This draft pilot worksheet does not reflect current CMS policy and will not be used during current surveys. The questions on the worksheet reflect new regulatory language and will be tested during pilot surveys that will not result in citations. There is no CMS commitment to use this tool, or any version, on future surveys after the regulatory language is implemented.

NAME OF SURVEYOR AND CREDENTIALS	
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Draft Centers for Medicare and Medicaid Services
Pilot Long Term Care (LTC) Infection Control Worksheet

The following is a list of questions that will be used to assess infection prevention and control during 40 pilot on-site surveys, in order to develop policy for federal regulatory compliance with the Infection Prevention and Control Conditions of Participation in LTC facilities. The infection prevention and control program will be evaluated through a combination of observations; interviews with staff, residents and their family/support persons; review of medical records and pertinent infection control program documentation.

For these educational pilot surveys, surveyors will be reviewing ***all*** program documentation for which the worksheet prompts. Additionally, the facilities chosen for survey will be large and diverse enough to provide opportunity for surveyors to observe ***all*** care required to adequately answer worksheet questions. This approach is for testing purposes only and does not prohibit the surveyors from utilizing other information gathering processes if further investigation is needed to address areas of concern.

As stated in the SC17-09 policy memorandum released on November 18, 2016; while no citations will be issued, if an Immediate Jeopardy deficiency is noted, a referral to the CMS Regional Office will be made.

Note: Significant breaches of infection control practices or an immediate jeopardy finding would require notification of state health department or CMS Regional Office.

The assessment reviews the following domains:

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

Facility Information

LTC Facility Name:	
CMS Certification Number	☐☐☐ ☐☐☐
Start date/time:	____/____/____ and _____AM/PM
End date/time:	____/____/____ and _____AM/PM

Section A	Infection Prevention and Control Program (IPCP) Infrastructure	Assessments	Comments
A.1.	The facility has written infection prevention and control policies and procedures which are based on current nationally recognized evidence-based guidelines (e.g., CDC/HICPAC), regulations or standards for its Infection Prevention and Control Program (IPCP).	□ Yes □ No	
A.2.	The facility has evidence of mandatory personnel infection prevention and control training which includes the IPCP written standards, policies, and procedures.	□ Yes □ No	
A.3.	The facility has documentation of a facility infection control risk assessment conducted according to infection control professional organizations (e.g. APIC, SHEA) guidelines.	□ Yes □ No	
A.4.	Facility has documentation of an **annual** review of the IPCP using a risk assessment of both facility and community risks, and updates the program as necessary.	□ Yes □ No	
Section B	**Infection Preventionist**	**Assessments**	**Comments**
B.1.	The facility has designated one or more individuals with specialized training in infection prevention and control as the Infection Preventionist (IP). This individual works at least part-time in the facility. ***Examples of specialized training may include: Successful completion of initial and/or recertification exams developed by the Certification Board for Infection Control & Epidemiology; Participation in infection control courses organized by the state or recognized professional societies (e.g., APIC, SHEA).***	□ Yes □ No	
B.2.	There is written evidence that the IP is a member of the facility's quality assessment and assurance committee and reports to the committee on a regular basis.	□ Yes □ No	
Section C	**Quality Assessment and Assurance (QAA) Committee**	**Assessment**	**Comments**
C.1.	The IP has provided documentation of incidents of communicable disease and infections identified under the facility's IPCP to the QAA Committee.	□ Yes □ No	
C.2.	The facility's written QAA Committee plan includes monitoring and evaluation of the activities of the IPCP.	□ Yes □ No	

C.3.	There is evidence that the QAA Committee develops plans of action to address incidents of communicable disease identified during review of infection surveillance, staff adherence to infection prevention practices, and antibiotic stewardship data provided by the IP.	□ Yes □ No	
C.4.	Adverse events related to breaches in infection prevention practices are analyzed using root cause analysis (RCA) in order to promote sustainable practice improvements throughout the facility.	□ Yes □ No □ N/A	
Section D	**Infection Surveillance** http://www.cdc.gov/nhsn/ltc/	**Assessment**	**Comments**
D.1.	The facility has a written surveillance plan, based on the risk assessment, outlining activities for monitoring/tracking infections occurring in residents of the facility.	□ Yes □ No	
D.2.	The facility has system in place for early detection and management of potentially infectious symptomatic residents at the time of admission, including implementation of precautions as appropriate ***Examples: Documenting recent antibiotic use, and history of infections or colonization with C. difficile or antibiotic-resistant organisms.***	□ Yes □ No	
D.3.	The facility has a system in place (e.g., notification of IP by clinical laboratory) for early detection and management of potentially infectious symptomatic residents, including implementation of precautions as appropriate.	□ Yes □ No	
D.4.	The facility surveillance practices include: a. Use of published surveillance criteria (e.g., 2012 CDC National Healthcare Safety Network (NHSN) Long Term Care Criteria) to define infections. b. Use of a data collection tool. c. Periodic update to QAA (e.g. quarterly). d. Follow-up activity in response to surveillance data (e.g. outbreaks). e. Report summarizing surveillance data annually.	□ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No □ Yes □ No	
D.5.	The facility has a current list of communicable diseases which are reportable to local/state public health authorities.	□ Yes □ No	
D.6.	The facility can demonstrate knowledge of when and to whom to report communicable diseases, healthcare associated infections (as appropriate), and potential outbreaks.	□ Yes □ No	
Section E	**Antibiotic Stewardship Programs** http://www.cdc.gov/longtermcare/prevention/antibiotic-stewardship.html	**Assessments**	**Comments**
E.1.	The facility has an antibiotic stewardship program that has been approved by the governing body (e.g. facility administrator and facility leadership) to improve antibiotic use.	□ Yes □ No	

E.2.	The facility has identified one or more clinical leaders accountable for antibiotic stewardship-related duties as per their position description (e.g. nursing director, medical director, or consultant pharmacist).	□ Yes □ No	
E.3.	The facility has written protocols on antibiotic prescribing. ***Note: The intent is to verify appropriateness based on clinical indications and laboratory findings, duration of use, and national standards.***	□ Yes □ No	
E.4.	The facility uses infection assessment tools or management algorithms for antibiotic use for one or more infections. *Examples: Use of an SBAR tool for UTI assessment, application of the Loeb minimum criteria for initiation of antibiotics.*	□ Yes □ No	
E.5.	The facility has a report summarizing antibiotic use from pharmacy data created within last 6 months. *Note: Report could include number of new starts, types of drugs prescribed, or number of days of antibiotic treatment per 1,000 resident days.*	□ Yes □ No	
E.6.	The facility has a report summarizing antibiotic resistance (i.e. antibiogram) based on laboratory data created within the past 24 months.	□ Yes □ No	
E.7.	The facility clinical leadership (e.g. medical director or director of nursing) provides clinical prescribers with feedback about their antibiotic prescribing practices.	□ Yes □ No	
E.8.	The facility clinical leadership (e.g. medical director or consulting pharmacist) has provided training on antibiotic use (stewardship) to all nursing staff and clinical providers with prescribing privileges within the last 12 months.	□ Yes □ No	
E.9.	The facility has educational materials on antibiotic stewardship for residents and families.	□ Yes □ No	
Section F	**Hand Hygiene**	**Assessments**	**Comments**
F.1.	***The facility hand hygiene policies promote preferential use of alcohol-based hand rub (ABHR) over soap and water in most clinical situations.*** ***Note: Soap and water should be used when hands are visibly soiled (e.g., blood, body fluids) and is also preferred after caring for a patient with known or suspected C. difficile or norovirus during an outbreak, or if rates of C. difficile infection in the facility are persistently high.***	□ Yes □ No	
F.2.	All personnel receive training **and competency** validation on HH at the time of employment.	□ Yes □ No	
F.3.	All personnel receive training and **competency validation** on HH at least every 12 months.	□ Yes □ No	

F.4.	The facility audits (monitors and documents) HH adherence and provides feedback among the following: a. Nursing staff including RNs, LPN, and CNAs b. Therapy staff (e.g., PT, OT, speech) c. Clinical staff including physicians, NPs, PAs d. Dietary and nutrition including food-preparers e. Environmental services personnel f. Contract staff (e.g. dialysis staff, physical therapy, respiratory therapy, phlebotomy)		
F.5.	Facility has written and implemented a resident HH policy (e.g. HH performed immediately before meals).	□ Yes □ No	
	Hand Hygiene Tracer Hand hygiene is performed in a manner consistent with the LTC facility infection control practices, policies, and procedures to maximize the prevention of infection and communicable disease including the following: ***Note: Observations for compliance with hand hygiene elements should be assessed throughout the facility.***		
F.6.	Soap, water, and a sink are readily accessible in appropriate locations including, but not limited to, resident care areas, food and medication preparation areas. ***Note: Resident care supplies should be protected from splashing water if located close to sinks.***	□ Yes □ No	
F.7.	Alcohol-based hand rub is readily accessible and placed in appropriate locations. Some examples may include: • Entrances to resident rooms, • At the bedside (as appropriate for resident population), • In individual pocket-sized containers carried by healthcare personnel, • Staff work station, and/or • Other convenient locations	□ Yes □ No	
F.8.	Personnel perform hand hygiene (even if gloves are used): • Before contact with the resident • Before performing an aseptic task (e.g. insertion of an invasive device (e.g. urinary catheter)	□ Yes □ No	
F.9.	Personnel perform hand hygiene: • After contact with the resident • After contact with blood, body fluids, or visibly contaminated surfaces • After contact with objects and surfaces in the resident's environment • After removing personal protective equipment (e.g., gloves, gown, facemask)	□ Yes □ No	

F.10.	When being assisted by healthcare personnel, resident hand hygiene is performed: • Prior to resident leaving room if on transmission-based precautions • After toileting • Before meals	□ Yes □ No	
Section G	**Standard Precautions Tracer**	**Assessments**	**Comments**
G.1.	Supplies necessary for adherence to proper PPE use (e.g., gloves, gowns, masks) are readily accessible in resident care areas (i.e., nursing units, therapy rooms).	□ Yes □ No	
G.2.	Gloves are worn if there is contact with blood or body fluid, mucous membranes, or non-intact skin.	□ Yes □ No	
G.3.	Gloves are removed after contact with blood or body fluids, mucous membranes, or non-intact skin.	□ Yes □ No	
G.4.	Gloves are changed and hand hygiene performed before moving from a contaminated-body site to a clean-body site during resident care.	□ Yes □ No	
G.5.	Gown are worn for direct resident contact if the resident has uncontained secretions or excretions.	□ Yes □ No □ N/A	
G.6.	Facemasks are worn if contact with residents with new acute cough or respiratory symptoms (e.g. influenza-like illness).	□ Yes □ No □ N/A	
G.7.	Appropriate mouth, nose and eye protection (e.g., facemasks, face shield) is worn for performing aerosol-generating and/or procedures that are likely to generate splashes or sprays of blood or body fluids.	□ Yes □ No □ N/A	
G.8.	PPE is appropriately discarded after resident care prior to leaving room, followed by hand hygiene.	□ Yes □ No	
Section H	**Transmission Based Precautions**	**Assessments**	**Comments**
H.1.	The facility has policies and procedures for transmission-based precautions (i.e. Contact Precautions, Droplet Precautions, Airborne Isolation Precautions) to be followed to prevent spread of infections; which includes selection and use of PPE (e.g., indications, donning/doffing procedures) and specifies the clinical conditions for which specific PPE should be used (e.g., C. difficile, Influenza).	□ Yes □ No	
H.2.	Residents with known or suspected infections, or with evidence of symptoms that represent an increased risk for transmission, are placed on the appropriate transmission based precautions. Note: Resident placement (e.g. single/private room or cohorted) is made on an individual case basis based on presence of risk factors for increased likelihood of transmission (e.g. uncontained drainage, stool incontinence). Note: Facility should have a process to manage residents on transmission based precautions when no single/private room is available.	□ Yes □ No	

H.3.	The facility limits the movement of residents (in accordance with policies) on transmission-based precaution with active symptoms (diarrhea, nausea and vomiting, draining wounds that cannot be contained for highly infectious diseases (e.g. norovirus, C difficile)) outside of their room for medically necessary purposes only.	□ Yes □ No	
H.4.	Facility has written policies and procedures to ensure that after resident discharge, all visibly or potentially contaminated surfaces are thoroughly cleaned and disinfected, and all linens and towels (e.g. textiles) are replaced. Note: Privacy curtains should be changed or cleaned with an EPA registered disinfectant after discharge.	□ Yes □ No	
	Transmission Based Precautions Tracer	**Assessments**	**Comments**
H.5.	Signs indicating a resident is on transmission-based precautions are clear and visible.	□ Yes □ No □ N/A	
H.6.	Staff are able to successfully verbalize the transmission based precautions required before entering a resident's room.	□ Yes □ No □ N/A	
H.7.	Hand hygiene is performed before entering resident care environment.	□ Yes □ No □ N/A	
H.8.	Gloves and gowns are donned upon entry into the environment (e.g. room or cubicle) of resident on Contact Precautions.	□ Yes □ No □ N/A	
H.9.	Dedicated or disposable noncritical resident-care equipment (e.g., blood pressure cuffs) is used, or if not available, then equipment is cleaned and disinfected according to manufacturers' instructions prior to use on another resident.	□ Yes □ No □ N/A	
H.10.	Gloves and gowns are removed and properly discarded, and hand hygiene is performed before leaving the resident care environment. ***Note: Although preferred for most clinical circumstances, ABHR is not appropriate when hands are visibly soiled (e.g., blood, body fluids) or after caring for a resident with known or suspected C. difficile or norovirus during an outbreak or if endemic rates of C. difficile infection (CDI) are high. In these circumstances, soap and water should be used.***	□ Yes □ No □ N/A	
H.11.	In rooms with residents on Contact Precaution, objects and environmental surfaces that are touched frequently (e.g., bed rails, over-bed table, bedside commode, lavatory surfaces in resident bathrooms) are cleaned and disinfected with an EPA-registered disinfectant for healthcare use at least daily and when visibly soiled.	□ Yes □ No □ N/A	
Section I	**Injection Practices and Sharps Safety (Medications and Infusates) Tracer**	**Assessments**	**Comments**
I.1.	Appropriate personnel receive training **and competency validation** on injection safety procedures at time of employment.	□ Yes □ No	
I.2.	Appropriate personnel receive training **and competency validation** on injection safety procedures at least every 12 months.	□ Yes □ No	

I.3.	The facility audits (monitors and documents) and provides feedback to personnel regarding their adherence to injection safety practices ***Note: If yes, facility should provide documentation of audits.***	□ Yes □ No	
I.4.	The facility has policies and procedures to monitor and track personnel with access to injectable controlled substances to prevent potential transmission of infections secondary to contamination of syringes and medication vials. Note: this question highlights the relationship between narcotics theft/drug diversion and contaminated syringes and medication vials.	□ Yes □ No	
I.5.	Injections are prepared using clean (aseptic) technique in an area that has been cleaned and is free of contamination (e.g., visible blood, or body fluids). ***Note: Clean technique includes performing hand hygiene before injection or medication preparation.***	□ Yes □ No □ Unable to observe	
I.6.	Needles are used for only one resident.	□ Yes □ No	
I.7.	Syringes are used for only one resident (this includes manufactured prefilled syringes).	□ Yes □ No	
I.8.	Insulin pens are used for only one resident.	□ Yes □ No	
I.9.	The rubber septum on any mediation vial, whether unopened or previously accessed, are disinfected with alcohol prior to piercing	□ Yes □ No N/A	
I.10.	Medication vials are entered with a new needle. ***Note: Reuse of syringes and/or needles to enter a medication vial contaminates the contents of the vial, making the vial unsafe for use on additional residents. If a surveyor sees needles being reused to enter a vial to obtain additional medication for the same patient, no citation should be made if the vial is discarded immediately.***	□ Yes □ No N/A	
I.11.	Medication vials are entered with a new syringe. ***Note: Reuse of syringes and/or needles to enter a medication vial contaminates the contents of the vial, making the vial unsafe for use on additional residents. If a surveyor sees syringes being reused to enter a vial to obtain additional medication for the same patient, no citation should be made if the vial is discarded immediately.***	□ Yes □ No □ Unable to observe	
I.12.	Medication vials labeled for single dose – single use is only used for one resident.	□ Yes □ No	
I.13.	Bags of IV solutions are used for only one resident (and not as a source of flush solution for multiple residents).	□ Yes □ No	
I.14.	Medication administration tubing and connectors are used for only one resident.	□ Yes □ No	

I.15.	Multi-dose medication vials are dated when they are first opened and discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that opened vial. ***Note: The beyond-use date is different from the expiration date for the vial. The multi-dose vial can be dated with either the date opened or the discard date as per facility policy, as long as it is clear what the date represents and the same policy is used consistently throughout the facility.***	□ Yes □ No	
I.16.	Multi-dose medication vials used for more than one resident are stored appropriately and do not enter the immediate resident care area (e.g. procedure rooms, resident room). ***NOTE: If multi-dose vials enter the immediate resident care area, they must be dedicated for single resident use and discarded immediately after use***.	□ Yes □ No □ Unable to observe	
I.17.	All sharps are disposed of in puncture-resistant sharps containers.	□ Yes □ No	
I.18.	Sharps containers are replaced when the fill line is reached.	□ Yes □ No	
I.19.	Sharps containers are disposed of appropriately as medical waste.	□ Yes □ No	
Section J	**Point Of Care Devices (e.g. Blood Glucose Meter, INR Monitor) Tracer**	**Assessment**	**Comments**
J.1	Appropriate personnel receive training **and competency validation** on point of care testing procedures (e.g. during assisted blood glucose monitoring) at time of employment.	□ Yes □ No	
J.2.	Appropriate personnel receive training **and competency validation** on point of care testing procedures (e.g. during assisted blood glucose monitoring) at least every 12 months.	□ Yes □ No	
J.3.	Supplies necessary for adherence to safe point of care testing (e.g., single-use, auto-disabling lancets, sharps containers) are readily accessible in resident care areas.	□ Yes □ No	
J.4.	Hand hygiene is performed before and after the procedure for each resident.	□ Yes □ No	
J.5.	Gloves are worn by healthcare personnel when performing the finger stick procedure to obtain the sample of blood, and are removed after the procedure (followed by hand hygiene).	□ Yes □ No	
J.6.	Finger stick devices are not used for more than one resident. ***Note: This includes both the lancet and the lancet holding device.***	□ Yes □ No	

J.7.	If used for more than one resident, the point-of-care testing device (e.g., blood glucose meter, INR monitor) is cleaned and disinfected after every use according to manufacturer's instructions. ***Note: if manufacturer does not provide instructions for cleaning and disinfection, then the device should not be used for >1 resident.***	□ Yes □ No	
J.8.	The facility has protocols for performing finger sticks and point of care testing (e.g., assisted blood glucose monitoring)	□ Yes □ No	
J.9.	The facility audits (monitors and documents) and provides feedback to personnel regarding their adherence to point of care testing practices ***Note: If yes, facility should provide documentation of audits.***	□ Yes □ No	
Section K	**Central Venous Line/Catheters: Accessing and Maintenance Tracer**	**Assessment**	**Comments**
K.1.	The facility provides evidence that only properly trained personnel who demonstrate competence for access and maintenance of central venous catheters are given this responsibility. ***Mark N/A if facility does not accept residents with a central line and then skip the remainder of K.2.-K.9.***	□ Yes □ No □N/A	
K.2.	If the facility accepts residents with central lines, the expectation is that observations would be made. If no observations were available, the surveyors is to skip questions 2 through 9.	□ No observations available	**Must document why not:**
K.3.	Central venous line/catheter insertion date and indication are documented.	□ Yes □ No	
K.4.	Hand hygiene is performed before and after manipulating catheter.	□ Yes □ No	
K.5.	Central line dressings are observed to be clean, dry, and intact.	□ Yes □ No	
K.6.	Dressing is changed with clean (aseptic) technique using clean gloves or sterile gloves.	□ Yes □ No	
K.7.	Access port is scrubbed with an appropriate antiseptic (chlorhexidine, povidone iodine, iodophor, or 70% alcohol) prior to accessing.	□ Yes □ No	
K.8.	Catheter is accessed only with sterile devices.	□ Yes □ No	
K.9.	Residents with central venous catheters are assessed regularly to determine continued need for the catheter and this assessment is documented in the medical record. (The central line is promptly removed when no longer needed.)	□ Yes □ No	
Section L	**Indwelling Urinary Catheters Tracer**	**Assessment**	**Comments**

L.1.	The attending physician/practitioner has provided a written rationale for the use of a urinary catheter consistent with evidence-based guidelines (e.g. acute urinary retention, bladder outlet obstruction, neurogenic bladder or terminally ill for comfort measures). ***Note: 483.25(e)(2)(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that the catheterization was necessary.***	□ Yes □ No	
L.2.	There is evidence that only trained personnel who have demonstrated competency are given the responsibility of inserting urinary catheters.	□ Yes □ No	
L.3.	Catheter is secured properly.	□ Yes □ No	
L.4.	Catheter insertion date and indication are documented.	□ Yes □ No	
Section M	**Urinary Catheter Access and Maintenance Tracer:**	**Assessment**	**Comments**
M.1.	The facility provides evidence that only trained personnel who have demonstrated competency are given the responsibility of maintaining urinary catheters.	□ Yes □ No	
M.2.	Hand hygiene is performed before and after manipulating the urinary catheter and gloves are worn.	□ Yes □ No N/A	
M.3.	Urine collection bag is kept below the level of the bladder and off the floor at all times.	□ Yes □ No	
M.4.	Urinary catheter tubing is unobstructed and free of kinking.	□ Yes □ No	
M.5.	Urine bag is emptied using a separate, clean collection container for each resident; drainage spigot does not touch collecting container.	□ Yes □ No	
M.6.	Urine samples are obtained via needleless port and not obtained from the collection bag.	□ Yes □ No N/A	
M.7.	Residents with indwelling urinary catheters are assessed regularly for continued need for the catheter, and the need is documented. The attending physician/practitioner has documented a valid clinical indication for the use of the catheter and ongoing assessment and orders for the removal when the clinical condition demonstrates that catheterization is no longer necessary. The written rationale for the use of a urinary catheter is consistent with evidence-based guidelines (e.g. acute urinary retention, bladder outlet obstruction, neurogenic bladder or terminally ill for comfort measures).	□ Yes □ No □ Yes □ No	
Section N	**Respiratory Therapy Tracer**	**Assessment**	**Comments**
N.1	If no observations available for respiratory therapy, skip questions 1 through 8.	□ No observations available	

N.2.	Hand hygiene is performed before and after contact with a resident or any respiratory equipment used on the resident.	□ Yes □ No	
N.3.	Gloves are worn when in contact with respiratory secretions and changed before contact with another resident, object, or environmental surface.	□ Yes □ No	
N.4.	Only sterile solutions (e.g. water or saline) are used for nebulization.	□ Yes □ No	
N.5.	Single-dose vials for aerosolized medications are not used for more than one resident.	□ Yes □ No	
N.6.	If multi-dose vials for aerosolized medications are used, manufacturers' instructions for handling, storing, and dispensing the medications are followed.	□ Yes □ No □N/A	
N.7.	If multi-dose vials for aerosolized medications are used for more than one resident, they are stored appropriately and do not enter the immediate resident treatment area.	□ Yes □ No □N/A	
N.8.	Jet nebulizers are for single resident use and are cleaned and stored as per facility policy, rinsed with sterile water, and air-dried between treatments on the same resident. ***Note: Mesh nebulizers which remain in the ventilator circuit and are not cleaned or disinfected are changed at an interval recommended by manufacturer's instructions. Nebulizers/drug combination systems are cleaned and disinfected according to the manufacturer's instructions.***	□ Yes □ No □N/A	
N.9.	The head of the bed is elevated at an angle of 30-45^{o,} in the absence of medical contraindications, for residents at high risk for aspiration (e.g. resident with an enteral tube in place).	□ Yes □ No □N/A	
Section O	**Wound Management Tracer**	**Assessment**	**Comments**
O.1.	Hand hygiene is performed before a wound procedure.	□ Yes □ No	
O.2.	Gloves are worn during the dressing procedure.	□ Yes □ No	
O.3.	A gown is worn if healthcare personnel contamination is anticipated during the dressing procedure (e.g. excessively draining wounds).	□ Yes □ No □ N/A	
O.4.	Reusable dressing care equipment (e.g., bandage scissors) must be cleaned and reprocessed (i.e., disinfected or sterilized according to manufacturer's instructions) if shared between residents. Refer to current CDC guidelines CDC Guideline for Disinfection and Sterilization in Healthcare Facilities,2008 https://www.cdc.gov/hicpac/Disinfection_Sterilization/6_0disinfection.html	□ Yes □ No	

O.5.	Clean wound dressing supplies are handled in a way to prevent cross contamination between residents (e.g. wound care supply cart which remains outside of resident care areas; unused supplies are discarded or remain dedicated to resident).	□ Yes □ No	
O.6.	The dressing change is conducted per physician/practitioner orders.	□ Yes □ No	
O.7.	Multi-dose wound care medications (e.g., ointments, creams) should be dedicated to one resident whenever possible. ***NOTE: If multi-dose wound care medications (e.g., ointments, creams) are used for more than one resident, then the medications should be stored in a central medication area and should not enter the resident treatment area. For example, a small aliquot of medication should be dispensed into a clean container for single-resident use***.	□ Yes □ No	
O.8.	Gloves are removed and hand hygiene is performed immediately after the procedure.	□ Yes □ No	
O.9.	Wound care documentation in resident's medical record reflects the condition of the wound and includes the following: a. Type of dressing b. Frequency of dressing change c. Wound description (e.g., measurement, characteristics)	 □ Yes □ No □ Yes □ No □ Yes □ No	
Section P	**Environmental Cleaning And Disinfection**	**Assessment**	**Comments**
P.1.	The facility has cleaning/disinfection policies which include routine and terminal cleaning and disinfection of resident rooms, and high-touch surfaces in common areas. ***Note: Privacy curtains should be changed after resident is discharged, or cleaned with an EPA approved disinfectant as needed.***	□ Yes □ No	
P.2.	The facility cleaning/disinfection policies include handling of equipment shared among residents (e.g., blood pressure cuffs, rehab therapy equipment, etc.)	□ Yes □ No	

P.3.	Facility has policies and procedures to ensure that reusable medical devices (e.g., wound care equipment, podiatry equipment, and dental equipment) are cleaned and reprocessed appropriately prior to use on another resident. ***Note: If external consultants (e.g., wound care nurses, dentists or podiatrists) provide services in the facility, the facility must verify these providers have adequate supplies and space to follow appropriate cleaning/disinfection (reprocessing) procedures to prevent transmission of infectious agents*** ***Note: Select "not applicable" if any of the following are true:*** ***1. All medical devices are single use only or dedicated to individual residents*** ***2. No procedures involving medical devices are performed in the facility by staff or external consultants*** *3.* ***External consultants providing services which involve medical devices have adequate supplies, no devices are shared on-site, and all reprocessing is performed off-site****.*	□ Yes □ No □ Not applicable	
P.4.	Appropriate personnel receive job-specific training and competency validation on cleaning and disinfection procedures at the time of employment and within the past 12 months. ***Note: If environmental services are performed by contract personnel, the facility should verify that training is provided by contracting company.***	□ Yes □ No	
P.5.	The facility audits (monitors and documents) and provides feedback to personnel regarding the quality of cleaning and disinfection procedures. ***Note: If yes, facility should provide documentation of audits.***	□ Yes □ No	
P.6.	Supplies necessary for appropriate cleaning and disinfection procedures (e.g., EPA-registered for use in healthcare facilities, including products labelled as effective against *C. difficile* and Norovirus) are available and used according to manufacturer instructions for use. ***Note: If environmental services are performed by contract personnel, facility should verify that appropriate EPA-registered products are provided by contracting company.***	□ Yes □ No	

Section Q	HealthCare Personnel Safety	Assessment	Comments
Q.1.	The facility has policies prohibiting contact with residents or their food when personnel have potentially communicable diseases or infected skin lesions.	□ Yes □ No	
Q.2.	The employee health policies address the following: a. Work-exclusion policies that encourage reporting of illnesses. b. Education of personnel on prompt reporting of illness to supervisor and/or employee health.	□ Yes □ No □ Yes □ No	

Q.3.	The facility based on applicable State law, has a written policy to provide personnel TB screening	□ Yes □ No	
Q.4.	Documentation of a protocol for monitoring and evaluating clusters or outbreaks of illness among healthcare personnel.	□ Yes □ No	
Q.5.	The facility has an exposure control plan which address potential hazards posed by specific services provided by the facility (i.e., OSHA requirement for blood-borne pathogens).	□ Yes □ No	
Q.6.	All personnel receive training and competency validation on managing a blood-borne pathogen exposure at the time of employment and at least every 12 months.	□ Yes □ No	
Section R	**Respiratory Disease Prevention [(e.g. Pneumococcal, Influenza and Tuberculosis (TB)]**	**Assessment**	**Comments**
R.1.	The facility has a written policy to assess risk for TB (based on local health department data) and provide screening to residents on admission.	□ Yes □ No	
R.2.	The resident's medical record includes documentation of TB screening on admission. ***Note: Review may focus on recent admissions to the facility.***	□ Yes □ No	
R.3.	The facility has a written policy that requires family and visitors take appropriate precautions if they are having symptoms of respiratory infection during their visit.	□ Yes □ No	
R.4.	Signs are posted at the entrances with instructions to individuals with symptoms of respiratory infection to: cover their mouth/nose when coughing or sneezing, use and dispose of tissues, and perform hand hygiene after contact with respiratory secretions. ***Note: See CDC website for examples of signage.***	□ Yes □ No	
R.5	The facility provides resources for performing hand hygiene (i.e. alcohol based hand-rub) near the entrance and in common areas.	□ Yes □ No	
R.6	The facility has policy to provide facemasks to residents with a new acute cough and other symptomatic persons upon entry to the facility.	□ Yes □ No	
R.7.	All personnel receive education the at the time of employment and at least every 12 months on the importance of infection prevention measures to contain respiratory secretions to prevent the spread of respiratory pathogens.	□ Yes □ No	
R.8.	The facility documents resident immunization status for pneumococcal and influenza vaccination at time of admission (or as required by per state law). ***Note: The process by which a facility determines resident immunization status may include information provided by the resident/or family member healthcare designated power of attorney.***	□ Yes □ No	

R.9.	The resident's medical record includes documentation that indicates (at a minimum) either the resident received the pneumococcal immunizations, or the resident refused or had a contraindication to one or both pneumococcal vaccinations.	□ Yes □ No	
R.10.	The resident's medical record includes documentation that an influenza immunization is offered annually. ***Note: The resident or the resident's representative has the opportunity to refuse influenza immunization.***	□ Yes □ No	
R.11	Facility has policy and procedures to ensure the resident or resident's representative receives education regarding benefits and potential side effects of each immunization.	□ Yes □ No	
Section S	**Linen Management**	**Assessment**	**Comments**
S.1.	Healthcare handle soiled linens with minimum agitation to avoid contamination of the environment.	□ Yes □ No	
S.2.	Soiled linens are bagged or otherwise contained at the point of collection in leak-proof containers or bags, and are not sorted or rinsed in the location of use. ***Note: Covers are not needed on contaminated textile hampers in resident care areas.***	□ Yes □ No	
S.3.	The receiving area for contaminated/soiled linen is clearly separated from clean laundry areas. ***Note: Workflow should prevent cross contamination (i.e. If fans are used the ventilation should not flow from dirty to clean laundry areas).***	□ Yes □ No	
S.4.	If facility laundry services are contracted out and performed offsite, the contract must show evidence that the contractor's laundry service meets healthcare industry laundry standards.	□ Yes □ No □N/A	
S.5.	Clean linen are packaged, transported, and stored in a manner that ensures cleanliness and protection from contamination (e.g. dust and soil).	□ Yes □ No	
S.6.	The facility should be using the fabric manufacturer's recommended laundry cycles, water temperatures, and chemical/detergent products.	□ Yes □ No	
S.7.	The facility has handwashing stations in areas where non-bagged, soiled linen is handled.	□ Yes □ No	
S.8.	The facility has a policy for cleaning and disinfecting linen carts on the premises or for cart exchange off the premises.	□ Yes □ No	

Section T	Infection Prevention, Stewardship, and Responsibility of Care During Care Transitions	Assessment	Comments
T.1.	When transferring a resident to another facility, the LTC facility has a process, and can demonstrate evidence, that resident documentation sent to the receiving facility providers includes direct contact information [name, phone number, email] for the resident's treating clinician (MD, APN, PA), transferring nursing unit and case manager (if applicable) before or at the time of transfer? CDC sample transfer form: Example1.pdf for the Inter-facility Infection Control Transfer Form https://www.cdc.gov/hai/pdfs/toolkits/InfectionControlTransferFormExample1.pdf	□ **Yes** □ **No**	
T.2.	The LTC facility has a process, and can demonstrate evidence, that documentation of resident infection, colonization or known history of positive culture with multidrug-resistant organism, *C. difficile,* or other epidemiologically important organism (e.g. scabies) is sent to receiving provider (e.g. hospital) before or at the time of transfer?	□ **Yes** □ **No**	
T.3.	The LTC facility has a process and can demonstrate evidence that documentation of the presence of clinical signs or symptoms of potentially communicable diseases (e.g., vomiting, diarrhea, cough) is sent to receiving provider before or at the time of transfer?	□ **Yes** □ **No**	
T.4.	The LTC facility has a process and can demonstrate evidence that communication of critical information regarding central lines and urinary catheters (i.e. insertion date, rationale), or other medical devices, is sent to receiving provider before or at the time of transfer?	□ **Yes** □ **No**	
T.5.	The LTC facility has a process and can demonstrate evidence that communication of the rationale and use of transmission-based precautions/PPE is sent to receiving provider before or at the time of transfer (e.g. C difficile with diarrhea)?	□ **Yes** □ **No**	
T.6.	The LTC facility has a process and can demonstrate evidence that communication of current or recent (i.e. within past 7 days) antibiotic use, which includes dose, route, indication, start date/stop date, and date and time of last antibiotic administered is sent to receiving provider before or at the time of transfer?	□ **Yes** □ **No**	

T.7.	The LTC facility verifies that critical medications and equipment are available at the receiving facility (e.g. Critical Access Hospital) at the time of transfer to prevent disruptions in the continuity of care (e.g., IV antibiotics and administration equipment).	□ **Yes** □ **No NA**	
T.8.	The LTC facility has a process for and can demonstrate evidence that they have sent additional information about potentially transmissible infections, resistant organisms, and antibiotic use if missing or unavailable at the time of resident transfer to the hospital.	□ **Yes** □ **No**	**blank**
T.9.	The LTC facility has evidence that essential resident information about potentially transmissible infections, resistant organisms, and antibiotic use is reviewed and addressed (e.g. transmission-based precautions) at the time of arrival from a hospital.	□ **Yes** □ **No**	**blank**