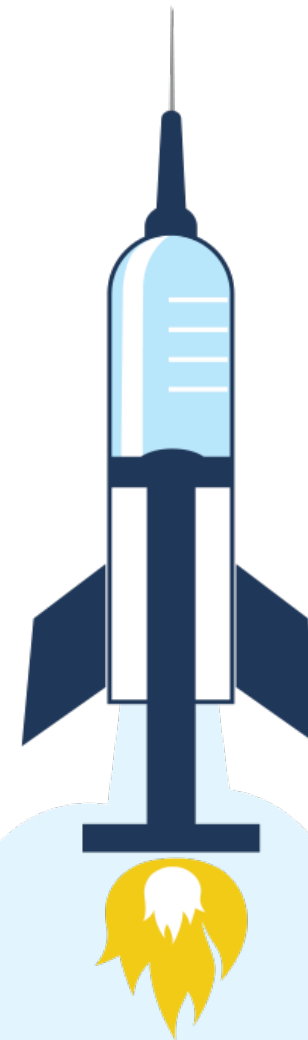


Surveyor's Here!

Is your vaccine data ready?

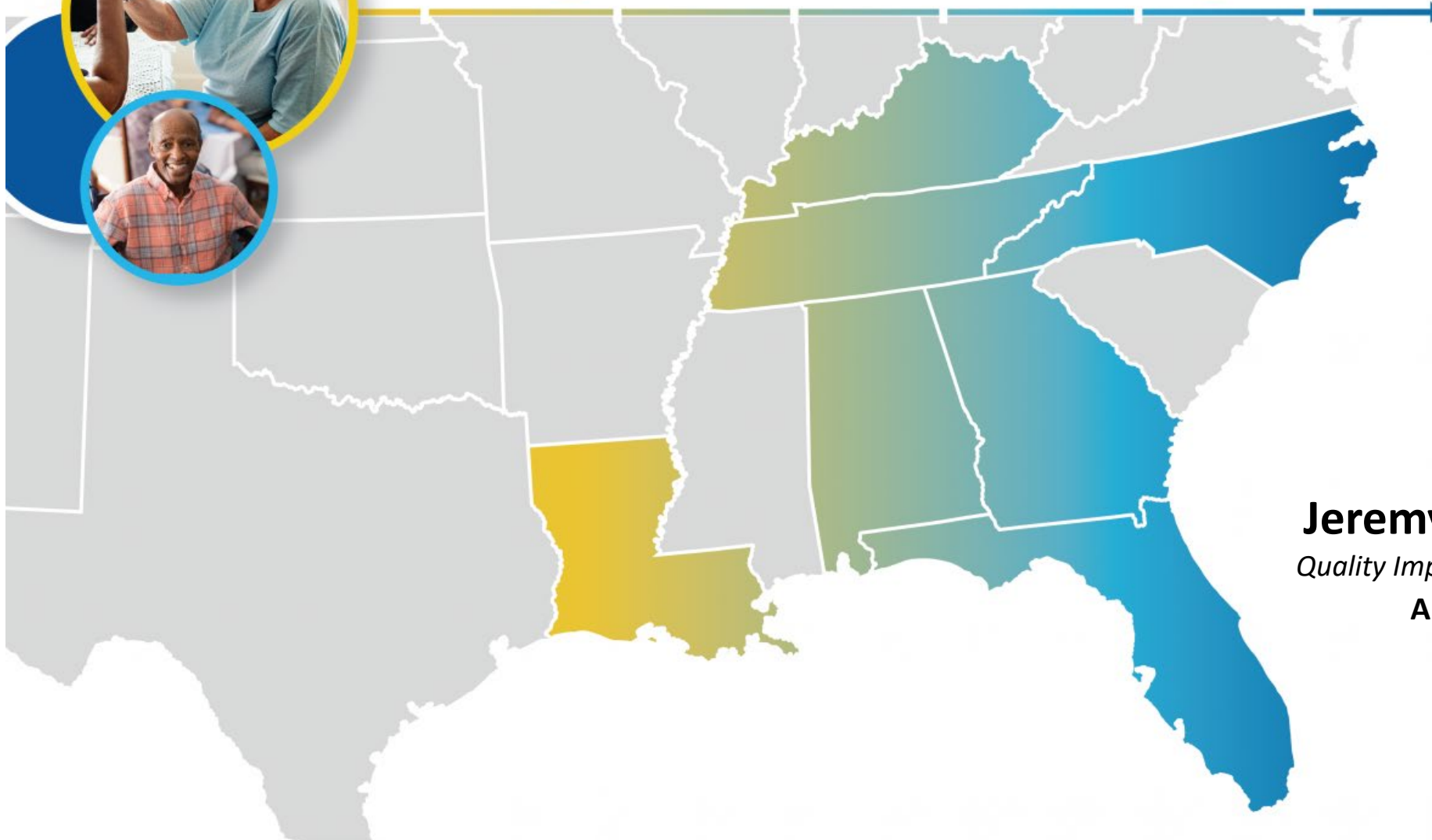
May 26, 2022



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CENTERS FOR MEDICARE & MEDICAID SERVICES
QUALITY IMPROVEMENT & INNOVATION GROUP

Making Health Care Better *Together*



Jeremy Bischoff, LNHA, BS
Quality Improvement Initiative- Vaccine Lead
Alliant Health Solutions

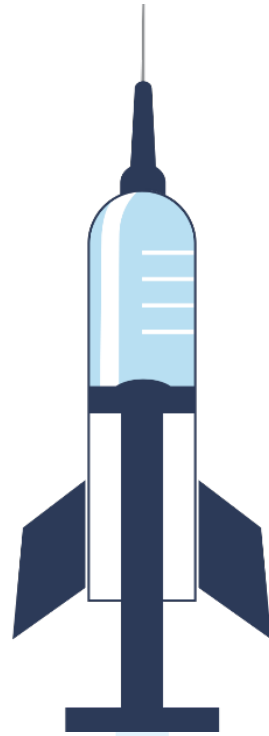
Since March 2020, nursing home guidance, regulations and processes have changed drastically in response to COVID-19.

As a result, finding the most current information can be challenging.

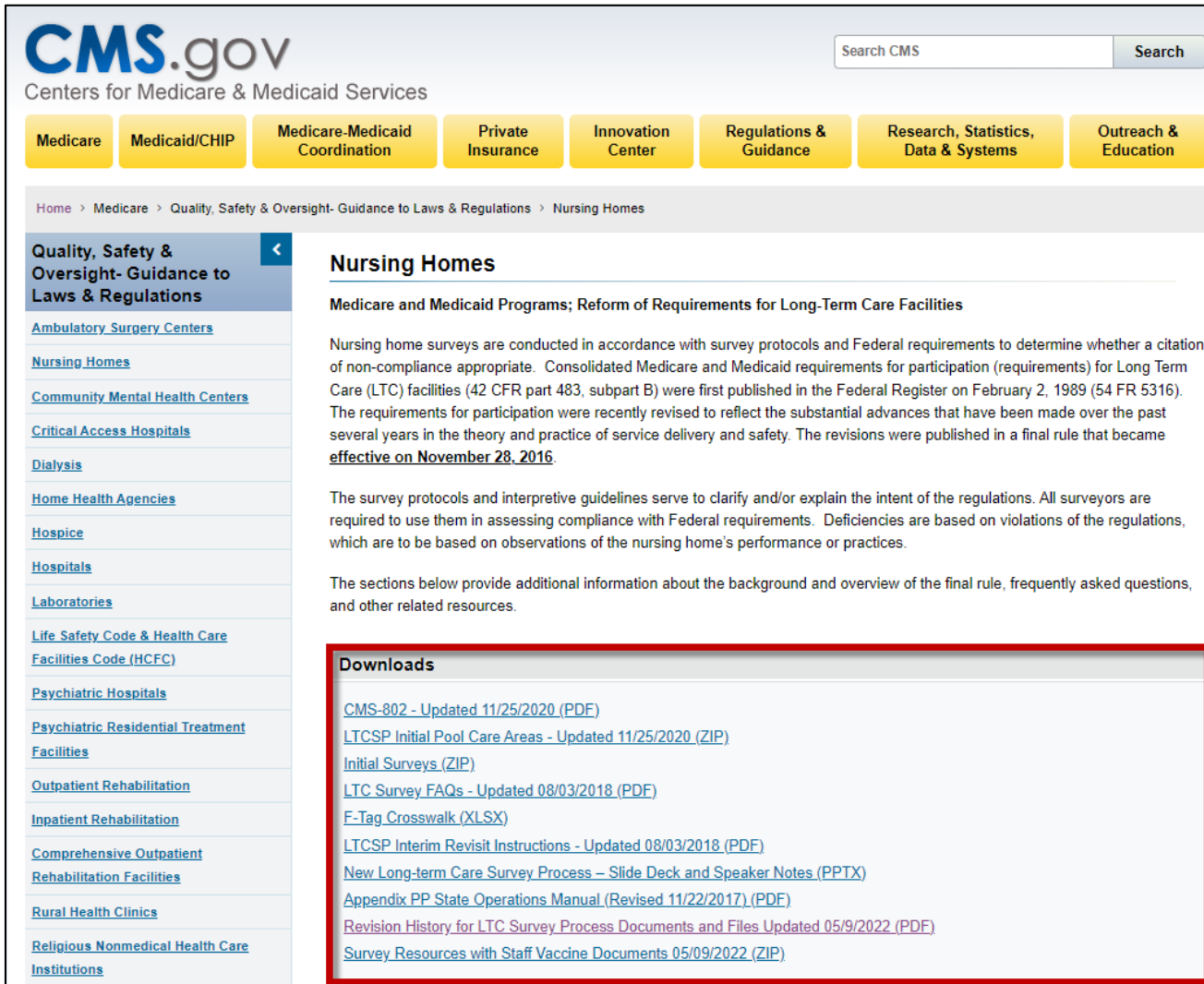
Know your sources.

Today's Focus:

- 1) Where to find the guidance you need.
- 2) A deeper dive into COVID-19-related surveys.



CMS Survey Guidance



CMS.gov
Centers for Medicare & Medicaid Services

Search CMS Search

Medicare Medicaid/CHIP Medicare-Medicaid Coordination Private Insurance Innovation Center Regulations & Guidance Research, Statistics, Data & Systems Outreach & Education

Home > Medicare > Quality, Safety & Oversight- Guidance to Laws & Regulations > Nursing Homes

Quality, Safety & Oversight- Guidance to Laws & Regulations

- [Ambulatory Surgery Centers](#)
- [Nursing Homes](#)
- [Community Mental Health Centers](#)
- [Critical Access Hospitals](#)
- [Dialysis](#)
- [Home Health Agencies](#)
- [Hospice](#)
- [Hospitals](#)
- [Laboratories](#)
- [Life Safety Code & Health Care Facilities Code \(HCFC\)](#)
- [Psychiatric Hospitals](#)
- [Psychiatric Residential Treatment Facilities](#)
- [Outpatient Rehabilitation](#)
- [Inpatient Rehabilitation](#)
- [Comprehensive Outpatient Rehabilitation Facilities](#)
- [Rural Health Clinics](#)
- [Religious Nonmedical Health Care Institutions](#)

Nursing Homes

Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities

Nursing home surveys are conducted in accordance with survey protocols and Federal requirements to determine whether a citation of non-compliance appropriate. Consolidated Medicare and Medicaid requirements for participation (requirements) for Long Term Care (LTC) facilities (42 CFR part 483, subpart B) were first published in the Federal Register on February 2, 1989 (54 FR 5316). The requirements for participation were recently revised to reflect the substantial advances that have been made over the past several years in the theory and practice of service delivery and safety. The revisions were published in a final rule that became **effective on November 28, 2016**.

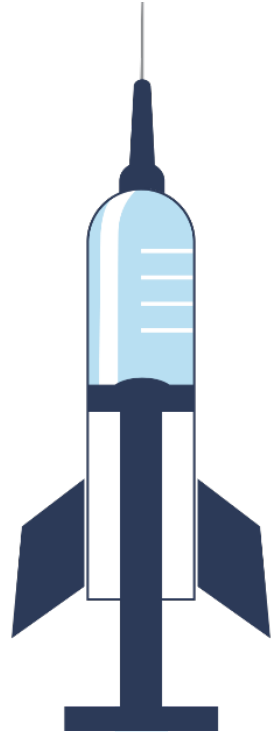
The survey protocols and interpretive guidelines serve to clarify and/or explain the intent of the regulations. All surveyors are required to use them in assessing compliance with Federal requirements. Deficiencies are based on violations of the regulations, which are to be based on observations of the nursing home's performance or practices.

The sections below provide additional information about the background and overview of the final rule, frequently asked questions, and other related resources.

Downloads

- [CMS-802 - Updated 11/25/2020 \(PDF\)](#)
- [LTCSP Initial Pool Care Areas - Updated 11/25/2020 \(ZIP\)](#)
- [Initial Surveys \(ZIP\)](#)
- [LTC Survey FAQs - Updated 08/03/2018 \(PDF\)](#)
- [F-Tag Crosswalk \(XLSX\)](#)
- [LTCSP Interim Revisit Instructions - Updated 08/03/2018 \(PDF\)](#)
- [New Long-term Care Survey Process – Slide Deck and Speaker Notes \(PPTX\)](#)
- [Appendix PP State Operations Manual \(Revised 11/22/2017\) \(PDF\)](#)
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- [Survey Resources with Staff Vaccine Documents 05/09/2022 \(ZIP\)](#)

Tip: Bookmark this website for quick reference in the future



<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes>

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A circular logo with a dark blue background. Inside the circle, a white and blue syringe is depicted as a rocket, angled upwards and to the right. The syringe has a yellow flame at its base, suggesting it is launching. The words "Give The BOOST" are written in white, bold, sans-serif font along the top arc of the circle, and "A Shot" is written along the bottom arc. A dashed yellow line separates the text from the central graphic.

Downloads

[Survey Resources with Staff Vaccine Documents 05/09/2022 \(ZIP\)](#)

MATRIX FOR PROVIDERS

[illegible]

CMS-802 (11/2020)

Inside the Downloads

LTCSP Initial Pool Care Areas:

Resident Interviews/Observations/Responsible Party Interviews

Downloads

[CMS-802 - Updated 11/25/2020 \(PDF\)](#)

[LTCSP Initial Pool Care Areas - Updated 11/25/2020 \(ZIP\)](#)

[Initial Surveys \(ZIP\)](#)

[LTC Survey FAQs - Updated 08/03/2018 \(PDF\)](#)

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Initial Pool Process: Resident Interview

Care Area	Probes	Response Options
Choices	<ul style="list-style-type: none"> Are you able to make choices about your daily life that are important to you? I'd like to talk to you about your choices. Are you able to get up and go to bed when you want to? How about bathing, are you able to choose a bath or shower? Do you choose how often you bathe? How about food, does the facility honor your preferences or requests regarding meal times, food and fluid choices? How about activities, are you able to choose when you go to activities? How about meds, are you able to choose when you receive your medications? Did you choose your doctor? Do you know their name and how to contact them? Can you have visitors any time or are there restricted times? 	No Issues/NA Further Investigation
Activities	<ul style="list-style-type: none"> Do you participate in activities here? If not, why? Do the activities meet your interests? If not, what type of activities would you like the facility to offer? Are activities offered on the weekends and evenings? 	No Issues/NA Further Investigation

Initial Pool Process – Limited Record Review

Care Area	Probe	Response Options
For any resident marked as non-interviewable, refused, unavailable or out of facility the following areas should be reviewed in the record regardless of whether the area is an indicator for the resident.		
Pressure Ulcers	<ul style="list-style-type: none"> Did the resident develop a pressure ulcer in the facility that has not healed? Did the resident have a pressure ulcer that worsened and hasn't improved recently? Note: Exclude Stage 1 pressure ulcers.	No Issues/NA Further Investigation MDS Discrepancy
Dialysis	<ul style="list-style-type: none"> Is the resident receiving peritoneal dialysis or hemodialysis? 	No Issues Further Investigation NA MDS Discrepancy
Respiratory Infection	<ul style="list-style-type: none"> Does the resident currently have a respiratory infection? 	No Issues/NA Further Investigation MDS Discrepancy

Initial Pool Process: Resident Observation

Care Area	Probes	Response Options
Activities	<ul style="list-style-type: none"> Did you observe the resident in activities? Is the resident actively participating or engaged in activities? Do staff encourage the resident to participate? Is a younger resident engaged in age appropriate activities? Are there a variety of activities available for all residents? 	No Issues/NA Further Investigation
Dignity	<ul style="list-style-type: none"> Observe to determine whether staff failed to: <ul style="list-style-type: none"> Knock/ask permission to enter room or wait to enter until permission given Explain service or care to be provided Include resident in conversations while providing care or services Provide visual privacy of resident's body while transporting through common areas, or uncovered in their room but visible to others Cover a urinary catheter bag/other body fluid collection device Respond to the resident's call for assistance in a 	No Issues/NA Further Investigation

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTCSP-Initial-Pool-Care-Areas.zip>

Inside the Downloads

Initial Surveys: Certification

LTCSP Initial Survey and Certification Process

Instructions for the Interim LTCSP Initial Survey and Certification Process

Policy:





Adapted from Chapter 2 of the State Operations Manual (SOM) 2005A2 – Approval or Denial of Certification Based on Survey Findings: All references below to SA surveys also apply to surveys conducted by the RO. The SA completes the initial survey for applicants that are subject to an on-site certification survey after they receive the recommendation of approval from the Medicare Administrative Contractor (MAC), unless the applicant has the option of participation via deemed status (see Sections 2003C and 2005A4 in Chapter 2 of the State Operations Manual). Additionally, the applicant must be operational and providing care to residents in order for a certification survey to be conducted. (See Section 2008A.) <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c02.pdf>

All surveys are unannounced.

Downloads

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Downloads > Initial Surveys > Initial Surveys

Name	
	Instructions for the Interim LTC Initial Survey and Certification Process
	Instructions for the Interim LTC Initial Survey and Certification Process
	LTCSP Initial Certification Tag Review Tool
	LTCSP Initial Certification Tag Review Tool

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Initial-Surveys.zip>

Inside the Downloads

LTC Survey FAQs

Frequently Asked Questions related to LTC regulations, Survey process and training

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H.	483.30 Physician Services	7
I.	483.35 Nursing Services	7

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTC-Survey-FAQs.pdf>

Downloads

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A. 483.10 Resident Rights

If a resident is declining to be weighed or has asked that weights be discontinued can the MD write an order for weights to be discontinued? Will the facility incur a citation if we do not obtain weight and are aware that the resident is losing weight?

Per federal requirements at §483.10(c)(6), the resident has “The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.” If a resident declines treatment, the resident may not be treated against his or her wishes. This would include a decline or discontinuation of weights. To meet the requirements at §483.10(c)(6), the resident must be provided with the necessary information, i.e., risks related to the discontinuation of weights, to make an informed decision and the resident’s medical record should contain appropriate documentation of this process.

Can we put signs at the head of a resident’s bed if they have impaired vision or hearing so staff will know?

Per federal requirements at §483.10(h) - “The resident has a right to personal privacy and confidentiality of his or her personal and medical records.” Posting signs in residents’ rooms or in areas visible to others that include clinical or personal information could be considered a violation of a resident’s privacy. It is allowable to post signs with this type of information in more private locations not visible to the public. An exception can be made in an individual case if a resident or his or her representative requests the posting of information at the bedside (such as instructions to not take blood pressure in right arm). This does not prohibit the display of resident names on their doors nor does it prohibit display of resident memorabilia and/or biographical information in or outside their rooms with their consent or the consent of his or her representative. (This does not include isolation precaution information for public health protection, as long as the sign does not reveal the type of infection).

Inside the Downloads

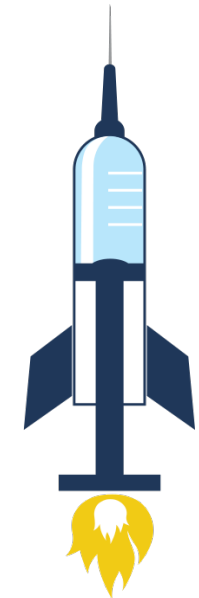
F-Tag Crosswalk

Provides guidance related to the November 2017 changes to F-Tag numbers

Downloads

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LTC FTags_Phase 2_Crosswalk - Excel							
File Home Insert Page Layout Formulas Data Review View Developer Tell me what you want to do...							
A1 Tag #							
Tag # (As of Nov. 28, 2017)	SQC Tag? X = Yes	Tag Title	CFR	Regulatory Groupings	Tags / Subparts Implemented in Phase 3	Old Tag (Taken from App PP 03-08-2017)	RegulationText that was Moved to New Tag
F540		Definitions	483.5			F150	483.5
F550	X	Resident Rights/Exercise of Rights	483.10(a)(1)(2)(b)(1)(2)	483.10 Resident Rights		F151	483.10(b)(1)(2)
F551		Rights Exercised by Representative	483.10(b)(3)-(7)(i)-(iii)	483.10 Resident Rights		F152	483.10(b)(3)-(7)
F573		Right to Access/Purchase Copies of Records	483.10(g)(2)(i)(ii)(3)	483.10 Resident Rights		F153	483.10(g)(2)(3)
F552		Right to be Informed/Make Treatment Decisions	483.10(c)(1)(4)(5)	483.10 Resident Rights		F154	483.10(c)(1)(4)(5)



<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/F-Tag-Crosswalk.xlsx>

Inside the Downloads

LTCSP Interim Revisit Instructions

Investigative process for onsite revisits

Downloads

[CMS-802 - Updated 11/25/2020 \(PDF\)](#)
[LTCSP Initial Pool Care Areas - Updated 11/25/2020 \(ZIP\)](#)
[Initial Surveys \(ZIP\)](#)
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[Survey Resources with Staff Vaccine Documents 05/09/2022 \(ZIP\)](#)

LTCSP Interim Paper-Based Onsite Revisit Instructions

Purpose

The purpose of a revisit is to determine:

- If the facility has corrected identified substantial noncompliance and is now in substantial compliance; or
- If immediate jeopardy (IJ) has been removed based upon the implementation of an accepted, written removal plan (for IJs not removed onsite during the original survey).

The revisit **must** be conducted **onsite** in the following circumstances:

- A facility's original survey finds deficiencies that constitute substandard quality of care (SQC), and/or deficiencies at severity level three (harm), and/or severity level four (IJ) that was not removed during the original survey. *Onsite revisits must continue for these deficiencies even if they lessen to lower levels of noncompliance until the noncompliance is corrected;*

NOTE: If the first onsite revisit finds substantial compliance with these deficiencies, it is not necessary to conduct additional onsite revisits for any newly cited tags that are cited at or below level F, if the level F deficiency is not substandard quality of care.

OR

LTCSP Interim Paper-Based Onsite Revisit Instructions

Revisit/Date of Compliance Policy

Revisit #	Substantial Compliance	Old deficiencies corrected but continuing noncompliance at F (no SQC) or below	Old deficiencies corrected but continuing noncompliance at F (SQC), harm or IJ	Noncompliance continues	Any noncompliance
1st revisit	Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the 1st onsite revisit, or correction occurred sooner than the latest correction date on the PoC.	<p>1. A 2nd onsite revisit is discretionary if acceptable evidence is provided.</p> <p>When evidence is accepted with no 2nd onsite revisit, compliance is certified as of the date confirmed by the evidence.</p> <p>2. When a 2nd onsite revisit is conducted, acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered for the compliance date.</p>	<p>1. A 2nd onsite revisit is required.</p> <p>2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered for the compliance date.</p>	1. A 2nd onsite revisit is required. 2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered as the compliance date.	
2nd revisit	Compliance is certified as of the date of the 2nd onsite revisit or the date confirmed by the acceptable evidence, whichever is sooner.				<p>1. A remedy must be imposed if not already imposed.</p> <p>2. Either conduct a 3rd onsite revisit or proceed to termination.</p>
A 3rd REVISIT IS NOT ASSURED AND MUST BE APPROVED BY THE RO					
3rd revisit	Compliance is certified as of the date of the 3rd onsite revisit.				Proceed to termination.

Examples of acceptable evidence may include, but are not limited to:

- An invoice or receipt verifying purchases, repairs, etc.
- Sign-in sheets verifying attendance of staff at in-services training.

Given:

- Interviews with more than 1 training participant about training.
- Contact with resident council, e.g., when dignity issues are involved.

<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/LTCSP-Interim-Revisit-Instructions.pdf>

Inside the Downloads

New (2017) Long-Term Care Survey Process

PowerPoint slide deck highlighting changes to survey process (2017)



<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/New-Long-term-Care-Survey-Process%E2%80%93Slide-Deck-and-Speaker-Notes.pptx>

Downloads
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Survey Resources with Staff Vaccine Documents 05/09/2022 (ZIP)



Inside the Downloads

Appendix PP State Operators Manual (SOM)

PowerPoint slide deck highlighting changes to survey process (2017)

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State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities Table of Contents

(Rev. 11-22-17)

Transmittals for Appendix PP

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§483.12 Freedom from Abuse, Neglect, and Exploitation
§483.15 Admission Transfer and Discharge Rights
§483.20 Resident Assessment
§483.21 Comprehensive Person-Centered Care Plans
§483.24 Quality of Life
§483.25 Quality of Care
§483.30 Physician Services

GUIDANCE §483.12(a)(1)

NOTE: For purposes of this guidance, “staff” includes employees, the medical director, consultants, contractors, and volunteers. Staff would also include caregivers who provide care and services to residents on behalf of the facility, students in the facility’s nurse aide training program, and students from affiliated academic institutions, including therapy, social, and activity programs.

ABUSE

Sections §§1819 and 1919 of the Social Security Act provide that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility must provide a safe resident environment and protect residents from abuse.

Staff to Resident Abuse of Any Type

Nursing homes have diverse populations including, among others, residents with dementia,

**Tip: Use CTRL+F to
search within
document!**



<https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Downloads/Appendix-PP-State-Operations-Manual.pdf>

Inside the Downloads

Revision History for LTC Survey Process Documents and Files

Notes revision history for survey process documents and files with dates of change

Revision History for LTC Survey Process Documents and Files		
This document will identify revisions made to documents and files that are related to the LTC Survey Process. The revisions will be grouped by effective date.		
Effective Date	Document/File Name	Description of Change
05/09/2022	Survey Resources with Staff Vaccine Documents Folder	Updated: 1. F Tag Waiver Guide 2. Appendix PP – added 2018 revision 3. Appendix Z – added 2021 version 4. Chapter 7 – added 2018 version 5. Mapping Document-Streamlined
04/26/2022	Survey Resources with Staff Vaccine Documents Folder	Updated: 1. Staff Formula for F888 2. Staff Matrix for F888 3. LTCSP Complaints Guide 4. Entrance Conference Worksheet 5. FIC Folder (Staff Formula for F888, Staff Matrix for F888)
04/07/22	Survey Resources with Staff Vaccine Documents Folder	Updated: 1. FIC folder (FIC Survey Protocol, FIC Survey Entrance Conference Worksheet, CMS 20054-Infection Prevention Control and Immunization, QSO-20-39-NH Revised, QSO-20-38-NH Revised, Staff Matrix for F888 only) 2. Entrance Conference Worksheet 3. LTCSP Procedure Guide 4. Staff Matrix for F888 5. LTC Survey Pathways (CMS 20054-Infection Prevention Control and Immunization) 6. F Tag Waiver Guide 7. K Tag Waiver Guide
02/22/2022	Surveyor Resources Folder	1. Deleted Surveyor Resources (Updated 01/25/2022) 2. Updated List of Revised Ftags • Added F608 back onto the job aide
01/28/2022	Survey Resource Folder – January 2022	Change the folder name to Survey Resources w/Staff Vaccine Documents Updated CMS 20054, Infection Prevention Control and Immunization.
	Survey Resources Folder	Updated QSO-20-39-NH Revised

<https://www.cms.gov/files/document/revision-history-ltc-survey-process-documents-and-files-updated-0592022.pdf>

Downloads

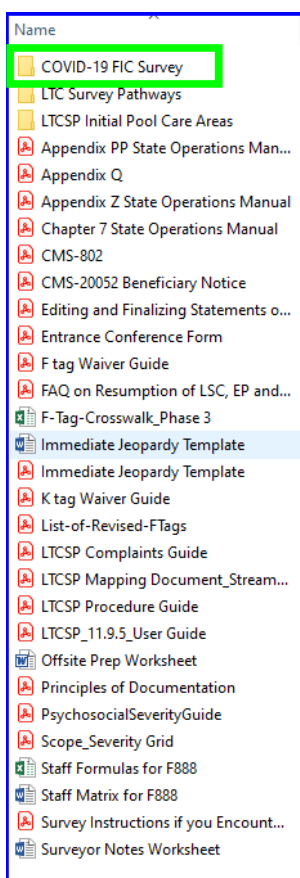
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[Survey Resources with Staff Vaccine Documents 05/09/2022 \(ZIP\)](#)



Inside the Downloads

Survey Resources with Staff Vaccine Documents

Notes revisions and processes related to changes with the vaccine and COVID-19



Contents of COVID-19 FIC Survey:

- CMS-20054 Infection Prevention Control and Immunization
- CMS-20054 Infection Prevention Control and Immunization
- FIC Survey Entrance Conference worksheet
- FIC Survey Protocol
- QSO-20-38-NH REVISED
- QSO-20-39-NH REVISED
- QSO-21-19-NH
- Staff Formulas for F888
- Staff Matrix for F888

Tip: These resources will assist you in COVID-19- and vaccine-related survey processes

Downloads

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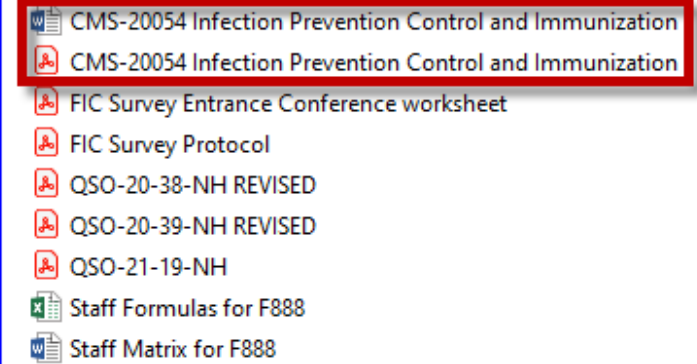


<https://www.cms.gov/files/zip/survey-resources-staff-vaccine-documents-05092022.zip>

Deeper Look at COVID-19 FIC Survey

CMS-20054 Infection Prevention Control and Immunization

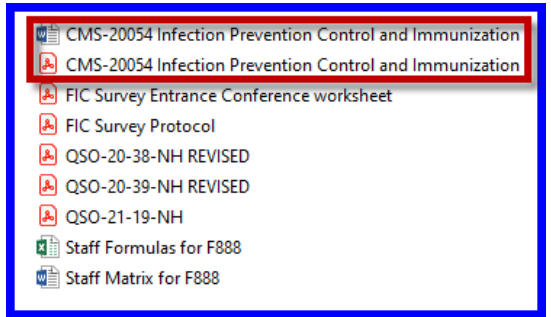
Facility task used to investigate compliance at F880, F881, F882, F883, F885, F886, F887, and F888



1. Did the staff implement appropriate standard (e.g., hand hygiene, appropriate use of PPE, environmental cleaning and disinfection, and reprocessing of reusable resident medical equipment) and transmission-based precautions (if applicable)? ☐ Yes ☐ No F880
2. Did staff provide appropriate resident care for COVID-19 related concerns? ☐ Yes ☐ No F880
3. Does the facility have a facility-wide IPCP including standards, policies, procedures and education that are current, based on national standards, and reviewed at least annually? ☐ Yes ☐ No F880
4. Did the facility provide appropriate infection surveillance? ☐ Yes ☐ No F880
5. Did the facility inform visitors when they should not enter the facility and inform the visitor of appropriate infection prevention and control actions to take while in the facility? ☐ Yes ☐ No F880
6. Did the facility inform residents, their representatives, and families of suspected or confirmed COVID-19 cases in the facility along with mitigating actions in a timely manner? ☐ Yes ☐ No F885 ☐ N/A
7. Is the facility in compliance with requirements for staff and resident COVID-19 testing? ☐ Yes ☐ No F886
8. Did the facility store, handle, transport, and process linens properly? ☐ Yes ☐ No F880 ☐ N/A, not a recertification survey
9. Did the facility conduct ongoing review for antibiotic stewardship? ☐ Yes ☐ No F881 ☐ N/A, not a recertification survey
10. Did the facility designate at least one qualified IP, who is responsible for the facility's IPCP? ☐ Yes ☐ No F882
11. Did the facility provide influenza and/or pneumococcal immunizations as required or appropriate for residents?
☐ Yes ☐ No F883
12. Did the facility provide COVID-19 immunization as required or appropriate for residents? ☐ Yes ☐ No F887

Deeper Look at COVID-19 FIC Survey

CMS-20054 Infection Prevention Control and Immunization - COVID-19 Vaccination for Facility Staff

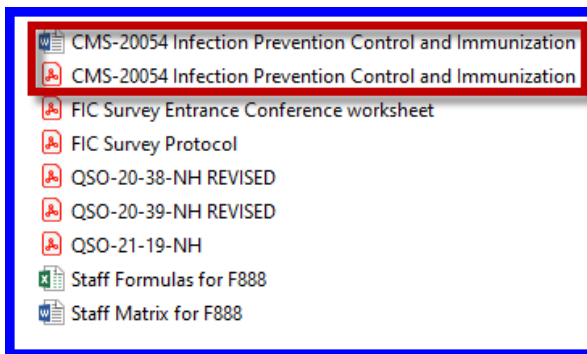


Determine whether the facility's COVID-19 vaccination policies and procedures for staff include the following:

- All staff (except pending or granted requests for exemptions/temporarily delayed) have received, at a minimum, one dose of COVID-19 vaccine prior to providing care/treatment/services for the facility and/or its residents;
- *A process to ensure that all staff (except those who have been granted an exemption or have a temporary delay) are fully vaccinated for COVID-19;*
- Track and securely document the COVID-19 vaccination status for all staff, including booster doses;
- Process by which staff may request an exemption from the COVID-19 Health Care Staff vaccination requirements;
- Track and securely document staff who have requested or have been granted an exemption by the facility for COVID-19 vaccination;
- Documentation for each staff who requests medical exemption must include:
 - o The authorized COVID-19 vaccines that are contraindicated and the clinical reasons; and
 - o A practitioner statement that the staff member be exempted from the facility's COVID-19 vaccination requirements; and
 - o Must be signed and dated by a licensed practitioner who is not the individual requesting the exemption.
- Track/secure documentation of delayed staff vaccination for clinical precautions/considerations; and
- Contingency plans for staff that are not fully vaccinated for COVID-19:
 - o What are the actions the facility will take when staff indicate they will not get vaccinated and do not qualify for an exemption?
 - o Review the facility's plan to ensure it addresses staff who are not fully vaccinated due to an exemption or temporary delay in vaccination. The plan should prioritize those staff that have obtained no doses of any vaccine over staff that have received a single dose of a multi-dose vaccine.
 - o Does the contingency plan include a deadline for staff to have obtained the COVID-19 vaccine?
 - o Does the plan indicate the action taken if the deadline is not met?

Deeper Look at COVID-19 FIC Survey

CMS-20054 Infection Prevention Control and Immunization - COVID-19 Vaccination for Facility Staff



Facility staff that are NOT up to date on vaccination MUST adhere to additional precautions

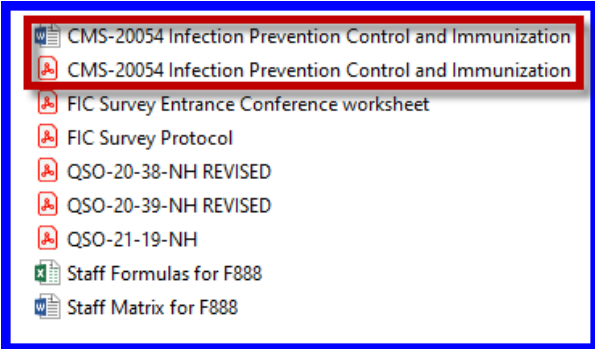
Additional precautions that may include but are not limited to:

- **Reassigning staff** who have not completed their primary vaccination series (including those who have pending requests or been granted an exemption or who have a temporary delay) to non-resident areas, to duties that can be performed remotely (i.e., telework), or to duties which limit exposure to those most at risk (e.g., assign to residents who are not immunocompromised, unvaccinated).
- Requiring staff who have not completed their primary vaccination series (including those who have pending requests or been granted an exemption, or who have a temporary delay) to **follow additional CDC-recommended precautions**, such as adhering to universal source control and physical distancing measures in areas that are restricted from resident access (e.g., staff meeting rooms, kitchen), even if the facility or service site is located in a county with low to moderate community transmission.
- **Requiring at least weekly testing for staff** who have not completed their primary vaccination series (including those who have pending requests or been granted an exemption or a temporary delay) for or until the regulatory requirement is met. Weekly testing should be conducted in the facility or services site regardless of the level of community transmission.
- Requiring staff who have not completed their primary vaccination series (including those who have a pending request or been granted an exemption or who have a temporary delay) to **use a NIOSH-approved N95 or equivalent or higher-level respirator for source control**, regardless of whether they are providing direct care to or otherwise interacting with residents.
- *NOTE: The examples above are not all-inclusive and represent actions that can be implemented. However, facilities can choose other precautions that align with the intent of the regulation, which is intended to “mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated.”*

<https://www.cms.gov/files/zip/survey-resources-staff-vaccine-documents-05092022.zip>

Deeper Look at COVID-19 FIC Survey

CMS-20054 Infection Prevention Control and Immunization - COVID-19 Vaccination for Facility Staff



Contracted Staff:

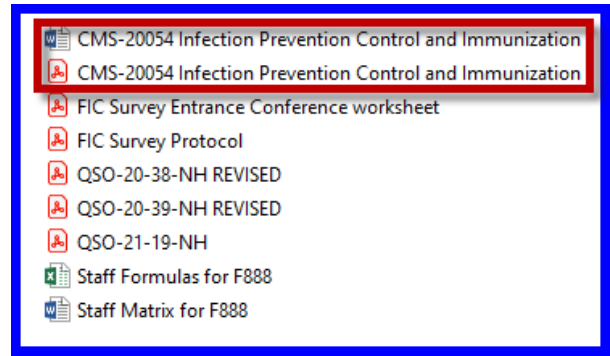
- ☐ *Ask the facility for information on how they ensure that their contractor staff are compliant with the vaccination requirement.*
- ☐ *From the list of contracted companies provided by the facility during the entrance conference, select 2 contract companies (1 direct care and 1 non-direct care). Ask the facility for a list of contracted staff from each of the two companies selected who are scheduled to provide services during the survey. Randomly select 2 contracted staff from each list.*
 - *2 direct care contracted staff*
 - *2 non-direct care contracted staff*
- ☐ *Ask facilities to obtain the contracted staff vaccination status for these individuals from the contract company.*

Note: If there are no contracted staff scheduled to be onsite during the survey, you do not need to increase the sample size for another category. Failure of contract staff to provide evidence of vaccination status reflects noncompliance and should be cited at F888 under the requirement to have policies and procedures for ensuring that all staff are fully vaccinated, except for those staff who have been granted exemptions or a temporary delay at 483.80(i)(3)(ii).

<https://www.cms.gov/files/zip/survey-resources-staff-vaccine-documents-05092022.zip>

Deeper Look at COVID-19 FIC Survey

CMS-20054 Infection Prevention Control and Immunization - COVID-19 Vaccination for Facility Staff



Vaccination Exemptions

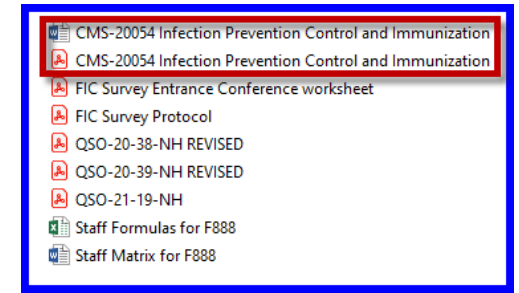
Facilities must have a process by which staff may request exemption from COVID-19 vaccination based on applicable federal law. This process should clearly identify how an exemption is requested and to whom the request must be made. Additionally, **facilities must have a process for collecting and evaluating such requests, including the tracking and secure documentation of information provided by those staff who have requested exemption, the facility's determination of the request and any accommodations that are granted.** Note: Staff who are unable to furnish proper exemption documentation must be vaccinated, or the facility must follow the actions for unvaccinated staff.

Staff who have been granted an exemption to COVID-19 vaccination requirements should adhere to national infection prevention and control standards for unvaccinated health care personnel. For additional information, see the CDC's [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic webpage](https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

<https://www.cms.gov/files/zip/survey-resources-staff-vaccine-documents-05092022.zip>
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>

CMS-20054 Infection Prevention Control and Immunization - COVID-19 Vaccination for Facility Staff

Medical Exemptions

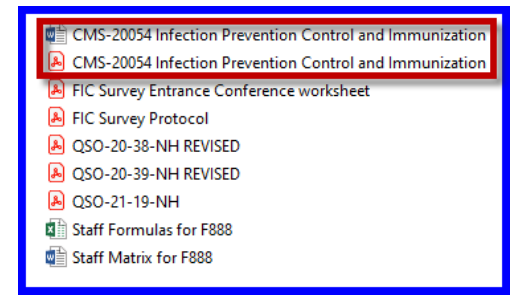


Certain allergies or recognized medical conditions may provide grounds for a medical exemption. With regard to recognized clinical contraindications to receiving a COVID-19 vaccine, facilities should refer to the CDC informational document, Summary Document for Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States, accessed at <https://www.cdc.gov/vaccines/covid-19/downloads/summary-interim-clinical-considerations.pdf>.

- Medical exemption documentation must *specify which authorized or licensed COVID-19 vaccine is clinically contraindicated* for the staff member and *the recognized clinical reasons for the contraindication*.
- The documentation must also include a *statement recommending* that the staff member be exempted from the facility's COVID-19 vaccination requirements based on the medical contraindications.
- A staff member who requests a medical exemption from vaccination must provide *documentation signed and dated by a licensed practitioner acting within their respective scope of practice* and in accordance with all applicable state and local laws.
- The individual who signs the exemption documentation *cannot be the same* individual requesting the exemption.
- Facilities must have a *process to track and secure documentation* of the vaccine status of staff whose vaccine is temporarily delayed. CDC recommends a temporary delay in administering the COVID-19 vaccination due to clinical considerations, including known COVID-19 infection, until recovery from the acute illness (if symptoms were present) and criteria to discontinue isolation have been met.

CMS-20054 Infection Prevention Control and Immunization - COVID-19 Vaccination for Facility Staff

Non-Medical Exemptions, including Religious



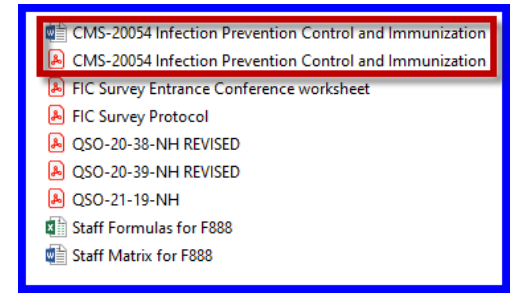
Requests for non-medical exemptions, such as a religious exemption in accordance with Title VII, must be documented and evaluated in accordance with applicable federal law and each facility's policies and procedures. **We direct providers and suppliers to the Equal Employment Opportunity Commission (EEOC) Compliance Manual on Religious Discrimination** (<https://www.eeoc.gov/laws/guidance/section-12-religious-discrimination>) for information on evaluating and responding to such requests.

Note: Surveyors will not evaluate the details of the request for a religious exemption, nor the rationale for the facility's acceptance or denial of the request. Rather, surveyors will review to ensure the facility has an *effective process for staff to request a religious exemption for a sincerely held religious belief*.

Accommodations of Unvaccinated Staff with a Qualifying Exemption: While accommodations could be appropriate under certain limited circumstances, no accommodation should be provided that is not legally required or, if it is requested, solely to evade vaccination. For individual staff members that have valid reasons for exemption, the facility can address those individually.

CMS-20054 Infection Prevention Control and Immunization - COVID-19 Vaccination for Facility Staff

Good Faith Effort:



Surveyors and CMS may *lower the scope and severity* of a citation and/or enforcement action if they identify that any of the following have occurred prior to the survey (Note: noncompliance is still cited, only the scope, severity and/or enforcement is adjusted).

- a) If the facility has no or has limited access to the vaccine, and the facility has documented attempts to obtain vaccine access (e.g., contact with the health department and pharmacies).
- b) If the facility provides evidence that they have taken aggressive steps to have all staff vaccinated, such as advertising for new staff, hosting vaccine clinics, etc. ****INCLUDING WORKING WITH YOUR QIO****

For example, if the facility staff vaccination rate is 90% or more, there has been no resident outbreak in the previous four weeks, and all policies and procedures were developed and implemented, per Table 1, this would be cited “D.” However, if the facility provides evidence that it has made a good faith effort by taking aggressive steps to get all staff vaccinated, surveyors may lower the citation to “A.”

<https://www.cms.gov/files/document/attachment.pdf>

CMS-20054 Infection Prevention Control and Immunization

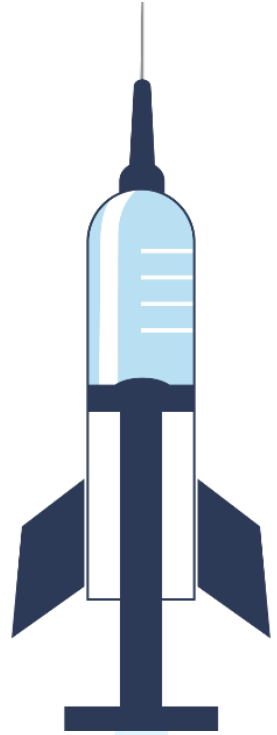
Scope and Severity Grid

Table 1: Scope and Severity Grid

Severity & Scope for F888	<u>ISOLATED</u> 1% <u>or more</u> , but <u>less than 25%</u> of staff are unvaccinated (76% – 99% of staff are vaccinated).	<u>PATTERN</u> 25% <u>or more</u> , but <u>less than 40%</u> of staff are unvaccinated (61% – 75% of staff are vaccinated).	<u>WIDESPREAD</u> 40% <u>or more</u> of staff are unvaccinated (0% - 60% of staff are vaccinated), OR 1 or more components of the P&Ps were not developed and implemented.
Level 4 - Immediate Jeopardy: Noncompliance resulting in serious harm or death : <ul style="list-style-type: none"> Did not meet the requirement of staff vaccinated <i>or has no policies and procedures developed or implemented</i>; and 3 or more resident infections in the last 4 weeks resulting in at least one resident experiencing hospitalization (i.e., serious harm) or death. OR, Noncompliance resulting in a likelihood for serious harm or death: <ul style="list-style-type: none"> Did not meet the requirement of staff vaccinated; and 3 or more resident infections in the last 4 weeks that did not result in serious harm or death; and One of the following: <ul style="list-style-type: none"> Any observations of noncompliant infection control practices by staff; or 1 or more components of the policies and procedures were not developed or implemented. OR, <ul style="list-style-type: none"> More than 40% of staff are unvaccinated and there is evidence of a lack of effort to increase staff vaccination rates. 	J	K	L
Level 3 – Actual Harm: <ul style="list-style-type: none"> Did not meet the requirement of staff vaccinated; and 3 or more resident infections in the last 4 weeks which did not result in hospitalization (i.e., serious harm) or death, or the likelihood for IJ for one or more residents; and 1 or more components of the policies and procedures were not developed and implemented 	G	H	I
Level 2: No actual harm w/potential for more than minimal harm that is not IJ: <ul style="list-style-type: none"> Did not meet the requirement of staff vaccinated; and No resident infections OR, <ul style="list-style-type: none"> Did not meet the <i>requirement</i> of staff vaccinated; and 1 or more components of the policies and procedures were not developed and implemented. 	D	E	F
Level 1: No actual harm w/potential for minimal harm: <ul style="list-style-type: none"> Met the requirement of staff vaccinated; and 1 or more components of the P&Ps were not developed and implemented (cited as widespread (“C”). 	A	B	C

What We Have Learned...

- **Preparation is key to survey success**
- **Know what the surveyors will review**
- **Review your processes**
- **Ensure your COVID Response Binder is up to date**
- **Make sure you have an owner for your data and a cadence to update frequently**



What We Have Learned (continued)...

Be prepared to answer questions regarding your unvaccinated HCP

- What additional protections have you put in place?
- Have you audited to ensure compliance and effectiveness?

Review your Exemption Documentation

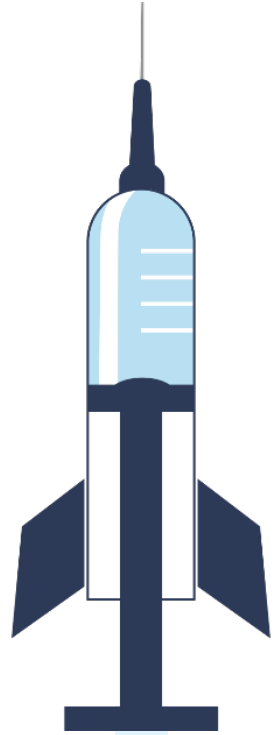
- Are you following your company's policy?
- Is it being applied fairly?
- Are the required documents present in the records?
 - Several key areas for both religious and medical

What steps have you taken to overcome vaccine safety and hesitancy?

- Education, visuals, partner with QIO, Clinic frequency, MD involvement

Ensure your NHSN Data is being reported accurately

- Have at least 2 Level 3 Access team members.
- Know how to review what has been entered.



Final Thoughts...

Information Overload: Since COVID, we continue to see changes to guidance and regulations. Know your sources of information. Ensure you are utilizing the most up-to-date.

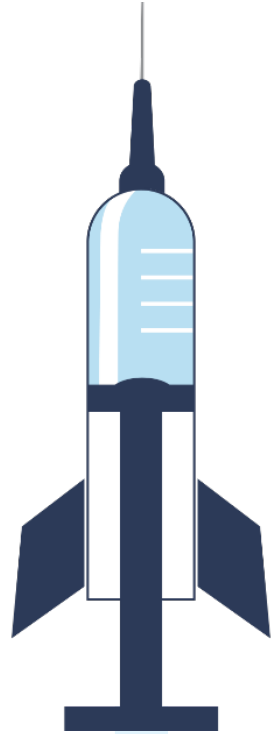
Document, Document, Document: Ensure your records are in order. Each record should have an owner, frequency for updating and a check to the process (Think QA review).

Partner with your QIO (Alliant): We are here to help you navigate the changes, assist with providing resources and ultimately to improve the quality of care for your residents.

Be Proactive

Be Prepared

Be Survey Ready



Thoughts?

Best Practices?

Questions?

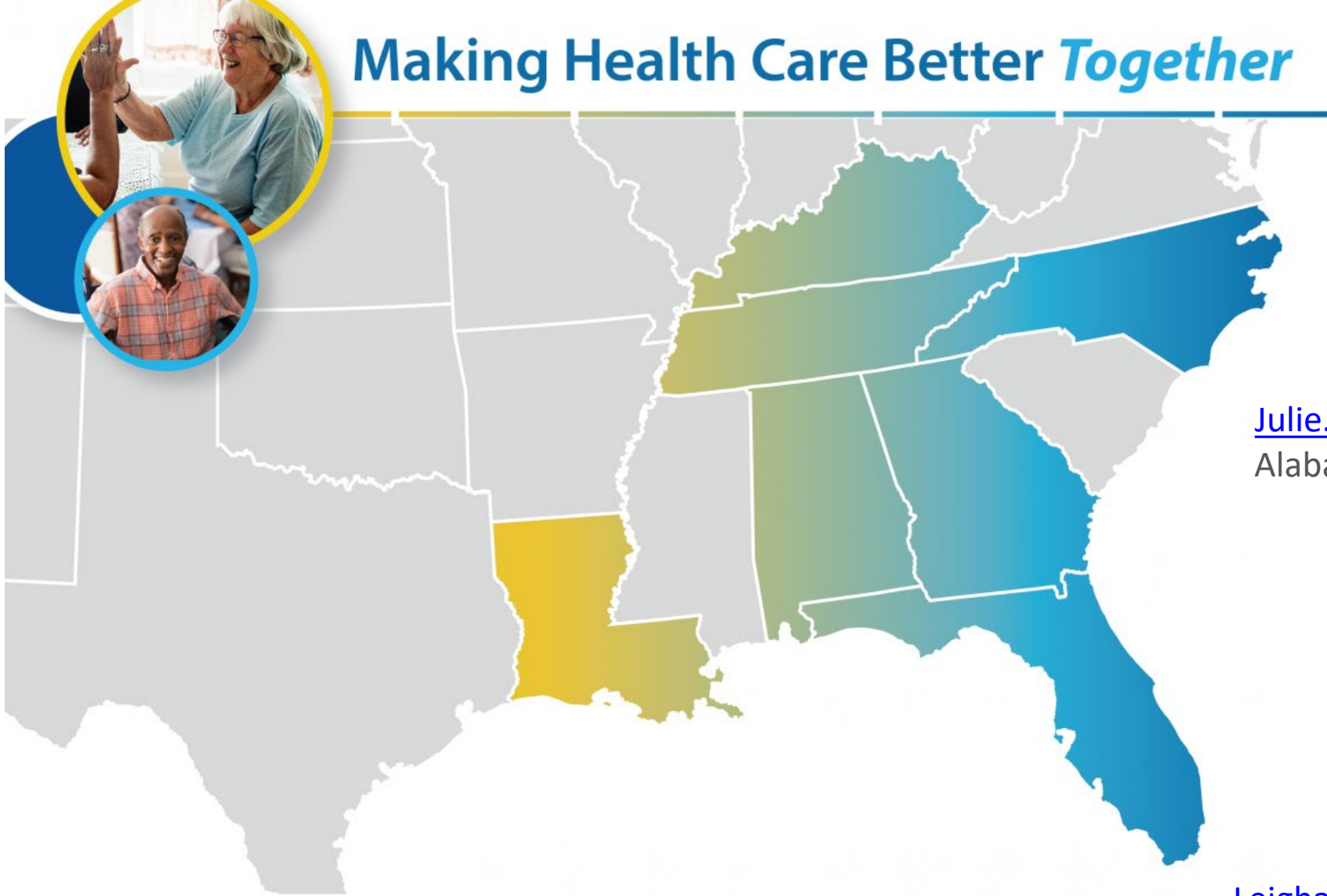


VISIT ALLIANT's Give The Boost a Shot Resource Page

<https://quality.allianthealth.org/topic/give-the-boost-a-shot/>

Send us a Question or Best Practice via email! Booster@AlliantHealth.org

Making Health Care Better *Together*



Julie Kueker

Julie.Kueker@AlliantHealth.org

Alabama, Florida and Louisiana



Leighann Sauls

Leighann.Sauls@AlliantHealth.org

Georgia, Kentucky, North Carolina and Tennessee

Program Directors

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BOOST Education Events

[BOOST Kick-Off Event | 1.19.22](#)

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Social Media Graphics



Mask Up, Sleeve Up

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Don't Miss Your Shot

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BOOST Bulletin Board

Booster Bulletin | Jan. 25, 2022



Booster Bulletin | Feb. 1, 2022



Booster Bulletin | Feb. 8, 2022



Booster Bulletin | Feb. 15, 2022



Booster Bulletin | Feb. 22, 2022

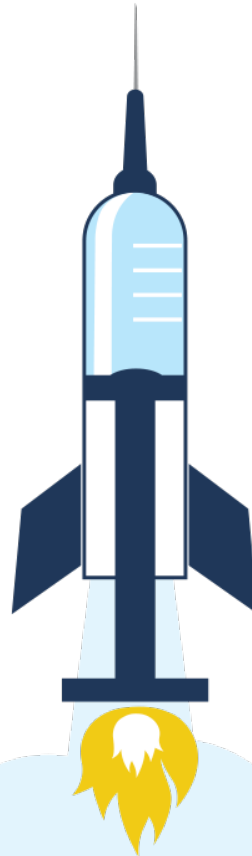


Booster Bulletin | March 1, 2022



#GivetheBoostaShot #VaxToTheMax





Thank you



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