funeral home upon arrival unless they are able to bring their own:
  - Gown, Facemask (not just nose/mouth mask), gloves, surgical hat. **Once someone is deceased, they can still contaminate via body fluids particularly of the nose, eyes, and mouth.**

What to Do with a COVID Body Leaving the Building...

1. Wash down walls, closets, and floors—basically every surface
2. If able to spray disinfectant on the ceilings, they should do so.
3. Wash all linens, including privacy curtain.
5. Wash mattress with hot, soapy water and allow to completely air dry.

NOTE: You are not required to have body bags on-site. These should be provided by your county coroner if needed.
After COVID Outbreak

Congratulations! You made it through a round of COVID. Hopefully there won’t be many more to follow. This final section of Clinical Management will deal with issues we are starting to see from a physical and mental “recovered” post-COVID infection; we’ll talk about some ideas for post-COVID rehabilitation; you’ll find details on the vaccination and the tiers; and finally, we’ll talk about reopening.

a. Clinical manifestations
b. Post-COVID rehabilitation
c. Vaccinations
d. Reopening

Clinical Manifestations

As the COVID outbreaks continue across the world, we are getting more and more information on post-COVID clinical manifestations. Some people have few symptoms that last a short time while others have many that last months. It’s too early to have all the details but here is what we do know so far.

- Mild symptoms (dry cough, fatigue, aches) should recover within 7-10 days
- Monitor for symptoms of fatigue, shortness of breath, muscle pain, confusion, headaches and even hallucinations
- Keep in mind that inflammation in the heart can lead to long-lasting cardiac disease and failure
- If breathing problem, consider pulmonary evaluation for treatment and rehabilitation to help rebuild strength
- COVID-19 can affect the brain and central nervous system. Monitor for headaches, dizziness, trouble concentrating or recalling things, stroke, TIA and even hallucinations
- Pulmonary rehabilitation: breathing exercises and muscle strengthening, mobility, monitoring oxygen
- Continue nursing assessments for major system: heart and lung gastrointestinal
- Continue implementing social distancing and wearing mask
- Mental health: counseling, encouraging, monitoring depression, self-esteem. Monitor for:
  o distressing memories or avoiding thinking of the event or strong physiological reactions to reminders of the event
  o Flashbacks, hallucinations
  o Distrust in self, others, the world
  o Persistent negative emotions and emotional numbing
  o Trouble with concentration

TIP: After COVID

- Get plenty of rest, fresh air, and sunshine!
- Keep cleaning! Most infections are coming in from staff—don’t let down your guard.
- Start rehab, slow and easy...walking, talking, breathing, building up lung capacity, building up strength.
- Start living!
Post-COVID Rehabilitation

As we enter the world of post-COVID on a large scale, therapy companies and nursing are reassessing the needs of residents. We are seeing more than ever the necessity of therapy and nursing working together to get residents in a better place physically and mentally. Great information can be accessed at from the QIPMO February 2021 monthly meeting on Taking on the Triple Pandemic Through Therapy and Nursing Interventions. [https://nursinghomehelp.org/wp-content/uploads/2021/02/Univeristy-of-Missouri-webinar-Updated-2.2.21.pdf](https://nursinghomehelp.org/wp-content/uploads/2021/02/Univeristy-of-Missouri-webinar-Updated-2.2.21.pdf)

Vaccinations

There have been a lot of questions and concerns about the COVID vaccine and equally in the beginning as many for it, as against it. There are multiple guidelines and fact sheets available to help you navigate questions and procedures. By now most facilities should have received round 2 of the Moderna vaccine.

The CDC's Long-term Care Facility Toolkit: Preparing for COVID-19 Vaccine at Your Facility is a great resource for you to distribute information staff, residents, and families about COVID-19 vaccination. The resource includes fact sheets, FAQs, and much more. Find it here: [https://www.cdc.gov/vaccines/covid-19/toolkits/long-term-care/index.html](https://www.cdc.gov/vaccines/covid-19/toolkits/long-term-care/index.html).

With vaccines now available from Pfizer, Moderna, and Johnson & Johnson, it is hopeful we will begin to see a herd immunity take place and the decreased possibility of serious infection from COVID-19.

Additional resources include:


Stronger Together: MO Vaccination Information: [https://covidvaccine.mo.gov/](https://covidvaccine.mo.gov/)

Pfizer FDA Emergency Use Authorization Fact Sheet: [https://www.fda.gov/media/144413/download](https://www.fda.gov/media/144413/download)

Modera FDA Emergency Use Authorization Fact Sheet: [https://www.fda.gov/media/144638/download](https://www.fda.gov/media/144638/download)

Missouri Phase and tier vaccination implementation program
Facts about COVID-19 vaccines

Vaccines (shots) are one of the tools we have to fight the COVID-19 pandemic.

To stop this pandemic, we need to use all of our prevention tools. Vaccines are one of the most effective tools to protect your health and prevent disease. Vaccines work with your body's natural defenses so your body will be ready to fight the virus. If you are exposed (also called immunity). Other steps, like wearing a mask that covers your nose and mouth and staying at least 6 feet away from other people you don't live with, also help stop the spread of COVID-19.

Studies show that COVID-19 vaccines are very effective at keeping you from getting COVID-19. Experts also think that getting a COVID-19 vaccine may help keep you from getting seriously ill even if you do get COVID-19. These vaccines cannot give you the disease itself.

The vaccines are safe. The U.S. vaccine safety system makes sure that all vaccines are as safe as possible. All the COVID-19 vaccines that are being used have gone through the same safety tests and meet the same standards as any other vaccines produced through the years. A system in place across the entire country that allows CDC to watch for safety issues and make sure the vaccines stay safe.

Different types of COVID-19 vaccines will be available. Most of these vaccines are given in two shots, one at a time and spaced apart. The first shot gets your body ready. The second shot is given at least three weeks later to make sure you have full protection. If you are told you need two shots, make sure that you get both of them. The vaccines may work in slightly different ways, but all types of the vaccines will help protect you.

www.cdc.gov/coronavirus/vaccines

CDC COVID-19 Vaccination fact sheet

Reopening

In July of 2020, DHSS published a reopening guidance for long-term care facilities. That guidance can be found at this link: https://ltc.health.mo.gov/archives/14325

Early in March 2021 Missouri was able to announce for the first time in 12 months that we had no red states, meaning the positivity rates for every county in Missouri were less than 10%. While we wait on further guidance from CMS and DHSS, homes are encouraged to refer to the CMS guidance from September 17, 2020, https://www.cms.gov/files/document/qso-20-39-nh.pdf, the July 2020 guidance mentioned above, and holiday leave guidance https://ltc.health.mo.gov/wp-content/uploads/sites/18/2020/11/DHSS-LTCF-Holiday-Guidance-11-18-2020.pdf to decide what is appropriate for reopening in your community.


After-Action Hot Wash

Emergency management uses a term they call a “hot wash.” This simply means that once a crisis is over, key players sit down and discuss all aspects of event—broken down as we have here throughout Part II. The conversation should include all members of your infection control team as well as getting input from other staff members. Refer back to the incident command system to get yourself organized and then go piece-by-piece and see what worked and how; what didn’t and why; and what to do moving forward with a new emergency management mitigation plan.


The FEMA hot wash form can be found here https://training.fema.gov/is/flupan/references/02_course%20forms%20and%20templates/02_hot%20wash%20form-508.pdf.
APPENDIX

1.1 FACILITY ASSESSMENT TOOL

Requirement

Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents (§483.70(e)).

The requirement for the facility assessment may be found in Attachment 1.

Purpose

The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs, as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being.

The intent of the facility assessment is for the facility to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require.

Overview of the Assessment Tool

This is an optional template provided for nursing facilities, and if used, it may be modified. Each facility has flexibility to decide the best way to comply with this requirement.

The tool is organized in three parts:

1. Resident profile including numbers, diseases/conditions, physical and cognitive disabilities, acuity, and ethnic/cultural/religious factors that impact care

2. Services and care offered based on resident needs (includes types of care your resident population requires; the focus is not to include individual level care plans in the facility assessment)

3. Facility resources needed to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, education and training, physical environment and building needs, and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community-based risk assessment, and other information that you may choose

This assessment asks you to collect and use information from a variety of sources. Some of the sources may include but are not limited to MDS reports, Quality Measures, 672 (Resident Census and Conditions of Residents) and/or 802 (Roster/Sample Matrix Form) reports, the Payroll-Based Journal, and in-house designed reports.

Guidelines for Conducting the Assessment

1. To ensure the required thoroughness, individuals involved in the facility assessment should, at a minimum, include the administrator, a representative of the governing body, the medical director, and the director of nursing. The environmental operations manager and other
department heads (e.g., the dietary manager, director of rehabilitation services, or other individuals including direct care staff) should be involved as needed. Facilities are encouraged to seek input from residents, their representative(s), or families, and consider that information when formulating their assessment.

2. While a facility may include input from its corporate organization, the facility assessment must be conducted at the facility level.

3. The facility must review and update this assessment annually or whenever there is/the facility plans for any change that would require a modification to any part of this assessment. For example, if the facility decides to admit residents with care needs who were previously not admitted, such as residents on ventilators or dialysis, the facility assessment must be reviewed and updated to address how the facility staff, resources, physical environment, etc., meet the needs of those residents and any areas requiring attention, such as any training or supplies required to provide care.

   • It is not the intent that the organizational assessment is updated for every new person that moves into the nursing home, but rather for significant changes such as when the facility begins admitting residents that require substantially different care. Likewise, hiring new staff or a director of nursing or even remodeling should not require an update of the facility assessment, unless these are actions that the facility assessment indicated the facility needed to do.

4. The facility assessment should serve as a record for staff and management to understand the reasoning for decisions made regarding staffing and other resources and may include the operating budget necessary to carry out facility functions.

5. Appendix PP provides surveyor guidance through Interpretive Guidelines in the State Operations Manual. With regard to the facility assessment, Appendix PP states, “If systemic care concerns are identified that are related to the facility’s planning, review the facility assessment to determine if these concerns were considered as part of the facility’s assessment process. For example, if a facility recently started accepting bariatric residents, and concerns are identified related to providing bariatric services, did facility staff update its assessment before accepting residents with these needs to identify the necessary equipment, staffing, etc., needed to provide care that is effective and safe for the residents and staff?”

6. For a suggested process for conducting the assessment, including synthesis and use of findings, see Attachment 2.

**Facility Assessment Tool**

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</thead>
</table>
### PART 1: OUR RESIDENT PROFILE

#### NUMBERS

1.1. Indicate the number of residents you are licensed to provide care for: (enter number of beds) ____________.

*Consider if it would also be helpful to differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators).*

1.2. Indicate your average daily census: (enter a range) ____________.

*Consider if it would also be helpful to differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators).*

1.2.a. Consider if it would be helpful to describe the number of persons admitted and discharged, as these processes can impact staffing needs.

<table>
<thead>
<tr>
<th></th>
<th>Number (enter average or range) of persons admitted</th>
<th>Number (enter average or range) of persons discharged</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weekday</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weekend</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### DISEASES/CONDITIONS, PHYSICAL, AND COGNITIVE DISABILITIES

1.3. Indicate if you may accept residents with, or your residents may develop, the following common diseases, conditions, physical and cognitive disabilities, or combinations of conditions that require complex medical care and management.

*For example, start with this list and modify as needed. The intent is not to list every possible diagnosis or condition. Rather, it is to document common diagnoses or conditions in order to identify the types of human and material resources necessary to meet the needs of resident’s living with these conditions or combinations of these conditions.*

<table>
<thead>
<tr>
<th>Category</th>
<th>Common diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric/Mood Disorders</td>
<td>Psychosis (Hallucinations, Delusions, etc.), Impaired Cognition, Mental Disorder, Depression, Bipolar Disorder (i.e., Mania/Depression), Schizophrenia, Post-Traumatic Stress Disorder, Anxiety Disorder, Behavior that Needs Interventions</td>
</tr>
<tr>
<td>Heart/Circulatory System</td>
<td>Congestive Heart Failure, Coronary Artery Disease, Angina, Dysrhythmias, Hypertension, Orthostatic Hypotension, Peripheral Vascular Disease, Risk for Bleeding or Blood Clots, Deep Venous Thrombosis (DVT), Pulmonary Thrombo-Embolism (PTE)</td>
</tr>
<tr>
<td>Neurological System</td>
<td>Parkinson’s Disease, Hemiparesis, Hemiplegia, Paraplegia, Quadriplegia, Multiple Sclerosis, Alzheimer’s Disease, Non-Alzheimer’s Dementia, Seizure Disorders, CVA, TIA, Stroke, Traumatic Brain Injuries, Neuropathy, Down’s Syndrome, Autism, Huntington’s Disease, Tourette’s Syndrome, Aphasia, Cerebral Palsy</td>
</tr>
</tbody>
</table>
### Vision
- Visual Loss, Cataracts, Glaucoma, Macular Degeneration

### Hearing
- Hearing Loss

### Musculoskeletal System
- Fractures, Osteoarthritis, Other Forms of Arthritis

### Neoplasm
- Prostate Cancer, Breast Cancer, Lung Cancer, Colon Cancer

### Metabolic Disorders
- Diabetes, Thyroid Disorders, Hyponatremia, Hyperkalemia, Hyperlipidemia, Obesity, Morbid Obesity

### Respiratory System
- Chronic Obstructive Pulmonary Disease (COPD), Pneumonia, Asthma, Chronic Lung Disease, Respiratory Failure

### Genitourinary System
- Renal Insufficiency, Nephropathy, Neurogenic Bowel or Bladder, Renal Failure, End Stage Renal Disease, Benign Prostatic Hyperplasia, Obstructive Uropathy, Urinary Incontinence

### Diseases of Blood
- Anemia

### Digestive System
- Gastroenteritis, Cirrhosis, Peptic Ulcers, Gastroesophageal Reflux, Ulcerative Colitis, Crohn’s Disease, Inflammatory Bowel Disease, Bowel Incontinence

### Integumentary System
- Skin Ulcers, Injuries

### Infectious Diseases
- Skin and Soft Tissue Infections, Respiratory Infections, Tuberculosis, Urinary Tract Infections, Infections with Multi-Drug Resistant Organisms, Septicemia, Viral Hepatitis, *Clostridium difficile*, Influenza, Scabies, Legionellosis

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**Decisions Regarding Caring for Residents with Conditions Not Listed Above**

1.4. Describe the process to make admission or continuing care decisions for persons that have diagnoses or conditions that you are less familiar with and have not previously supported. For example, how do you determine, if you have the opportunity to admit a person with a new diagnosis to your facility, or to continue caring for a person that has developed a new diagnosis, condition or symptom, if you have the resources, or how you might secure the resources, to provide care and support for the person?

**Acuity**

1.5. Describe your residents’ acuity levels that help you to understand potential implications regarding the intensity of care and services needed. The intent of this is to give an overall picture of acuity – **over the past year, or during a typical month**, for example. Potential data sources include RUGs, MDS data, and resident/patient acuity tools.

Consider if it would also be helpful to differentiate between long-stay and short-stay residents or other categorizations (e.g., unit floors or specialty areas or units, such as those that provide care and support for persons living with dementia or using ventilators).

Examples of different ways to look at acuity are provided in the tables below. **Choose a methodology that works best for your organization.** You may elect to use some or all of the tables below or choose your own methodology.
**Example 1:** Major RUG-IV Categories

<table>
<thead>
<tr>
<th>Major RUG-IV Categories</th>
<th>Number/Average or Range of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Plus Extensive Services</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Extensive Services</td>
<td></td>
</tr>
<tr>
<td>Special Care High</td>
<td></td>
</tr>
<tr>
<td>Special Care Low</td>
<td></td>
</tr>
<tr>
<td>Clinically Complex</td>
<td></td>
</tr>
<tr>
<td>Behavioral Symptoms and Cognitive Performance</td>
<td></td>
</tr>
<tr>
<td>Reduced Physical Function</td>
<td></td>
</tr>
</tbody>
</table>

**Example 2:** Special Treatments and Conditions

<table>
<thead>
<tr>
<th></th>
<th>Special Treatments</th>
<th>Number/Average or Range of Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cancer Treatments</strong></td>
<td>Chemotherapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Radiation</td>
<td></td>
</tr>
<tr>
<td><strong>Respiratory Treatments</strong></td>
<td>Oxygen therapy</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Suctioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Tracheostomy Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ventilator or Respirator</td>
<td></td>
</tr>
<tr>
<td></td>
<td>BIPAP/CPAP</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>Behavioral Health Needs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Active or Current Substance Use Disorders</td>
<td></td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>IV Medications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Injections</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Transfusions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dialysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ostomy Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospice Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respite Care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Isolation or Quarantine for Active Infectious Disease</td>
<td></td>
</tr>
</tbody>
</table>
Example 3: Assistance with Activities of Daily Living

<table>
<thead>
<tr>
<th>Assistance with Activities of Daily Living</th>
<th>Independent</th>
<th>Assist of 1-2 Staff</th>
<th>Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transfer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other care (describe)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mobility</th>
<th>Independent</th>
<th>Assistive Device Used to Ambulate</th>
<th>In Chair Most of Time</th>
</tr>
</thead>
</table>

ETHNIC, CULTURAL, OR RELIGIOUS FACTORS

1.6. Describe ethnic, cultural, or religious factors or personal resident preferences that may potentially affect the care provided to residents by your facility. Examples may include activities, food and nutrition services, languages, clothing preferences, access to religious services, or religious-based advanced directives.

OTHER

1.7. Describe other pertinent facts or descriptions of the resident population that must be taken into account when determining staffing and resource needs (e.g., residents’ preferences with regard to daily schedules, waking, bathing, activities, naps, food, going to bed, etc.)

PART 2: SERVICES AND CARE WE OFFER BASED ON OUR RESIDENTS’ NEEDS

RESIDENT SUPPORT/CARE NEEDS

2.1 List the types of care that your resident population requires and that you provide for your resident population. List by general categories, adding specifics as needed. It is not expected that you quantify each care or practice in terms of the number of residents that need that care or enter an aggregate of all resident care plans here. The intent is to identify and reflect on resources needed (in Section 3) to provide these types of care.

For example, start with this list and modify as needed:

<table>
<thead>
<tr>
<th>General Care</th>
<th>Specific Care or Practices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities of daily living</td>
<td>Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment; supporting resident independence in doing as much of these activities by himself/herself</td>
</tr>
<tr>
<td>Mobility and fall/fall with injury prevention</td>
<td>Transfers, ambulation, restorative nursing, contracture prevention/care; supporting resident independence in doing as much of these activities by himself/herself</td>
</tr>
<tr>
<td>Bowel/bladder</td>
<td>Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to</td>
</tr>
<tr>
<td><strong>the bathroom/toilet promptly in order to maintain continence and promote resident dignity</strong></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>Skin integrity</strong></td>
<td>Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds)</td>
</tr>
<tr>
<td><strong>Mental health and behavior</strong></td>
<td>Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnoses, intellectual or developmental disabilities</td>
</tr>
<tr>
<td><strong>Medications</strong></td>
<td>Awareness of any limitations of administering medications Administration of medications that residents need By route: oral, nasal, buccal, sublingual, topical, subcutaneous, rectal, intravenous (peripheral or central lines), intramuscular, inhaled (nebulizer), vaginal, ophthalmic, etc. Assessment/management of polypharmacy</td>
</tr>
<tr>
<td><strong>Pain management</strong></td>
<td>Assessment of pain, pharmacologic and nonpharmacological pain management</td>
</tr>
<tr>
<td><strong>Infection prevention and control</strong></td>
<td>Identification and containment of infections, prevention of infections</td>
</tr>
<tr>
<td><strong>Management of medical conditions</strong></td>
<td>Assessment, early identification of problems/deterioration, management of medical and psychiatric symptoms and conditions such as heart failure, diabetes, chronic obstructive pulmonary disease (COPD), gastroenteritis, infections such as UTI and gastroenteritis, pneumonia, hypothyroidism</td>
</tr>
<tr>
<td><strong>Therapy</strong></td>
<td>PT, OT, Speech/Language, Respiratory, Music, Art, management of braces, splints</td>
</tr>
<tr>
<td><strong>Other special care needs</strong></td>
<td>Dialysis, hospice, ostomy care, tracheostomy care, ventilator care, bariatric care, palliative care, end of life care</td>
</tr>
<tr>
<td><strong>Nutrition</strong></td>
<td>Individualized dietary requirements, liberal diets, specialized diets, IV nutrition, tube feeding, cultural or ethnic dietary needs, assistive devices, fluid monitoring or restrictions, hypodermoclysis</td>
</tr>
<tr>
<td><strong>Provide person-centered/directed care</strong></td>
<td>Build relationship with resident/get to know him/her; engage resident in conversation Find out what resident’s preferences and routines are; what makes a good day for the resident; what upsets him/her and incorporate this information into the care planning process. Make sure staff caring for the resident have this information Record and discuss treatment and care preferences Support emotional and mental well-being; support helpful coping mechanisms Support resident having familiar belongings Provide culturally competent care: learn about resident preferences and practices with regard to culture and religion; stay open to requests and preferences and work to support those as appropriate Provide or support access to religious preferences, use or encourage prayer as appropriate.desired by the resident</td>
</tr>
</tbody>
</table>
Provide opportunities for social activities/life enrichment (individual, small group, community)
Support community integration if resident desires
Prevent abuse and neglect
Identify hazards and risks for residents
Offer and assist resident and family caregivers (or other proxy as appropriate) to be involved in person-centered care planning and advance care planning
Provide family/representative support

**PART 3: FACILITY RESOURCES NEEDED TO PROVIDE COMPETENT SUPPORT AND CARE FOR OUR RESIDENT POPULATION EVERY DAY AND DURING EMERGENCIES**

**STAFF TYPE**

3.1 Identify the type of staff members, other health care professionals, and medical practitioners that are needed to provide support and care for residents. Potential data sources include staffing records, organization chart, and Payroll-Based Journal reports.

*Considering the following type of staff and other professionals/practitioners, list (or refer to or provide a link to) your staffing data, directories, organization chart, or other lists that show the type of staff needed to care for your resident population.*

- Administration (e.g., Administrator, Administrative Assistant, Staff Development, QAPI, Infection Control and Prevention, Environmental Services, Social Services, Discharge Planning, Business Office, Finance, Human Resources, Compliance and Ethics)
- Nursing Services (e.g., DON, RN, LPN or LVN, CNA or NAR, medication aide or technician, MDS nurse)
- Food and Nutrition Services (e.g., Director, support staff, registered dietician)
- Therapy Services (e.g., OT, OTA, PT, PTA, RT, RT tech, speech language pathology, audiologist, optometrist, activities professionals, other activities staff, social worker, mental health social worker)
- Medical/Physician Services (e.g., Medical Director, Attending Physician, Physician Assistant, Nurse Practitioner, Dentist, Podiatrist, Ophthalmologist)
- Pharmacist
- Behavioral and mental health providers
- Support Staff (e.g., engineering, plant operations, information technology, custodians, housekeeping, maintenance staff, groundskeepers, laundry services)
- Chaplain/Religious services
- Volunteers, students
- Other (vocational services worker, clinical laboratory services worker, diagnostic X-ray services worker, blood services worker) psychiatric services and mental health providers

**STAFFING PLAN**

3.2. Based on your resident population and their needs for care and support, describe your general approach to staffing to ensure that you have sufficient staff to meet the needs of the residents at any given time.
Examples of two different ways to look at your staffing plan are provided in the tables below. Choose a methodology that works best for your organization. You may elect to use one or both tables below or choose your own methodology. It may be helpful to review specific staffing references in the regulation regarding the facility assessment (see attachment 1). For a discussion on how to determine sufficient staffing, see attachment 2, section 7.b.

**Example 1.** Evaluation of overall number of facility staff needed to ensure a sufficient number of qualified staff are available to meet each resident’s needs. Refer to the guidance in the various tags that have requirements for staffing to be based on/in accordance with the facility assessment, for example, Nursing (F725), Behavioral Health (F741), Nutrition (F802), and Administration (F839). Enter number of staff needed or an average or range:

<table>
<thead>
<tr>
<th>Position</th>
<th>Total Number Needed or Average or Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed nurses providing direct care</td>
<td></td>
</tr>
<tr>
<td>Nurse aides</td>
<td></td>
</tr>
<tr>
<td>Other nursing personnel (e.g., those with administrative duties)</td>
<td></td>
</tr>
<tr>
<td>In addition to nursing staff, other staff needed for behavioral healthcare and services (list other staff positions/roles)</td>
<td></td>
</tr>
<tr>
<td>Dietician or other clinically qualified nutrition professional to serve as the director of food and nutrition services</td>
<td></td>
</tr>
<tr>
<td>Food and nutrition services staff</td>
<td></td>
</tr>
<tr>
<td>Respiratory care services staff</td>
<td></td>
</tr>
</tbody>
</table>

**Example 2.** Describe your general staffing plan to ensure that you have sufficient staff to meet the needs of the residents at any given time. Consider if and how the degree of fluctuation in the census and acuity levels impact staffing needs. For example:

<table>
<thead>
<tr>
<th>Staff</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Licensed Nurses (LN): RN, LPN, LVN providing direct care</td>
<td>DON: 1 DON RN full-time Days; if has other responsibilities, add x more RN as Asst. DON to equal one FTE</td>
</tr>
<tr>
<td></td>
<td>RN or LPN Charge Nurse: 1 for each shift</td>
</tr>
<tr>
<td></td>
<td>1-x residents DON may be Charge Nurse</td>
</tr>
<tr>
<td></td>
<td>1:x LN ratio Days and Evenings (consider breaking this down by RN and LPN per shift)</td>
</tr>
<tr>
<td></td>
<td>1:x LN ratio Nights (consider breaking this down by RN and LPN per shift)</td>
</tr>
<tr>
<td>Direct care staff</td>
<td>1:x ratio Days (total licensed or certified)</td>
</tr>
<tr>
<td></td>
<td>1:x ratio Evenings</td>
</tr>
<tr>
<td></td>
<td>1:x ratio Nights</td>
</tr>
<tr>
<td></td>
<td>Or</td>
</tr>
</tbody>
</table>
| x hours per resident days (HPRD) indicating: a) total number of licensed nurse staff hours per resident per day, b) RN hours per resident per day, c) LPN/LVN hours per resident per day, d) Certified Nursing Assistant hours per resident per day, e) Physical therapy staff hours per resident per day  

Note: comparative data for HPRD are available on Nursing Home Compare |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Other (e.g., department heads, nurse educator, quality assurance, ancillary staff in maintenance, housekeeping, dietary, laundry)</td>
</tr>
</tbody>
</table>

**INDIVIDUAL STAFF ASSIGNMENT**

3.3. Describe how you determine and review individual staff assignments for coordination and continuity of care for residents within and across these staff assignments.

**STAFF TRAINING/EDUCATION AND COMPETENCIES**

3.4. Describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. Potential data sources include hiring, education, training, competency instruction, and testing policies.

It may be helpful to review specific references in the regulation regarding the facility assessment (see Attachment 1).

List (or refer to or provide a link to) all staff training and competencies needed by type of staff. Consider if it would be helpful to indicate which competencies are reviewed at the time the staff member is hired, and how often they are reviewed after that.

Consider the following training topics (this is not an inclusive list):

- Communication – effective communications for direct care staff
- Resident’s rights and facility responsibilities – ensure that staff members are educated on the rights of the resident and the responsibilities of a facility to properly care for its residents
- Abuse, neglect, and exploitation – training that at a minimum educates staff on—(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedures for reporting incidents, of abuse, neglect, exploitation, or the misappropriation of resident property; and (3) Care/management for persons with dementia and resident abuse prevention.
- Infection control – a facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program
- Culture change (that is, person-centered and person-directed care)
- Required in-service training for nurse aides. In-service training must:
- Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year.
- Include dementia management training and resident abuse prevention training.
- Address areas of weakness as determined in nurse aides’ performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff.
- For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

- Required training of feeding assistants – through a State-approved training program for feeding assistants
- Identification of resident changes in condition, including how to identify medical issues appropriately, how to determine if symptoms represent problems in need of intervention, how to identify when medical interventions are causing rather than helping relieve suffering and improve quality of life
- Cultural competency (ability of organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of residents)

Consider the following competencies (this is not an inclusive list):

- Person-centered care - This should include but not be limited to person-centered care planning, education of resident and family/resident representative about treatments and medications, documentation of resident treatment preferences, end-of-life care, and advance care planning
- Activities of daily living - bathing (e.g., tub, shower, sitz, bed), bed-making (occupied and unoccupied), bedpan, dressing, feeding, nail and hair care, perineal care (female and male), mouth care (brushing teeth or dentures), providing resident privacy, range of motion (upper or lower extremity), transfers, using gait belt, using mechanic lifts
- Disaster planning and procedures - active shooter, elopement, fire, flood, power outage, tornado
- Infection control- hand hygiene, isolation, standard universal precautions including use of personal protective equipment, MRSA/VRE/CDI precautions, environmental cleaning
- Medication administration – injectable, oral, subcutaneous, topical
- Measurements: blood pressure, orthostatic blood pressure, body temperature, urinary output including urinary drainage bags, height and weight, radial and apical pulse, respirations, recording intake and output, urine test for glucose/acetone
- Resident assessment and examinations - admission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observations of response to treatment, pain assessment
- Caring for persons with Alzheimer’s or other dementia
- Specialized care - catheterization insertion/care, colostomy care, diabetic blood glucose testing, oxygen administration, suctioning, pre-op and post-op care, trach care/suctioning, ventilator care, tube feedings, wound care/dressings, dialysis care
- Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, and implementing nonpharmacological interventions

**Policies and Procedures for Provision of Care**

3.5. Describe how you evaluate what policies and procedures may be required in the provision of care, and how you ensure those meet current professional standards of practice. Include, for example, your process to determine if new or updated policies are needed, and how they are developed or updated. Examples of policies and procedures include pain management, IV therapy, fall prevention, skin and wound care, restorative nursing, specialized respiratory care for tracheostomy or ventilator, storage of medications and biologicals, and transportation.

**Working with Medical Practitioners**

3.6. Describe your plan to recruit and retain enough medical practitioners (e.g., physicians, nurse practitioners) who are adequately trained and knowledgeable in the care of your residents/patients, including how you will collaborate with them to ensure that the facility has appropriate medical practices for the needs and scope of your population.

3.7. Describe how the management and staff familiarize themselves with what they should expect from medical practitioners and other healthcare professionals related to standards of care and competencies that are necessary to provide the level and types of support and care needed for your resident population. For example, do you share expectations for providers that see residents in your nursing home on the use of standards, protocols, or other information developed by your medical director? Do you have discussions on what providers and staff expect of each other in terms of the care delivery process and clinical reasoning essential to providing high quality care?

**Physical Environment and Building/Plant Needs**

3.8. List (or refer to or provide a link to inventory) physical resources for the following categories. Review the resources in the example below and modify as needed. If applicable, describe your processes to ensure adequate supplies and to ensure equipment is maintained to protect and promote the health and safety of residents.

<table>
<thead>
<tr>
<th>Physical Resource Category</th>
<th>Resources</th>
<th>If applicable, process to ensure adequate supply, appropriate maintenance, replacement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Buildings and/or other structures</td>
<td>Building description, garage, storage shed</td>
<td></td>
</tr>
<tr>
<td>Vehicles</td>
<td>Transportation van</td>
<td></td>
</tr>
<tr>
<td>Physical equipment</td>
<td>Bath benches, shower chairs, bathroom safety bars, bathing tubs, sinks for residents and for staff, scales, bed scales, ventilators, wheelchairs and associated positioning devices, bariatric beds, bariatric wheelchairs, lifts, lift slings, bed frames, mattresses, room and common space furniture, exercise equipment, therapy tables/equipment, walkers, canes, nightlights, steam table, oxygen tanks and tubing, dialysis chair and station, ventilators</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>Waste management, hazardous waste management, telephone, HVAC, dental, barber/beauty, pharmacy, laboratory, radiology, occupational, physical, respiratory, and speech therapy, gift shop, religious, exercise, recreational music, art therapy, café/snack bar/bistro</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Other physical plant needs</td>
<td>Sliding doors, ADA compliant entry/exit ways, nourishment accessibility, nurse call system, emergency power</td>
<td></td>
</tr>
<tr>
<td>Medical supplies (if applicable)</td>
<td>Blood pressure monitors, compression garments, gloves, gowns, hand sanitizer, gait belts, infection control products, heel and elbow suspension products, suction equipment, thermometers, urinary catheter supplies, oxygen, oxygen saturation machine, Bi-PAP, bladder scanner</td>
<td></td>
</tr>
<tr>
<td>Non-medical supplies (if applicable)</td>
<td>Soaps, body cleansing products, incontinence supplies, waste baskets, bed and bath linens, individual communication devices, computers</td>
<td></td>
</tr>
</tbody>
</table>

**Other**

3.9. List contracts, memoranda of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies. Consider including a description of your process for overseeing these services and how those services will meet resident needs and regulatory, operational, maintenance, and staff training requirements.

3.10. List health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. Consider including a description of a) how the facility will securely transfer health information to a hospital, home health agency, or other providers for any resident transferred or discharged from the facility; b) how downtime procedures are developed and implemented; and c) how the facility ensures that residents and their representative can access their records upon request and obtain copies within required timeframes.

3.11. Describe how you evaluate if your infection prevention and control program includes effective systems 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, that follow accepted national standards.

3.12. Provide your facility-based and community-based risk assessment, utilizing an all-hazards approach (an integrated approach focusing on capacities and capabilities critical to preparedness for a full spectrum of emergencies and natural disasters). Note that it is acceptable to refer to the risk assessment of your emergency preparedness plan (§483.73), and focus on high-volume, high-risk areas.
Attachment 1: Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities

Federal Register / Vol. 81, No. 192 / Tuesday, October 4, 2016 / Rules and Regulations

Also see Survey & Certification memos and Appendix PP in the State Operations Manual for additional information.

§483.70(e): Facility Assessment

The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

(1) The facility’s resident population, including, but not limited to,
   (i) Both the number of residents and the facility’s resident capacity;
   (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population;
   (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;
   (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and
   (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

(2) The facility’s resources, including but not limited to,
   (i) All buildings and/or other physical structures and vehicles;
   (ii) Equipment (medical and nonmedical);
   (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies;
   (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care;
   (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and
   (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

Additional References to the Facility Assessment:

Nursing Services § 483.35 - The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity
and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e).

Behavioral Health Services § 483.40(a) - The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility’s resident population in accordance with §483.70(e).

-These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: 483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.70(e).

Food and Nutrition Services § 483.60(a) - Staffing. The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility’s resident population in accordance with the facility assessment required at §483.70(e).

§483.75(c) QAPI Program feedback, data systems, and monitoring. The policies and procedures must include, at a minimum, the following: ... (2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(e) QAPI Program activities .... (3) ... The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility’s services and available resources, as reflected in the facility assessment required at §483.70(e).

Infection Control §483.80(a) - Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) 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 conducted according to §483.70(e) and following accepted national standards.

§483.95 Training Requirements. A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e).

§483.95(i) Behavioral health. A facility must provide behavioral health training consistent with the requirements at §483.40 and as determined by the facility assessment at §483.70(e).

§483.95(g) Required in-service training for nurse aides. In-service training must—§483.95(g)(3) Address areas of weakness as determined in nurse aides’ performance reviews and facility assessment at §483.70(e) and may address the special needs of residents as determined by the facility staff.
Attachment 2: Sample Process for Conducting the Facility Assessment

Plan for the Assessment

1. The administrator or designated individual assigns a person to lead the facility assessment process.

2. The facility assessment leader:
   a. Reviews the regulation for the facility assessment requirements.
   b. Reviews the Interpretive Guidelines, Appendix PP for F838 Facility Assessment, and other areas that refer to the Facility Assessment.
   c. Reviews the optional tool made available by CMS.

3. The leader identifies and invites team members to be on the assessment team, including the administrator, representative of the governing body, medical director, and director of nursing, and considers other persons to be on the team.
   a. Consider and plan for how you will get input and participation from residents, their representatives and/or family members and CNAs (who provide most of the hands-on care) throughout the assessment process. This could include a) asking for input from both the resident council and the family council (if there is one; if not, a meeting of families could be held to obtain such input); b) getting feedback from the local long-term care ombudsman program; and c) involving residents, their representatives, and/or family members and CNAs as part of the facility assessment team (for instance, the president of the resident council could represent residents).
   b. Consider and plan for how you will engage the medical director and medical practitioners in discussing the entire approach to, and ability to care for, residents/patients.

4. The leader convenes a team to work on the assessment, and with the team:
   a. Review and discuss the requirement.
   b. Review the process with the team; discuss and clarify steps needed.
   c. Discuss and establish a timeline for the assessment.
      i. Consider if the facility assessment timing should align with the budgeting process.
   d. Discuss and decide how the assessment will be completed.
      i. One person takes the lead on the first draft, or
      ii. Assign persons to complete different sections.

Complete the Facility Assessment

5. The team leader and others assigned complete the assessment.

6. Team leader and others completing the assessment check-in as needed to discuss any questions or barriers that are coming up to completing the assessment.
Synthesize and Use the Assessment Findings

7. Review the findings of your assessment as a leadership team and discuss the following questions. The goal is to make decisions about needed resources, including direct care staff needs, as well as their capabilities to provide services to the residents in the facility. This step in the process is to use the assessment findings to ensure you are providing competent care to residents every day and during emergencies, and work to continuously identify and act on opportunities for improvement. Documentations of discussions or responses to the questions below are intended for facility use. Consider the questions below:

a. How has the resident population - diseases, conditions, acuity, etc. changed since the last assessment?

b. Do we need to make any changes in staffing?
   i. Based on resident number, acuity, and diagnoses of resident population and our current level of staffing, do we have sufficient nursing staff (nurses and CNAs) with the appropriate competencies and skills?
   How do we determine if we have sufficient staffing? Consider the following:
   ▪ Gather input from residents, family members, and/or resident representatives, CNAs, licensed nurses providing direct care, and the local long-term care ombudsman about how well the current staffing plan has been working and any concerns, and make sure to consider this information when developing the staffing plan.
   ▪ Calculate the type of staff and the amount of staff time needed to meet residents’ daily needs, preferences, and routines in order to help each resident attain or maintain the highest practicable physical, mental, and psychosocial well-being.
   ▪ Review expectations for minimum staffing requirements at the federal and state level. Federal law requires nursing homes to have sufficient staff to meet the needs of residents, to use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(1) and must designate a licensed nurse to serve as a charge nurse on each tour of duty (§483.35(a)(2). However, there is no current federal requirement for specific nursing home staffing levels.
   ▪ Review comparative data (at the nursing home, state and national level) available on the staff measure on Nursing Home Compare. Ask how do we compare, and if we have different HRPD from other homes, the state, and nation, why? What might that mean and how might it inform our staffing plan? Note that the Nursing Home Compare staffing rating takes into account differences in the levels of residents' care needs in each nursing home. For example, a nursing home with residents that have more health problems would be expected to have more nursing staff than a nursing home where the residents need less health care.
   ii. Based on resident number, acuity, and diagnoses of resident population, do we have sufficient staff with the appropriate skills and competencies to carry out functions of food and nutrition services; for example, dietitian?

c. Are there any training, education and/ or competency needs based on resident and/or staff data or trends identified in the Facility Assessment?
i. Does our current behavioral health training sufficiently address our resident population, as identified by the Facility Assessment?

ii. Does our current CNA training program sufficiently address our resident population as identified by the Facility Assessment?

iii. Do we need to update job descriptions to coincide with new competencies identified?

iv. Are new requirements incorporated into our annual performance evaluation process?

d. What opportunities do we have to further collaborate closely with our medical practitioners to enhance our approaches to resident/patient care?

e. Are there any infection control issues (e.g., increase in or new infectious diseases, surveillance needs) that require a change in our infection prevention resources and methods?

f. What opportunities exist for quality initiatives (QAA/QAPI) as a result of what we learned from the Facility Assessment to improve our facility’s services and resources?

i. Do the trends identified in the Facility Assessment suggest areas where we need to improve the quality of our care, quality of life for our residents and/or quality of our services?

ii. What findings in the assessment indicate a need for us to collect and use additional data to inform decision making for future care and improvement?

g. Are there any other resources we need to care for residents competently during day-to-day operations and emergencies, based on the Facility Assessment?

h. Has our facility’s anticipated income been evaluated with relation to anticipated needs in the coming year, as identified in the assessment? Are adjustments needed in our operating budget to address any gaps in resource needs?

<table>
<thead>
<tr>
<th>Areas Facility Assessment Informed</th>
<th>Action to Be Taken/Already Taken This Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staffing</td>
<td></td>
</tr>
<tr>
<td>Infection Prevention/Control</td>
<td></td>
</tr>
<tr>
<td>Training, Competencies</td>
<td></td>
</tr>
<tr>
<td>QAPI Initiatives/Performance Improvement Projects</td>
<td></td>
</tr>
<tr>
<td>Business Strategy</td>
<td></td>
</tr>
</tbody>
</table>

Evaluate Your Process and Plan for Future Assessments

8. Review the facility assessment requirements and guidance at F838. Be prepared to respond to the surveyor on the following questions.

a. How did the facility assess the resident population? Does this reflect the population observed?

b. How did the facility determine the acuity of the resident population?

c. How did the facility determine the staffing level?
d. How did the facility determine what skills and competencies would be required by those providing care?

e. Who was involved in conducting the facility assessment?

f. How did the facility determine what equipment, supplies, and physical environment would be required to meet all resident needs?

g. How did the facility develop its emergency plan?

9. Evaluate with your team the process to conduct the assessment and use the findings. What went well? What will you do differently next time?

10. Establish a process for updating the assessment in one year or earlier of there are substantive changes.

This material (template) was prepared by Telligen, the Quality Innovation Network National Coordinating Center, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 11SOW-QINNCC-01587-08/15/17. No permissions are required to edit the contents.
1.2 INTERACT STOP AND WATCH TOOL

[Link to tool]
### 1.3 Nursing Home Antibiotic Stewardship Log

>>[Link to tool]<<

| Month | Resident Name/Number | Room | Start Ant. Date | End Ant. Date | Urinary Tract Infection | Respiratory | Skin/Soft Tissue | Gastrointestinal | Other Infection (Specify) | Signs & Symptoms | Indicate Diagnostic Tool Used and Whether Criteria Were Met | HAC/CA/NHA/Other Nosocomial† | Lab Results (organism identified) | X-ray | Other Contributing Factors | Prescribing Clinician (PC) | Prescription Date | Prescription Duration | Antibiotic Name | Dose | Change of Antibiotic (if needed) | Follow-up With PC | Follow-up With Resident/Family | Comments/Notes |
|-------|----------------------|-----|-----------------|---------------|------------------------|-------------|-----------------|-------------------|------------------------|-----------------|---------------------------------|--------------------------------|-------------------------|--------|-----------------------------|-----------------|----------------|-----------------------------|----------------|-----------------------------|----------------|
## 1.4 Sample Vaccination Consent Form

[Link to tool]

### Influenza/Pneumococcal Immunization Consent Form

<table>
<thead>
<tr>
<th>Name [Please Print]</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>County of Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>City</td>
<td>State</td>
<td>ZIP</td>
</tr>
<tr>
<td>Phone</td>
<td></td>
<td>For Persons Under 19 Years Old, Mother's Maiden Name</td>
<td></td>
</tr>
<tr>
<td>Medicare Claim Number</td>
<td>Doctor's Name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Insurance Provider</td>
<td>Doctor's Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy Number</td>
<td>Clinic/Office Site Where Vaccine Administered</td>
<td>NYSIS Permission ≥ 19 Years Old</td>
<td></td>
</tr>
</tbody>
</table>

Please complete the questions below for yourself or the person receiving the vaccine.

- [ ] No  [ ] Yes  Are you currently sick with a fever?
- [ ] No  [ ] Yes  Have you ever had a life threatening allergy to any component (or part) of the flu or pneumonia vaccine? If yes, please describe: __________________________________________________________________________________________
- [ ] No  [ ] Yes  Have you ever developed Guillain-Barre Syndrome within 6 weeks of receiving flu vaccine?
- [ ] No  [ ] Yes  Have you ever had a pneumonia shot?
- [ ] No  [ ] Yes  Are you a smoker or have a chronic medical condition such as asthma, heart or lung disease? If yes, please describe: __________________________________________________________________________________________
- [ ] No  [ ] Yes  Have you ever had a severe life threatening allergy to eggs or egg products?
- [ ] No  [ ] Yes  Are you currently pregnant?
- [ ] No  [ ] Yes  Do you have a history of asthma or wheezing?
- [ ] No  [ ] Yes  Are you a child or adolescent receiving long-term aspirin therapy?
- [ ] No  [ ] Yes  Do you have a weakened immune system or have close contact with a person with an extremely weakened immune system who needs special care?
- [ ] No  [ ] Yes  Have you received any other vaccinations within the last 4 weeks?
- [ ] No  [ ] Yes  Have you taken an antiviral medication for the flu within the last 48 hours?

### Influenza Consent

I have read, or had explained to me, the Vaccine Information Statement about influenza vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the influenza vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

Signature of Recipient (Parent or Guardian)  __________________________  Date ________

### Pneumococcal Consent

I have read, or had explained to me, the Vaccine Information Statement about pneumococcal vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I request that the pneumococcal vaccination be given to me (or the person named above for whom I am authorized to make this request). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

Signature of Recipient (Parent or Guardian)  __________________________  Date ________

### Area Below to Be Completed by Nurse

#### Influenza Vaccine

- Administration Date  __________________________
- Administration Site  
  - [ ] Left Arm  
  - [ ] Right Arm  
  - [ ] Nasal  
  - [ ] Left Thigh  
  - [ ] Right Thigh
- Dosage  
  - [ ] 0.5 ml  
  - [ ] 0.25 ml  
  - [ ] LAIV
- Manufacturer & Lot Number  __________________________
- VIT Date  __________________________
- Nurse Signature  __________________________
- Next Immunization Due:  
  - [ ] Next Year  
  - [ ] In 4 Weeks  
  - [ ] Other

#### Pneumococcal Disease Vaccine

- Administration Date  __________________________
- Administration Site  
  - [ ] Left Arm  
  - [ ] Right Arm  
  - [ ] Left Thigh  
  - [ ] Right Thigh
- Manufacturer & Lot Number  __________________________
- VIT Date  __________________________
- Nurse Signature  __________________________
- Next Immunization Due:  
  - [ ] None Needed  
  - [ ] Other

DOH 4156 (6/14) Immunizer – White  Provider – Yellow  Patient – Pink
### 1.5 TUBERCULOSIS SCREENING FORM

**>>Link to tool<<**

#### A. SELF-ASSESSMENT (TO BE COMPLETED BY PATIENT OR PARENT / GUARDIAN)

<table>
<thead>
<tr>
<th>Name Last</th>
<th>First</th>
<th>Middle</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Address:**

<table>
<thead>
<tr>
<th>Street</th>
<th>Apt.</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. Have you ever had a TB skin test? [ ] Yes [ ] No [ ] Don’t know  
   - [ ] Positive [ ] Negative [ ] Don’t know  
   - If positive, do you have the documentation? [ ] Yes [ ] No [ ]
2. Did you have a chest x-ray after your skin test? [ ] Yes [ ] No [ ]  
   - If yes, what? ____________________________
3. Have you been told that you have TB? If so, when? ________________________
4. Have you been treated for TB infection or TB disease? [ ] Yes [ ] No  
   - Which medicines did you take? ____________________________  
   - How long were you on the treatment? ________________________

**Please place a “+” mark in one of the columns to the right:**

- [ ] Yes [ ] No [ ] Don’t know

5. Have you ever been told, or suspected, that you were exposed to someone with TB? [ ] Yes [ ] No [ ]  
6. Have you ever had cancer of the head, neck or lung, leukemia, or lymphoma? [ ] Yes [ ] No [ ]
7. Have you ever had an organ or tissue transplant? [ ] Yes [ ] No [ ]
8. Are you taking steroid (like prednisone), chemotherapy or drugs that affect your immune system? [ ] Yes [ ] No [ ]
9. Do you have diabetes or high blood sugar? [ ] Yes [ ] No [ ]

10. Do you have any of the following symptoms:
    - [ ] Cough longer than 2 weeks? [ ] Yes [ ] No
    - [ ] Fever, chills, night sweats longer than 2 weeks? [ ] Yes [ ] No
    - [ ] Weight loss that was not planned? [ ] Yes [ ] No

11. Do you have renal failure, or are you on kidney dialysis? [ ] Yes [ ] No [ ]
12. Do you think you are at risk of having TB infection? [ ] Yes [ ] No [ ]
13. Have you ever injected street drugs? [ ] Yes [ ] No [ ]
14. Were you born outside of the United States? [ ] Yes, what country? [ ]
15. (Patient under 10) Has anyone who lives with you moved to the U.S. within the last 5 years?  
   - [ ] Yes, from which country? [ ]
16. Have you had any visitors from outside the U.S.? [ ] Yes [ ] No  
   - Where were they from? ____________________________
17. Have you traveled to any other counties recently? Where?  
   - How long did you stay? ____________________________
18. Have you ever lived or worked in a group setting such as a hospital, nursing home, drug treatment center, homeless shelter, jail, or prison? [ ] Yes [ ] No

If you answered “yes” to any of the questions from 5 to 18, you may be at increased risk of having TB. If you answered “no” to all questions, you are not considered at higher risk for TB.

#### B. ASSESSMENT OUTCOME AND TB TEST (TO BE COMPLETED BY CLINICIAN) ADMINISTRATION

- Prior Documentation (or convincing history) of TB or LTBI:  
  - No TB test needed. Patient may still need evaluation for treatment for LTBI or active TB

**TB Risk Category (check one box only):**

- [ ] Medical risk factor (includes contacts to active TB cases)  
- [ ] Population risk factor  
- [ ] Administrative TB test required only for work, school, etc.

**Screening Test:**  

- [ ] TST (PPD) Mantoux  
- [ ] Blood Test (QuantIFEC, IGRA, etc.)

**Test Date:** / /

- Tuberulin lot number: ____________________________
- Expiration date: / /
- Date interpreted: / /
- Date reported: / / (Positive / Negative)
- Blood test IFN-γ concentration: (IU/ml)
- (Positive / Negative / Indeterminate)

**Two Step Testing for Health Care Workers (applicable only if initial TST was negative):**

- [ ] TB test Mantoux date: ____________________________
- Tuberulin lot number: ____________________________
- Expiration date: / /
- Date interpreted: / /
- Date reported: / / (Positive / Negative)

**PHYSICAL EXAM:**

- Date: / /  
- No signs of TB [ ]  
- Unusual, suggesting TB [ ]

**CHEST X-RAY:**

- Date: / /  
- Reading: [ ]

**OUTCOME (check one box only):**

- [ ] TB treatment prescribed  
- [ ] No treatment needed (not infected)  
- [ ] Treatment indicated (Low TB risk)  
- [ ] Treatment deferred due to [ ]
- [ ] Patient being evaluated as a TB suspect  
- [ ] Patient treated for LTBI  
- [ ] Previously treated for TB or LTBI  
- [ ] Other

**Follow-up/Comments (include treatment regimen):**

- Name (Print): ____________________________
- Signature: ____________________________
- Date: / /

Developed by NYC Bureau of Tuberculosis Control, March 2006

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Created by QIPMO, MU MDS and Quality Research Team, March 2021
1.6 **Antibiotic Stewardship in LTC Information Sheet**

>>[Link to tool]<<

**Antibiotic Stewardship in Nursing Homes**

**4.1 MILLION**
Americans are admitted to or reside in nursing homes during a year

**UP TO 70%**
of nursing home residents received antibiotics during a year

**UP TO 75%**
of antibiotics are prescribed incorrectly

CDC recommends **7 Core Elements**
for antibiotic stewardship in nursing homes

- Leadership Commitment
- Accountability
- Drug Expertise
- Action
- Tracking
- Reporting
- Education

---

1. Incorrectly prescribing the wrong drug, dose, duration or reason

---

Created by QIPMO, MU MDS and Quality Research Team, March 2021

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1.7 Missouri State-Contracted Laboratories

>>Link to tool<<

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING

NOTIFICATION OF STATEWIDE CONTRACT

Date: December 8, 2020

Contract Title: State and Community-Based COVID-19 Testing QVL

Current Contract Period: Effective Date of Contract through March 31, 2021

Buyer Information: Kelly Miller
(573) 751-4885
Kelly.Miller@oa.mo.gov

All purchases made under this contract must be for public use only.

Purchases for personal use by public employees or officials are prohibited.

The entire contract document may be viewed and printed from the Division of Purchasing's Awarded Bid & Contract Document Search located on the Internet at

http://oa.mo.gov/purchasing.
### CDC Environmental Checklist for Monitoring Terminal Cleaning

Date: 
Unit:  
Room Number:  
Initials of ES staff (optional):  

**Evaluate the following priority sites for each patient room:**

<table>
<thead>
<tr>
<th>High-touch Room Surfaces</th>
<th>Cleaned</th>
<th>Not Cleaned</th>
<th>Not Present in Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed rails / controls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tray table</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV pole (grab area)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call box / button</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Telephone</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bedside table handle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room sink</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room light switch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room inner door knob</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom inner door knob / plate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom light switch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom handrails by toilet</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bathroom sink</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet seat</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet flush handle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toilet bedpan cleaner</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Evaluate the following additional sites if these equipment are present in the room:**

<table>
<thead>
<tr>
<th>High-touch Room Surfaces</th>
<th>Cleaned</th>
<th>Not Cleaned</th>
<th>Not Present in Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV pump control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi-module monitor controls</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi-module monitor touch screen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Multi-module monitor cables</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ventilator control panel</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Mark the monitoring method used:**

- [ ] Direct observation  
- [ ] Swab cultures  
- [ ] Fluorescent gel  
- [ ] ATP system  
- [ ] Agar slide cultures

1 Selection of detergents and disinfectants should be according to institutional policies and procedures.  
2 Hospitals may choose to include identifiers of individual environmental services staff for feedback purposes.  
3 Sites most frequently contaminated and touched by patients and/or healthcare workers.
1.9 101 IDEAS FOR IN-ROOM ACTIVITIES

>>Link to tool<<
1.10 N95 Fit Testing Chart

>>[Link to tool]<<
1.11 BIOHAZARD AND WASTE MANAGEMENT

>>Link to tool<<

COVID-19 BIOHAZARD MANAGEMENT AND MEDICAL WASTE

For medical waste with potential or known COVID-19 contamination, manage like any other regulated medical waste. COVID-19 is not a Category A infectious substance. The Centers for Disease Control and Prevention (CDC) has determined that medical waste generated in the treatment of COVID-19 patients and patients under investigation (PUIs) be managed in accordance with routine procedures.

For regulated medical waste information, consult the regulated medical waste information in CDC’s Guidelines for Environmental Infection Control in Health-Care Facilities (2003). This document provides additional information related to the management of waste streams from hospitals and other healthcare facilities.

CDC also provides information on medical waste management as a question and answer page on its coronavirus website.

Does NOT go in Biohazard
- Beverage containers
- Ear speculums
- Examining table paper
- Food wrappers
- Paper
- Paper towels
- Patient gowns or drapes
- Tongue depressors

The only reason any of the above items should be placed in the red bags is if they have been soiled with blood or bodily fluid, including fecal material.

Goes in Biohazard
- Drapes, gauze, or other absorbent material used to soak up blood or body fluids
- Expired drugs, vaccines, control solutions and medications (excluding controlled prescription drugs)
- Gloves contaminated with blood or body fluids (including fecal material)
- Paper towels used to absorb blood or body fluids
- Swabs used for obtaining specimens of blood or body fluids
- Used fecal occult blood tests
- Used urinary catheters and Foley bags
- Used urine dipsticks
- Used urine pregnancy tests
- Used urine specimen cups after the urine is discarded – preferably in the toilet

REMINDER—ALL DESIGNATED SHARPS CONTAINERS MUST BE CLOSED BEFORE PLACING INTO THE BIOHAZARD BAG.

ONLY GROSSLY CONTAMINATED PPE SHOULD BE PLACED INTO RED BAGS.

Sources:
https://www.stericycle.com/covid-hub/packaging-guidance

Created by MU MDS and Quality Research Team, January 2021
1.12 QIPMO PPE Protocol

>>Link to tool<<

### PPE Protocol

<table>
<thead>
<tr>
<th>Who/Where</th>
<th>PPE Required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visitors</td>
<td>Cloth mask for outdoor or indoor visit with barrier in non-resident care area</td>
<td>Cloth mask for outdoor or indoor visit with barrier in non-resident care area</td>
</tr>
<tr>
<td></td>
<td>Full PPE for room visits in resident room/patient area through resident care area</td>
<td>Full PPE for room visits in resident room/patient area through resident care area</td>
</tr>
<tr>
<td>Administrative/Nurse Staff (nursing, non-nursing)</td>
<td>Cloth mask during times of no outbreak</td>
<td>Cloth mask during times of no outbreak</td>
</tr>
<tr>
<td></td>
<td>Surgical mask, gloves, as needed during times of no outbreak</td>
<td>Surgical mask, gloves, as needed during times of no outbreak</td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>Surgical mask, gloves, as needed during times of no outbreak</td>
<td>Surgical mask, gloves, as needed during times of no outbreak</td>
</tr>
<tr>
<td></td>
<td>Masks required to wear once PPE is removed</td>
<td>Masks required to wear once PPE is removed</td>
</tr>
</tbody>
</table>

### Resident in quarantine

<table>
<thead>
<tr>
<th>Who/Where</th>
<th>PPE Required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residents in quarantine</td>
<td>Full PPE (N95 face shield, goggles, gown, gloves, head, and face cover)</td>
<td>Full PPE (N95 face shield, goggles, gown, gloves, head, and face cover)</td>
</tr>
<tr>
<td></td>
<td>Mask required as a precautionary measure and we should be worn 24/7. (Include a space inside the resident's room between the resident and the outside of the door for dressing and undressing)</td>
<td>Mask required as a precautionary measure and we should be worn 24/7. (Include a space inside the resident's room between the resident and the outside of the door for dressing and undressing)</td>
</tr>
</tbody>
</table>

### Negative, asymptomatic residents (fever, coughing, consistent sneezing, GI problems, headaches, etc.)

<table>
<thead>
<tr>
<th>Who/Where</th>
<th>PPE Required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct care staff</td>
<td>Minimum surgical mask (PPE) to be worn at all times</td>
<td>Minimum surgical mask (PPE) to be worn at all times</td>
</tr>
<tr>
<td></td>
<td>Non-direct care staff should not interact with these residents during the time they are asymptomatic</td>
<td>Non-direct care staff should not interact with these residents during the time they are asymptomatic</td>
</tr>
</tbody>
</table>

### Suspected, unvaccinated residents (checking temperatures or transporting residents)

<table>
<thead>
<tr>
<th>Who/Where</th>
<th>PPE Required</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgical mask, face shield, gloves</td>
<td>Surgical mask, face shield, gloves</td>
<td>Surgical mask, face shield, gloves</td>
</tr>
<tr>
<td>Laundry service</td>
<td>Non-COVID materials: cloth mask, gloves as required</td>
<td>Non-COVID materials: surgical mask or N95 respirator, gloves, face shield</td>
</tr>
<tr>
<td>Dietary staff</td>
<td>Non-COVID materials: surgical mask or N95 respirator, gloves, face shield</td>
<td>Non-COVID materials: surgical mask or N95 respirator, gloves, face shield</td>
</tr>
<tr>
<td>Residents</td>
<td>Cloth mask as able to function</td>
<td>Reminders, masks, and respirators should be disinfected after use</td>
</tr>
<tr>
<td>During testing</td>
<td>These performing the tests: surgical mask, face shield, gown, gloves</td>
<td>These performing the tests: surgical mask, face shield, gown, gloves</td>
</tr>
</tbody>
</table>

### General Reminders:

1. Cloth and surgical masks should be designated for one person.
2. If possible, cloth masks should be kept and laundered at the facility for use on entering the building.
3. In the event of supply shortages, N95 and surgical masks may be reused but must be stored in individual open paper bags labeled with each person's name. These should not be reused if soiled or for longer than 1 week.
4. Masks are to be worn over the nose and mouth so that both are completely covered at all times.
5. ANYONE having contact with an active COVID case should be in full PPE.

### Notes:

Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility wide depending on the situation) is recommended when even a single case among residents or HCWs is newly identified in the facility.

### Sources:


### Videos on PPE from the CDC:

- [https://youtu.be/empMhJy2pE](https://youtu.be/empMhJy2pE)
- [https://www.youtube.com/watch?v=YITATb9jy4v](https://youtube.com/watch?v=YITATb9jy4v)

Created by QIPMO, MU MDS and Quality Research Team, March 2021
1.13 **Families First Coronavirus Act**

[>>Link to information<<](#)
1.14 SAMPLE COVID SIGNAGE

<<Link to tool>>

Help Keep our Residents Safe from COVID-19

A message from:

Dear Residents, Families, Friends, and Volunteers:

We are committed to keeping our residents safe and we need your help. The virus causing Coronavirus Disease 2019 (abbreviated COVID-19) can cause outbreaks in nursing homes. Many of our residents are elderly and may have medical conditions putting them at a very high risk of becoming sick, or even severely ill, with COVID-19. Vitron, and healthcare personnel (HCP) are the most likely source of introduction of the virus that causes COVID-19 into a facility.

To protect our vulnerable residents, even before COVID-19 is seen in our community, we are immediately taking the following aggressive actions to reduce the risk of COVID-19 in our residents and staff:

1. Effective immediately: We are restricting all visits.

All visits are being restricted except for certain compassionate care situations, such as end-of-life situations. Those visitors will be screened for fever and respiratory symptoms. We know that your presence is important for your loved one but, your guidance from the Centers for Disease Control and Prevention (CDC), this is a necessary action to protect their health. We are introducing alternative methods of visiting (such as Skype and Facetime) so that you can continue to communicate with your loved ones. Visitors who are permitted to enter the building will be required to frequently clean their hands, limit their visit to a designated area within the building, and wear a mask. As the situation with COVID-19 is rapidly changing, we will continue to keep you updated.

2. We are monitoring healthcare personnel and residents for symptoms of respiratory illness.

Non-essential healthcare personnel and volunteers are now restricted from entering the facility. Healthcare personnel will be actively monitored for fever and symptoms of respiratory infection. Ill healthcare personnel will be asked to stay home. You may see healthcare personnel wearing face masks, eye protection, gloves, and gowns in order to prevent germs from spreading and help keep residents safe. Healthcare personnel will clean their hands frequently.

We are assessing residents daily for fever, and symptoms of respiratory infection in order to quickly identify ill residents and implement additional infection prevention activities. When ill residents are identified, they will be monitored closely, asked to stay in their rooms or wear a mask.

3. We are limiting activities within the facility.

We are canceling all group activities within the building and all community outings. We will be helping residents to practice social distancing, including during meals, and to frequently clean their hands.

We encourage you to review the CDC website for information about COVID-19, including its symptoms, how it spreads, and actions you can take to protect your health: https://www.cdc.gov/coronavirus/2019-ncov/index.html

Thank you very much for everything you are doing to keep our residents and facility staff safe and healthy. We continue to monitor the situation in our community, we will keep you informed about any new precautions we think are necessary to keep your loved one safe. Please contact us with additional questions at:

Sincerely,

<<Link to tool>>

Stop the spread of germs that can make you and others sick!

Wash your hands often

Wear a mask

Cover your coughs and sneezes

Keep 6 feet of space between you and your friends

6 feet

2 jump ropes

cdc.gov/coronavirus

<<Link to tool>>

How to Take off a Mask

1. Carefully, untie the strings behind your head or stretch the ear loops

2. Handle only by the ear loops or ties

3. Fold outside corners together

4. Be careful not to touch your eyes, nose, and mouth when removing and wash hands immediately after removing

cdc.gov/coronavirus

Created by QiPOMO, MU MDS and Quality Research Team, March 2021

121 | P a g e
1.15  SBAR FOR COVID-19

>>Link to tool<<
1.16 DOCUMENTATION GUIDELINES FOR COVID-19

**DOCUMENTATION GUIDELINES FOR RESIDENTS WITH POSITIVE OR SUSPECTED CASES OF COVID-19**

Sources:

Q 4 HOURS

**Symptoms**
- Temperature: remember to monitor for fluctuations from their baseline
- Respiratory rate
- Pulse ox on room air and/or on oxygen (note how many liters and by what method)
- Pulse
- BP

**Attitudes/Perceptions/Covert Symptoms**
- Unusual fatigue or malaise: "If sleeping a lot more than usual, chart this! And remember, sleep is healing"
- Headache
- Chills
- Sore muscles
- Skin color—are they pale, is there is a pallor or whiteness to their skin (particularly face and chest)?
- Lip color—if the lips are cyanotic, get oxygen ASAP and follow the TBAK immediately transport may be necessary
- Loss of taste or smell

**Constitutional**
- Skin color, particularly of lower extremities, including toes
- Edema to extremities
- Check for signs/symptoms of DVT and PE: *this is a common factor in patients with COVID and a common cause of death in COVID-19 deaths*

**Respiratory Status**
- Cough
  - Dry/wet
  - Productive/nonproductive
- Lung sounds: Listen posteriorly and anteriorly (here’s a video if you need a refresher [https://www.youtube.com/watch?v=6kM6m810YIY](https://www.youtube.com/watch?v=6kM6m810YIY))
  - Rhonchi
  - Wheezing
  - Fine/coarse crackles
- Sore throat
- Runny nose
- Congestion: "are they clearing their throat often?"
  - G/C/S
  - Nasal/oral l Spit

**Key Management Strategies**
- Frequent monitoring. Patients with this disease can decline very quickly. Know their baseline.
- Provide supplemental oxygen to keep O2 saturation >94%.
- Let the physician know about any corticosteroids the patient may be taking. This is counterproductive to treatment in some cases.

Remember, documentation will play a big part in appropriate care and treatment and also later reinforcement of that care. It’s important to assess and document thoroughly and accurately, at least daily. Symptomatic COVID positive or suspected positive should be assessed and documented more frequently, at minimum every 4 hours.

Created by MU MDS and Quality Research Team, March 2021
1.17 FACILITY NOTIFICATION REQUIREMENTS

>>Link to tool<<

CMS-5531-IFC § 483.80(g)(3)-New Onset: Notification Requirements to Residents, Representatives and Families

- Single confirmed infection of COVID-19.
- Three or more residents or staff with new onset of respiratory symptoms that occur within 72 hours of each other.

Inform residents, representatives and families by 5:00 pm the next calendar day.

CMS-5531-IFC § 483.80(g)(3)-Subsequent Occurrence: Weekly Cumulative Notification Requirements to Residents, Representatives and Families

- Each time a subsequent confirmed infection of COVID-19 occurs.
- Each time three or more residents or staff with new onset of respiratory symptoms that occur within 72 hours of each other.

Inform residents, representatives and families by 5:00 pm the next calendar day with weekly cumulative updates following the subsequent occurrence.

Information must not include personally identifiable information. Facilities must include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations in the nursing home will be altered such as restrictions or limitations to visitation or group activities. For purposes of this reporting requirement, facilities are not expected to make individual telephone calls. Instead, facilities can utilize communication mechanisms that make this information easily available to all residents, their representatives, and families, such as paper notification, listservs, website postings, and/or recorded telephone messages.
1.18 COVID-19 EMERGENCY DECLARATION WAIVERS, MDS CODING FOR COVID-19, AND COVID-19 CARE PLANS

Emergency Waivers
COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

MDS Coding for COVID-19

J12.82 - Pneumonia due to COVID-19
M35.81 - Multisystem Inflammatory Syndrome
M35.89 - Other specified systemic involvement of connective tissue
Z11.52 - Encounter for screening for COVID-1 (Note: Per ICD-10-CM coding guidelines, this code should NOT be used during the pandemic)
Z20.822 - Contact with and suspected exposure to COVID-19
Z86.16 - Personal History of COVID-19
U07.1 – Active COVID-19 infection

These new codes are typically expected to be used as secondary diagnosis codes to describe COVID-19 status or secondary or associated manifestations of COVID-19. When COVID-19 meets the definition of the principal diagnosis on the claim or reason for SNF stay in MDS item I0020B, then code U07.1 should continue to be used for that purpose.

Additional information and guidelines can be found at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/NHQIMDS30TechnicalInformation

COVID Care Plans
COVID should be included into every care plan. The following table lists those conditions that are considered high-risk for COVID-19 and should be included in the care plans for these residents particularly.

<table>
<thead>
<tr>
<th>COVID</th>
<th>Following conditions might be at increase risk for severe illness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any age are at increase risk of severe illness</td>
<td>Following conditions might be at increase risk for severe illness</td>
</tr>
<tr>
<td>Cancer</td>
<td>Asthma</td>
</tr>
<tr>
<td>Chronic kidney disease</td>
<td>Cerebrovascular disease</td>
</tr>
<tr>
<td>COPD</td>
<td>Cystic fibrosis</td>
</tr>
<tr>
<td>Immunocompromised</td>
<td>HTN</td>
</tr>
<tr>
<td>Obesity</td>
<td>Immunocompromised</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Neurological conditions</td>
</tr>
<tr>
<td>Sickle cell disease</td>
<td>Liver disease</td>
</tr>
<tr>
<td>DM Type 2</td>
<td>Pregnancy</td>
</tr>
<tr>
<td>Pulmonary fibrosis</td>
<td>Smoking</td>
</tr>
<tr>
<td>Thalassemia</td>
<td>DM Type 1</td>
</tr>
</tbody>
</table>
The following examples are ideas for person-centered care plans related to COVID-19, including isolation. If a resident IS on isolation, make sure you address the activities and accommodations you are providing during that time.

**COVID Person Centered Care Plan**

I have tested positive for Coronavirus but am not showing any symptoms at this time. I will be in droplet isolation for the next 14 days. Assess for COVID symptoms like fever, cough, shortness of breath or trouble breathing, headache, loss of taste or smell, congestion or runny nose, nausea or vomiting, new confusion or diarrhea. Please let my nurse know if any of these occur.

Re-educate me on why I am in isolation and remind me on how long I must be in isolation. I have a history of depression and feel like I am headed down that road again. Please provide virtual opportunities for me to visit with my family. I need assistance on putting on my mask and washing my hands. I like to keep busy with watching TV shows like NCIS and mystery shows. Christian and instrumental music helps me cope with COVID. I do enjoy 1:1 visits for conversation, manicures and reading with staff.

**COVID Person Centered Care Plan**

I have COVID-19 and am experiencing respiratory complications that require oxygen right now. I do not feel like drinking much right now so I am at risk for dehydration. I want to be comfortable and will not have pain above a 4 and maintain my oxygen saturation above 90%.

I am on droplet isolation precautions. Encourage me to turn, cough and deep breath and use my incentive spirometer. I do use a CPAP at night and will need assistance with putting on and off the face mask and turning on the machine. Check my oxygen saturation at least every 4 hours. Let my nurse know if it falls below 90%.

Encourage me to drink plenty of water with each staff interaction. I prefer to drink hot chocolate, apple juice and water.

I have chest and lung pain and can do the pain scale of 1-10. It has been about a 3-4 most of the time. I do not like to take medication so I may like a steam shower because this makes me feel better. I need extra rest right now so do not be surprised if I am in bed more often right now.
1.19 QIPMO ICAR Team

Contact us at: https://nursinghomehelp.org/icar-project/icar-team/
1.20  QIPMO CAT TEAM

2020 REOPENING OF LONG-TERM CARE IN MISSOURI

On behalf of the University of Missouri’s QIPMO team and MO DHSS… welcome to the launch of the 2020 reopening of long-term care! The first half of the year has been extremely challenging, arduous, and unfamiliar to all of us; we all had to just jump in feet-first to this whole new, unknown world. Now we all have to adjust to that world. (Any volunteers as tributes?!) Thankfully, we’re in this together.

Most of the SNFs and ICFs know and are familiar with the QIPMO team, and DHSS has asked us to expand our program to aide ALFs and RCFs in reopening under the State’s guidelines. There are three phases that MO’s LTC facilities will be progressed through in order to ease restrictions in your facilities. You can find the full guidance from MO DHSS HERE.

The “usual” QIPMO team of nurses and leadership coaches will always be available for assistance, but we’ve added a couple new (and returning!) team members to our new CAT group – the COVID Accountability Team. Please, please feel free to directly contact your “representative”. We’re ready, we’re willing, and we want to help!

Below you’ll find the contact information for SNFs (including hospital SNFs) and ICFs (you can reach out to your regional QIPMO nurse and/or leadership coach):

- Region 1 – Melody Schrock, Nicky Martin, and/or Mark Francis
- Region 2 – Wendy Boren and/or Nicky Martin
- Regions 3 and 4 – Katy Nguyen and/or Mark Francis
- Regions 5 and 6 – Crystal Plank, Nicky Martin, and/or Libby Youse
- Region 7 – Debbie Pool and/or Nicky Martin

Below you’ll find the contact information for ALFs and RCFs:

- Regions 1 and 2 – Rob Siem
- Regions 3, 4, and 5 – Sharon Thomas
- Regions 6 and 7 – Carol Siem

Please attend our joint webinar with the administrator of the DHSS Section for LTC Regulation, Shelly Williamson, on Friday, 7/10 at 10:30am. The replay is located here!

This does not apply to swing beds – please contact the Bureau of Hospital Standards at (573) 751-6303 for questions.

For more resources, visit QIPMO’s COVID-19 page.

Contact us at: https://nursinghomehelp.org/qipmo-program/team/
**RESOURCES**


Center for Medicare and Medicaid Services: [www.cms.gov](https://www.cms.gov)


Missouri Department of Health and Senior Services: [https://health.mo.gov/](https://health.mo.gov/)

Missouri Healthcare Association: [https://www.mohealthcare.com/](https://www.mohealthcare.com/)

MO COVID-10 Dashboard: [https://showmestrong.mo.gov/data/public-health/](https://showmestrong.mo.gov/data/public-health/)

QIPMO: [www.nursinghomehelp.org](https://www.nursinghomehelp.org)

Show-Me ECHO: [https://showmeecho.org/](https://showmeecho.org/)

Society for Post-Acute and Long-term Care Medicine: [https://paltc.org/](https://paltc.org/)
