Chiles Healthcare Consulting LLC
1908 Maple Shade Lane, Richmond, Virginia 23227
mary@chileshealthcare.com 804-690-5824

FOCUS POINT NEWSLETTER
SPECIAL FOCUS COVID ALERT 7/10/2020

Directed Plans of Correction [DPoC] – In the 6/1/2020 CMS QS0-20-32-ALL, CMS announced the enhancing of penalties for noncompliance with infection control to provide greater accountability and consequences for failures to meet the basic requirements of F-880, infection control. The enhanced enforcement actions are more significant for nursing homes with a history of past infection control deficiencies, or that cause actual harm to residents or Immediate Jeopardy. One of the enhanced enforcement penalties is the imposition of a Directed Plan of Correction [DPoC]. A DPoC is not a new enforcement strategy for CMS, however it was not widely used in Virginia prior to COVID-19. In recent weeks, the imposition of a DPoC has been cited multiple times in Virginia during the Focused Infection Control Surveys as a result of deficient practices in F-880. A Directed Plan of Correction is one of the category 1 remedies the State or Regional CMS office can select when it finds a facility out of compliance with federal requirements. Guidance and regulations for the DPoC can be reviewed in the State Operations Manual – Chapter 7 - 7500, CFR 483.80. In an effort to support client questions and provide clarity, the CHC team reached out to Kim Beazley from the Office of Licensure and Certification at VDH. Below is a recap of some of the answers to our questions:

Q: Is my understanding of the following timeline correct?

- POC must be submitted within 10 days of receipt of letter from OLC
- Any intent for IDR must be submitted within 10 days of receipt of letter from OLC
- DPoC must be submitted with 15 days of receipt of OLC letter and must include RCA related to the regulation[s] cited [i.e. F880 Infection Control]
- The RCA is to be completed by the facility with assistance from the Infection Preventionist, QAPI Committee, and the governing body
- In addition the DPoC must include any referenced education or other action included in the OLC instructions [i.e. education, etc.]

A: I believe your interpretation is correct

Q. If required does the facility have to submit a Rood Cause Analysis?

A. Facilities will need to provide credible evidence for all of the DPoC so yes, they should submit the RCA and results.

Q. Is there a required format for the DPoC?

A. I am not aware of any special format. The POC format can be used, but again they must have the credible evidence. The DPoC is however not completed on the 2567. If they are using e-POC, they can attach the DPoC as an attachment along with the credible evidence.

Q. When does the DPoC have to be completed?

A. The effective date is not a deadline for completion of the DPoC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPoC was completed in accordance with the specifications described in the notice.

Q. Is an onsite re-visit required for scope/severity of D,E, or F, or is there potential for desk review?

A. Yes, re-visits may be off site and it will depend on the levels cited and any additional guidance from CMS.

NEW CHC RESOURCE -CHC has experience assisting clients with competing a Root Cause Analysis (RCA) and developing a corresponding Directed Plan of Correction (DPoC). A new training tool has been developed to provide education on the enhanced enforcement of deficient practices cited in F-880. The Power Point presentation and follow up discussion will be facilitated by a CHC team member. The objectives for the participants of the training include:

- Exploring CMS regulatory guidance for enhanced enforcement for citations at F-880 Infection Control
- Exploring requirements for developing a DPoC
- Exploring Virginia OLC guidance on submitting and completing the DPoC

Be Infection Control Survey Ready: Join the Health Quality Innovation Network's Office Hours Series

The Health Quality Innovation Network (HQIN), the Quality Improvement Organization (QIO) for [state], is hosting an office hours series to support survey readiness and help nursing homes be responsive to identified opportunities, survey deficiencies and CMS enhanced enforcement actions. Each 30-minute session will demonstrate how to apply quality improvement principles to your infection control and prevention program and provide turnkey resources and tools to address gaps and drive improvement in your facility. A panel of nurses, infection preventionists and quality improvement professionals also will be available to answer questions.

The series begins July 14, 2020 and will cover the following topics:

July 14, 2020 | 2:00 p.m. ET/1:00 p.m. CT - Root Cause Analysis (RCA)

Your facility has worked hard to assess its infection control programs. But do you know the reason for the gaps or breakdowns in your program? During this session, HQIN will share its QAPI RCA resource which complements the CMS QAPI RCA Guide.

July 28, 2020 | 2:00 p.m. ET/1:00 p.m. CT - Infection Prevention Action Plans

Upon completion of the RCA process, the next step is to develop a plan of action. During this session, HQIN will share its Infection Prevention Action Plan Templates that complement the CDC Infection Control Assessment tool. A template for the key categories of improvement, i.e., hand hygiene, surveillance, environmental hygiene, etc. will be available.

August 11, 2020 | 2:00 p.m. ET/1:00 p.m. CT - Data Collection and Analysis

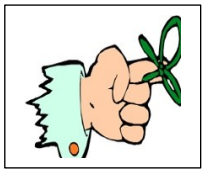
Once your plan is implemented, how do you know if it's working? During this session, HQIN will share data collection tools to help you track and trend your improvement related to hand hygiene, terminal cleaning and PPE.

August 25, 2020 | 2:00 p.m. ET/1:00 p.m. CT - QAPI: Everyone Has a Role and a Responsibility

It takes a team to ensure improvement is made and sustained. During this session, HQIN will discuss how to engage your team in the quality improvement process in order to hardwire systems, change behavior, reduce gaps and improve care and compliance.

Click here to register for one or all of these sessions. To learn more about HQIN, visit www.hqin.org.

NEW Resource Meal Service and Food Delivery During COVID-19



Remember the little things too!! COVID has certainly challenged all of us and has taught us to think outside the box more than ever. How to serve residents their meals in a safe and sanitary manner, while still being an enjoyable event is a battle that many facilities are facing. CHC has developed a new policy that offers guidance on serving meals to resident with confirmed or suspected cases of COVID-19 as well as serving residents who are not suspected or confirmed for COVID-19. The price of the policy is $50, please contact Mary at Mary@chileshealthcare.com if interested in purchasing.

NEW Resource for ALF – CHC has developed an Environment and Resident Rounding tool specific to the Assisted Living population. This tool is excellent for quality improvement initiatives but also serves as an educational tool to help orient new ALF team members on areas that needs frequent monitoring. Cost is $50. Contact Mary at Mary@chileshealthcare.com if you are interested.

Virginia COVID-19 Long-Term Care Facility Task Force Playbook

VDH developed this document to serve as a playbook on how to access various staffing, supplies, infection control, and other resources to support responses to COVID-19 cases and outbreaks in long-term care facilities (LTCFs) and in some circumstances, other residential facilities.

Topics included are:

• Outbreak Reporting	• Phased Reopening	• Staffing
• Healthcare Coalition	• Testing	• PPE
• Fit Testing	• Infection Control	• Behavioral Health
• Care Transitions	• Communication	•

The document also provided links to additional COVID-19 resources. The document may be found at: VDH Long Term Care Facility Task Force COVID Playbook

CDC Updated Guidance on COVID-19 Testing for Nursing Homes

On July 2, CDC updated guidance on testing in nursing homes. The document may be found at: Guidance on Testing Individuals in Nursing Homes

The new guidance includes key changes below:

- Facilities should have a SARS—CpV-2 testing plan in place following CDC, state, and national guidance.
- Testing conducted at nursing homes should be implemented in addition to recommended infection prevention control measures
- Nursing home residents are at high risk for infection, serious illness, and death from COVID-19. Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as viral testing) among residents in nursing homes. Viral testing of residents in nursing homes, with authorized nucleic acid or antigen detection assays, is an important addition to other infection prevention and control (IPC) recommendations aimed at preventing SARS-CoV-2 from entering nursing homes, detecting cases quickly, and stopping transmission. This guideline is based on currently available information about COVID-19 and will be refined and updated as more information becomes available.
- Testing practices should aim for rapid turnaround times (e.g., less than 24 hours) in order to facilitate effective interventions.
- Testing the same resident more than once in a 24-hour period is not recommended.
- Antibody (serologic) test results generally should not be used as the sole basis to diagnose an active SARS-CoV-2 infection and should not be used to inform IPC actions.
- While this guidance focuses on testing in nursing homes, several of the recommendations such as testing residents with signs or symptoms of COVID-19 and testing asymptomatic close contacts should also be applied to other long-term care facilities (e.g., assisted living facilities, intermediate care facilities for individuals with intellectual disabilities)

Diagnostic Testing

Testing resident with signs or symptoms of COVID-19

- Take temps of all residents and ask if they have any COVID-19 symptoms at least daily
- Perform viral testing of any resident that has signs or symptoms of COVID-19
- Clinicians should use their judgment to determine if a resident has s/s consistent with COVID-19 and whether the resident should be tested. Individuals may not show common symptoms such as fever or respiratory symptoms.
- Clinicians are encouraged to consider testing for other causes of respiratory illness, such as influenza, in addition to testing for SARS-CoV2.

Testing asymptomatic resident with known or suspected exposure to an individual infected with SARS CoV-2, including close or expanded contacts i.e. there is an outbreak in the facility.

- Perform expanded viral testing of **all** residents in the nursing home if there is an outbreak in the facility (i.e., a new SARS-CoV-2 infection in any HCP or any nursing home-onset SARS-CoV-2 infection in a resident).
- When undertaking facility-wide viral testing, facility leadership should expect to identify multiple asymptomatic and pre-symptomatic residents with SARS-CoV-2 infection and be prepared to cohort residents.
- If viral testing capacity is limited, CDC suggests first directing testing to residents who are close contacts (e.g., on the same unit or floor of a new confirmed case or cared for by infected HCP).

Initial (baseline) testing of asymptomatic residents without known or suspected exposure to an individual infected with SARS-CoV-2 is part of the recommended reopening process

- Perform initial viral testing of each resident in a nursing home as part of the recommended reopening process
- In any nursing home, initial viral testing of each resident (who is not known to have previously been diagnosed with COVID-19) is recommended because of the high likelihood of exposure during a pandemic, transmissibility of SARS-CoV-2, and the risk of complications among residents following infection.
- The results of viral testing inform care decisions, infection control interventions, and placement decisions (e.g., cohorting decisions) relevant to that resident.

Testing to determine resolution of infection

- A test-based strategy, which requires serial tests and improvement of symptoms, can be used as an alternative to a symptom-based or time-based strategy, to determine when a resident with SARS-CoV-2 infection no longer requires Transmission-Based Precautions.

Repeat Testing in Coordination with the Health Department

Non-diagnostic testing of asymptomatic residents without known or suspected exposure to an individual infected with hSARS-CoV-2 (apart from the initial testing referenced above)

- After initially performing viral testing of all residents in response to an outbreak, CDC recommends repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below. Repeat testing should be coordinated with the local, territorial, or state health department.
- Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result. This follow-up viral testing can assist in the clinical management of infected residents and in the implementation of infection control interventions to prevent SARS-CoV-2 transmission.
- If viral test capacity is limited, CDC suggests directing repeat rounds of testing to residents who leave and return to the facility (e.g., for outpatient dialysis) or have known exposure to a case (e.g., roommates of cases or those cared for by a HCP with confirmed SARS-CoV-2 infection). For large facilities with limited viral test capacity, testing only residents on affected units could be considered, especially if facility-wide repeat viral testing demonstrates no transmission beyond a limited number of units.

CHC has Encrypted Zoom - As we all have learned to do things differently in the era of COVID-19, CHC is no exception. We have the capability of conducting Zoom meeting and presentations with multiple participants. The account is encrypted so all information shared is protected. We also have the ability and experience of conducting remote chart and medical record reviews, however your do need a cloud based software with the ability to assign remote users view only privileges. Don't let COVID be a total distraction from the day to day operations of your facility. As the saying goes…."the show must go on" and so too shall our operations. Reach out to Mary at mary@chileshealthcare.com to schedule your education, training needs or chart reviews, focus audits, etc. Our clients remain our priority and we are committed to offering you the best service and guidance that we can.

6 Ways that COVID-19 has Helped Strengthen our Well-being

When COVID-19 made its way into our lives, the pace of life was a fast and furious race. From this pandemic, we have learned that we are more durable and more resilient than we ever thought. We have remembered many of the ways of living that were the norm to past generations.

1. Our routines have been softened, reorganized, or completely restructured. (We might like this new way of living.)
2. There is more family time and focus on things that can be done inside the home. (Game night is such fun!)
3. Extended family communications have been strengthened and have become more routine. (The fear of losing our loved ones has made us more appreciative of those special calls and times together.)
4. Instituting the slow and calm has helped us reflect on what is important and how we can achieve more with less. (Simplifying wasn't that hard.)
5. More in-depth conversations and active listening have brought a sense of healing and belonging in a time when little is within our control. (Nothing beats good communication.)
6. How we care for ourselves and others does matter. (Wellness is a priority.)