DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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Office of Clinical Standards & Quality/Survey & Certification Group

REF: S&C: 12-01-Hospital

DATE: **October 14, 2011**

TO: State Survey Agency Directors

FROM: Director
Survey & Certification Group

SUBJECT: Survey & Certification Focus on Patient Safety and Quality - Draft Surveyor Worksheets

Memorandum Summary

- ***Focused Survey Initiative*:** The Centers for Medicare & Medicaid Services (CMS) is testing three new surveyor worksheets for assessing compliance with three hospital Conditions of Participation (CoPs): Discharge Planning, Infection Control, and Quality Assessment and Performance Improvement (QAPI). A separate document containing instructions for the Infection Control worksheet is also included. We are focusing on compliance with these CoPs as a means to reduce healthcare-acquired conditions (HACs) and hospital readmissions.

- ***Draft Worksheets Made Public:*** Via this memorandum we are making these draft worksheets publicly available. We emphasize that we expect to revise these worksheets over the course of FY 2012 and that they will not be made a formal part of the federal hospital survey process before FY 2013.

The U.S. Department of Health & Human Services (HHS) is placing a high priority on improving patient safety and quality of care in our nation's health care system. For example, in April 2011, HHS announced a new initiative, the *Partnership for Patients: Better Care, Lower Costs (PfP),* which aims to keep hospital patients from getting injured or sicker, and to help them to heal without complication. The PfP brings together, on a voluntary basis, leaders of hospitals (over 2,500 to date), employers, health plans, physicians, nurses, and patient advocates, along with State and Federal governments, in a shared effort to achieve the ambitious goals of reducing hospital readmissions by 20% and HACs by 40% by 2013.

CMS is undertaking a wide range of actions to support the PfP goals. CMS' Survey & Certification (S&C) program, together with our partners in the State Survey Agencies (SAs), also have important roles to play to promote optimum patient safety and quality of care. Our working assumption is that hospitals with full compliance with the Medicare CoPs

pertaining to QAPI, infection control, and discharge planning requirements will be in a better position to reduce healthcare-acquired conditions (HACs) and the need for hospital readmissions. To this end, CMS is pre-testing three new surveyor worksheets that are intended to aid surveyors in assessing hospital compliance with these three Medicare CoPs. The draft worksheets being used in the pre-test are enclosed with this memo.

We expect that the new tool-guided assessment processes will promote a more in-depth, consistent approach to onsite hospital surveys related to the three target areas of the CoPs. The pre-testing process provides an opportunity for refinement of the worksheets through feedback from SA surveyors who use the worksheets and from hospitals that are surveyed. We also welcome feedback from the hospital industry at large, from patients and consumer groups, and others committed to quality and patient safety.

Several SAs have volunteered to assist us in the first pre-test phase of developing these worksheets. CMS has developed criteria to aid the SAs in selecting for pre-test surveys hospitals whose performance suggests they may be at greater risk of noncompliance with the three Medicare CoPs, based on their risk-adjusted all-cause readmission rates. Later in FY 2012, we expect that all SAs will be testing a revised version of each of the worksheets in a limited number of surveys. We will also make the revised draft worksheets public when they become available for the SAs to test.

The underlying CoPs for QAPI, infection control, and discharge planning have not changed. These regulations are the basis for any deficiencies that may be cited, not the tool itself. The tool is simply designed to assist surveyors (and hospital staff) to better identify when and where there are issues in compliance with the CoPs.

However, we are still working on precise guidance by which the classification of any deficiency (condition-level versus standard-level) is made once the tool is applied (other than immediate jeopardy). Therefore, unless an immediate jeopardy is found, we expect that all other findings involved in the use of the draft tool during this pre-test phase (2012) will be cited as standard-level (i.e., less serious) deficiencies. In the case of hospitals that participate in Medicare via deemed status through an approved accreditation program, surveys with only standard-level citations do not require submission of a plan of correction (although hospitals are free to do so). In the case of non-accredited hospitals, surveys with only standard-level citations will require submission of an acceptable plan of correction.

We emphasize, however, that if the SA applies the current guidance for the CoP in question (as well as the criteria in Appendix Q of the State Operations Manual (SOM)) and determines that an immediate jeopardy is present, the SA must follow the standard SOM enforcement procedures and cite the IJ. Such procedures may include, as applicable, removal of deemed status and a subsequent survey to confirm correction of deficiencies.

If you have questions or concerns regarding the testing of these draft worksheets, please contact Mary Ellen Palowitch at: PFP.SCG@cms.hhs.gov.

/s/
Thomas E. Hamilton

Attachments: (4)

Discharge Planning Surveyor Worksheet
Infection Control Surveyor Worksheet
Instructions Infection Control Surveyor Worksheet
QAPI Surveyor Worksheet

cc: Survey & Certification Regional Office Management

DRAFT #2 PRE-DECISIONAL SURVEYOR WORKSHEET

Assessing Hospital Compliance with the

Condition of Participation for Discharge Planning

Name of State Agency: _____

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Discharge Planning Condition of Participation. Items are to be assessed by a combination of observation, review of the hospital's discharge planning program documentation, interviews with hospital staff, patients and their family/support persons, and review of medical records.

The interviews should be performed with the most appropriate staff person(s) for the items of interest, as well as with patients, family members, and support persons.

Citation instructions are provided throughout this instrument, indicating the applicable regulatory provision to be cited on Form CMS-2567 when deficient practices are observed.

Section 1 Hospital Characteristics

1. Hospital name: _____
2. Address, State, Zip Code: _____

   _____
3. CMS Certification Number (CCN): | | | | | | |

4. Does the hospital participate in Medicare via accredited "deemed" status?

   a. If YES, which Accrediting Organization(s)?

      i. ○ American Osteopathic Association (AOA)/Healthcare Facilities Accreditation Program (HFAP)

      ii. ○ Det Norske Veritas Healthcare (DNV)

      iii. ○ The Joint Commission (TJC)

   b. If YES, according to the hospital, what was the end date of the most recent accreditation survey:

		/			/				

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5. What was the end date of the most recent previous State Agency Federal survey:

		/			/				

Section 2 Discharge Planning – Policies and Procedures		
Elements to be assessed		**Manner of Assessment Code (list all that apply) & Surveyor Notes**
2.1 Are discharge planning policies and procedures in effect for all inpatients? Specifically:		
2.1a In every inpatient unit surveyed is there evidence of applicable discharge planning activities?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2.1b Are staff members responsible for discharge planning activities correctly following the hospital's discharge planning policies and procedures?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no for either 2.1a or 2.1b cite the applicable standard for identification of patients needing discharge planning (42 CFR 482.43(a); discharge planning evaluation (42 CFR 482.43(b); or developing and implementing the discharge plan (42 CFR 482.43(c). **(Tags A-0800, A-0806, A-0817)**		
2.2 Does the discharge planning process apply to certain categories of outpatients?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If yes, check all that apply: ○ Same day surgery patients ○ Observation patients who are not subsequently admitted ○ ED patients who are not subsequently admitted ○ Other		
2.3 Is a discharge plan prepared for each inpatient?	○ Yes, skip to question 2.8 ○ No, go to question 2.4	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: No citation is made related to questions 2.2 and 2.3		

Elements to be assessed		Manner of Assessment Code (list all that apply) & Surveyor Notes
2.4 For patients not initially identified as in need of a discharge plan, is there a process for updating this determination based on changes in the patient's condition or circumstances? Specifically,		
2.4a Does the discharge planning policy address changes in patient condition that would call for the development of a discharge plan in patients not previously identified as in need of one?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2.4b Are inpatient unit staff aware of how, when, and whom to notify of such changes in patient condition?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no to either, cite 42 CFR 482.43(a) (Tag A-0800)		
2.5 Is there a process for patients or their representatives, and physicians to request a discharge planning evaluation? Specifically,		
2.5a Does the hospital have a standard process for notifying patients, their representative, and physicians that they may request a discharge planning evaluation and that the hospital will conduct an evaluation upon request?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2.5b Can discharge planning and unit nursing staff describe the process for a patient or the patient's representative to request a discharge planning evaluation?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2.5c Interview patients and their representatives. If they say they were not aware they could request a discharge planning evaluation, can the hospital provide evidence they received notice of their right?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Interview = 1 Observation = 2 Discharge Planning Document Review = 3 Medical Record Review = 4 Other Document Review = 5

Elements to be assessed		Manner of Assessment Code (list all that apply) & Surveyor Notes
2.5d Interview attending physicians. If they are not aware they can request a discharge planning evaluation, can the hospital provide evidence of how they inform the medical staff about this?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no to any part of question 2.5, cite 42 CFR 482.43(b)(1) (Tag A-0806)		
2.6 Interview attending physicians. If they are not aware they can request a discharge plan regardless of the outcome of the completed evaluation, can the hospital provide evidence of how they inform the medical staff about this?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(c)(2) (Tag A-0819)		
2.7 Can discharge planning personnel describe a process for physicians to order a discharge plan to be completed on a patient, regardless of the outcome of the evaluation?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(c)(1) (Tag A-0817)		
2.8 Does the hospital discharge planning policy include a process for ongoing reassessment of the discharge plan based on changes in patient condition, changes in available support, and/or changes in post-hospital care requirements?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(c)(4) (Tag A-0821)		

Interview = 1 Observation = 2 Discharge Planning Document Review = 3 Medical Record Review = 4 Other Document Review = 5

Section 3 Discharge Planning – Reassessment and QAPI		
Elements to be assessed		**Manner of Assessment Code (list all that apply) & Surveyor Notes**
3.1 Does the hospital review the discharge planning process in an ongoing manner (at least quarterly)?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.2 Does the hospital track its readmissions as part of its review of the discharge planning process?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.2a Does the assessment of readmissions include an evaluation of whether the readmissions were potentially preventable?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.3 Speak with QAPI and Discharge Planning staff members. Can they provide examples of readmission reviews that resulted in identification of problems in the discharge planning process and subsequent corrective actions to address the problems?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, to any one of 3.1 through 3.3, cite 42 CFR 482.43(e) (Tag A-0843) Consider citing QAPI 42 CFR 482.21(c) (Tag A-0283)		
3.4 Does the hospital have a process for collecting and considering feedback from post-acute providers in the community about the effectiveness of the hospital's discharge planning process?	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation is made related to this question		

Interview = 1 Observation = 2 Discharge Planning Document Review = 3 Medical Record Review = 4 Other Document Review = 5

Section 4 Discharge Planning Tracers

In this section, survey 1-2 current inpatients and review the closed medical records of 2-3 discharged patients. When possible, include one inpatient who was readmitted within 30 days of a previous admission. Note key at bottom of page for Manner of Assessment code.

DCP = Discharge Planning

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.1 When was the screening done to identify whether the inpatient needed a discharge planning evaluation? a. Before or at time of admission b. After admission but at least 48 hours prior to discharge c. N/A – all admitted patients receive a discharge plan d. None of the above	a. ○ b. ○ c. ○ d. ○	a. ○ b. ○ c. ○ d. ○	a. ○ b. ○ c. ○ d. ○	a. ○ b. ○ c. ○ d. ○
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If response 4.1d selected, cite 42 CFR 482.43(a) (Tag A-0800)				
4.2 Can hospital staff demonstrate that the hospital's criteria and screening process for a discharge planning evaluation were correctly applied?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(a) (Tag A-0800)				

Interview = 1 Observation = 2 Discharge Planning Document Review = 3 Medical Record Review = 4 Other Document Review = 5

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.3 If the patient did not meet the hospital's criteria for an evaluation, were the patient or patient's representative and the physician made aware they could still request a discharge planning evaluation?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(b)(1) (Tag A-0806)				
4.4 Was the discharge planning evaluation and, as applicable, the discharge plan developed by an RN, Social Worker, or other qualified personnel, as defined in the hospital discharge planning policies and procedures, or someone they supervise?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(b)(2)(evaluation) and/or 42 CFR 482.43 (c)(1)(plan) (Tag A-0807 and/or Tag A-0817 as applicable)				
4.5 Are the results of the discharge planning evaluation documented in the medical record?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.6 Did the evaluation include an assessment of the patient's post-discharge care needs being met in the environment from which he/she entered the hospital?	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No	○ Yes ○ No
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
For patients admitted from home				
4.7 Did the evaluation include an assessment of the patient's ability to perform activities of daily living (e.g. personal hygiene and grooming, dressing and undressing, feeding, voluntary control over bowel and bladder, ambulation, etc.)?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.8 Did the evaluation include an assessment of the patient's or family/support person's ability to provide self-care/care?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.9 Did the evaluation include an assessment of whether the patient will require specialized medical equipment or home and physical environment modifications?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.9a If yes, did the evaluation include an assessment of whether the equipment is available or if the modifications can be made to safely discharge the patient to that setting?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.10 If the patient or family/support person is unable to meet care needs or there are additional care needs above their capabilities, did the evaluation include an assessment of available community-based services to meet post-hospital needs?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If any no answer to questions 4.5 – 4.10, cite 42 CFR 482.43(b)(4) (Tag A-0806)				

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.11 If applicable, did the hospital provide the patient with lists of Medicare-participating HHAs or SNFs that provide post-hospital services that could meet the patient's medical needs?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.11a Were the lists geographically appropriate for the patient?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no to 4.11 or 4.11a, cite 42 CFR 482.43(c)(6) (Tag A-0823)				
For patients admitted from a nursing home/skilled nursing facility/assisted living				
4.12 Did the evaluation assess whether the prior facility has the capability to provide necessary post-hospital services to the patient (i.e. is the same, higher, or lower level of care required and can those needs be met?)	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
For all patients				
4.13 Did the evaluation include an assessment of the patient's insurance coverage (if applicable) and how that coverage might or might not provide for necessary services post-hospitalization?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to 4.12 or 4.13 cite 42 CFR 482.43(b)(4) (Tag A-0806)				
4.14 Was the discharge planning evaluation completed in a timely basis to allow for appropriate arrangements to be made for post-hospital care and to avoid delays in discharge?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(b)(5) (Tag A-0810)				
4.15 Was the patient or the patient's representative involved in a discussion of the evaluation results?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(b)(6) (Tag A-0811). Consider citing 42 CFR 482.13(b)(1) Patients Rights (Tag A-0130)				

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.16 Did the discharge plan match the identified needs as determined by the evaluation?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(c)(1) (Tag A-0817)				
4.17 If any significant changes in the patient's condition were noted in the medical record that changed post-discharge needs, was the discharge plan updated accordingly?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(c)(4) (Tag A-0821)				
4.18 For patients discharged to home, did the hospital arrange for the initial implementation of the discharge plan? Specifically, look for evidence of the following, if applicable, based on the discharge plan:				
4.18a Providing in-hospital training to patient and family/support persons, using recognized methods. (Examples include teach-back or repeat-back , simulation laboratories, etc. but specific methods are not required.)	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.18b Written discharge instructions that are legible and use non-technical language.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.18c Medication reconciliation that includes a clearly legible, complete medication list that highlights changes from the pre-hospital regimen.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.18d Referrals to established/new primary care physician or health center.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.18e Referrals to specialized ambulatory services, e.g. PT, OT, HHA, hospice, mental health, etc.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.18f Referrals to community-based resources other than health services, e.g. Depts. of Aging, elder services, transportation services, etc.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.18g Arranging essential durable medical equipment, e.g. oxygen, wheel chair, hospital bed, commode, etc.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.18h Sending a discharge summary to providers the patient was referred to prior to the first post-discharge appointment or within 7 days of discharge, whichever comes first.	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If implementation of the discharge plan was not initiated, cite 42 CFR 482.43(c)(3) (Tag A-0820). Cite 42 CFR 482.43(c)(5) when counseling of family members does not occur (Tag A-0822). If the answer to 4.18h is no, cite 42 CFR 482.43(d) (Tag 0837) and 42 CFR 482.24(c)(2)(vii) (Tag A-0468)				
4.19 For patients transferred to another inpatient facility, was a discharge summary ready at time of transfer and sent to the receiving facility with the patient?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If discharge summary was not ready at time of transfer, cite 42 CFR 482.24(c)(2)(vii) (Tag A-0468)				
4.20 Were there portions of the plan the hospital failed to begin implementing, resulting in delays in discharge?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If yes, cite 42 CFR 482.43(c)(3) (Tag A-0820)				

	Patient/Record #1	Patient/Record #2	Patient/Record #3	Patient/Record #4
4.21 *For information only*, were any of the following services initiated while the patient was hospitalized:				
a. Scheduling follow-up appointments b. Filling prescriptions c. Home setting visitation by hospital staff d. Transportation arranged for follow-up appointments e. Discharge planning checklists, e.g. CMS, AHRQ, CAPS checklists	a. ○ b. ○ c. ○ d. ○ e. ○	a. ○ b. ○ c. ○ d. ○ e. ○ f.	a. ○ b. ○ c. ○ d. ○ e. ○	a. ○ b. ○ c. ○ d. ○ e. ○
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: Do not cite; these are not required under the regulations				
4.22 Is there documentation in the medical record of providing the results of tests, pending at time of discharge, to the patient and/or post-hospital provider of care?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: If no, cite 42 CFR 482.43(d) (Tag A-0837)				
4.23 Is there any evidence the patient has been readmitted to this hospital within 30 days of a prior related admission?	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A	○ Yes ○ No ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
NOTE: Do not cite				

DRAFT PRE-DECISIONAL SURVEYOR WORKSHEET

Assessing Hospital Compliance with the

Condition of Participation for Infection Control

Name of State Agency: _____

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the Infection Control Condition of Participation. Items are to be assessed by a combination of observation, review of the hospital's infection control program documentation, interviews with hospital staff, patients and their family/support persons, and review of medical records.

The interviews should be performed with the most appropriate staff person(s) for the items of interest, as well as with patients, family members, and support persons.

Citation instructions are provided throughout this instrument, indicating the applicable regulatory provision to be cited on Form CMS-2567 when deficient practices are observed.

Section 1 Hospital Characteristics

1. Hospital name: _____
2. Address, State, Zip Code: _____

   _____
3. CMS Certification Number (CCN): | | | | | | |
4. Date of site visit:

		/			/					to			/			/			

5. Does the hospital participate in Medicare via accredited "deemed" status?

   a. If YES, which Accrediting Organization(s)?

      i. ○ American Osteopathic Association (AOA)/Healthcare Facilities Accreditation Program (HFAP)

      ii. ○ Det Norske Veritas Healthcare (DNV)

      iii. ○ The Joint Commission (TJC)

   b. If YES, according to the hospital, what was the end date of the most recent accreditation survey:

		/			/				

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6. What was the end date of the most recent previous State Agency Federal survey:

		/			/				

Module 1: Interview Questions

Section 1. A. Infection control/prevention program and resources		
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
1. A.1 The hospital has designated one or more individual(s) as its infection control officer(s)?	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		
1. A.2 The hospital has Infection Control policies and procedures developed and implemented by the infection control officer(s).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		
1. A.3 The hospital has evidence that demonstrates the infection control officer(s) is qualified and maintain(s) qualifications through education, training, experience or certification related to infection control consistent with hospital policy.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		
1. A.4 Hospital leadership ensures the hospital QAPI program effectively address identified problems in infection control on an ongoing basis.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756)		
1. A.5 The infection control officer(s) (ICO) can provide evidence that the hospital has developed general infection control policies and procedures that are based on internal organizational assessment, nationally recognized guidelines, and applicable state and federal law.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 482.42(a) (Tag A-0748)		

Section 1. B. Hospital QAPI systems related to Infection Prevention and Control		
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
The hospital infection prevention program is coordinated into the hospital QAPI program as evidenced by:		
1. B.1 The Infection Control Officer(s) can provide evidence of involvement in QAPI activities related to Infection prevention and control (e.g. risk assessment and indicator selection, data collection activities, and data analysis activities).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756) and 42 CFR 482.21(c)(1) (Tag A-0273)		
1. B.2 The Infection Control Officer(s) can provide evidence of involvement in QAPI activities related to infection prevention and control such as development and implementation of corrective interventions, and ongoing evaluation of interventions implemented for both success and sustainability.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(2) (Tag A-0756) and 42 CFR 482.21(c)(3) (Tag A-0283)		
1. B.3 Hospital staff report hospital acquired infections (through internal reporting systems) and those reports reach the QAPI program staff responsible for the assessment of adverse events in the hospital.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756) and 42 CFR 482.21(c)(2) (Tag A-0286)		
1.B.4 Hospital acquired infections that resulted in death or serious harm (adverse events) were identified, tracked, and analyzed by the hospital and such adverse events are included in the hospitals ongoing QAPI program.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756) and 42 CFR 482.21(a)(2) (Tag A-0286)		
1. B.5 The hospital-wide quality assurance program and training programs address problems identified by the infection control officer including but not limited to patient safety events.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756)		

1. B.6 Hospital leadership, which may include the CEO, Medical Staff, and/or the Director of Nursing Services ensures the hospital implements successful corrective action plans in affected problem area(s).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(2) (Tag A-0756) and 42 CFR 482.21(c)(3) (Tag A-0283)		
1. B.7 The hospital utilizes a risk assessment process to prioritize selection of quality indicators for infection prevention and control.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation		

Section 1. C. Systems to prevent transmission of MDROs and promote antibiotic stewardship, Surveillance		
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
1. C.1 The hospital identifies and tracks patients in the hospital with multiple drug resistant organisms (MDROs)?	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation		
1. C.2 Can the primary interview participants provide evidence that the hospital has developed and implemented policies and procedures aimed at preventing the development of, and preventing transmission of, MDROs?	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation		
1. C.2.a Facility has a multidisciplinary process in place to review antimicrobial utilization, local susceptibility patterns, and antimicrobial agents in the formulary *and* there is evidence that the process is followed.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

1. C.2.b Systems are in place to prompt clinicians to use appropriate antimicrobial agents (e.g., computerized physician order entry, comments in microbiology susceptibility reports, notifications from clinical pharmacist, formulary restrictions, evidenced based guidelines and recommendations).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
1. C.2.c Antibiotic orders include an indication for use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
1. C.2.d There is a mechanism in place to prompt clinicians to review antibiotic courses of therapy after 72 hours of treatment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
1. C.2.e The facility has a system in place to identify patients currently receiving intravenous antibiotics who might be eligible to receive oral antibiotic treatment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation for 1.C.2.a through 1.C.2.e		
1. C.3 Is there evidence of compliance with the hospital policies and procedures developed to ensure that the hospital minimizes risk of transmission of MDROs within the organization (between or amongst patients and HCP (health care personnel))?	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation		
1. C.4 The hospital has established systems with a Clinical microbiology laboratory that ensures prompt notification of IP staff or medical director/designee when a novel resistance pattern is detected.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation		
1.C.5 ICO maintains a log of incidents related to hospital associated infections (HAIs) and communicable diseases, including those identified in both patients and HCPs.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(2) (Tag A-750)		

1.C.6 HAIs, including but not limited to identified central line associated blood stream infections (CLABSI), catheter associated urinary tract infection (CAUTI), ventilator associated pneumonia (VAP), surgical site infection (SSI), methicillin resistant Staphylococcus Aureas (MRSA), Clostridium *Difficile* infection(CDI) and TB, are identified and recorded in the hospital's log by location throughout the hospital.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(2) (Tag A-750)		
1. C.7 Patients and HCP identified by laboratory culture as colonized or infected with MDROs are included in the log. (Note: The hospital is not required to perform routine surveillance of HCP.)	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(2) (Tag A-750)		
1. C.8 Patients who meet CDC criteria for requiring isolation precautions during their hospitalizations are identified in the log.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(2) (Tag A-750)		
1. C.10 Does the hospital have a system for identifying those present on admission (POA) infections in order to control (prevent spread of) those infections and communicable diseases in the hospital? (This may or may not include use of the hospital log and does not require the hospital to perform cultures on all patients admitted to the hospital.)	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		
1. C.11 The ICO can provide evidence that an updated list of diseases reportable to the local or state public health authority is available.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		
1. C.12 The ICO can provide evidence that reportable diseases are documented and submitted as required by the local health authority.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		

Section 1. D Personnel Education System / Infection Control Training		
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
1.D.1 HCP receive job-specific training on hospital infection control practices, policies and procedures upon hire and at regular intervals	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		
1. D.2 Competency and compliance with job-specific infection prevention policies and procedures are ensured through training when problems are identified by the ICO.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756)		
1. D.3 The hospital can provide evidence of HCP competencies including remediation results when applicable.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756)		
1. D.4 The hospital system for identifying, reporting, investigating, and controlling infections includes provisions to train HCP that are in contact with bloodborne pathogens on the bloodborne pathogen standards upon hire and when problems are indentified.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		
1. D.5 The hospital system for identifying, reporting, investigating, and controlling infections addresses needle sticks, sharps injuries, and other employee exposure events.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		
1. D.6 Following an exposure event, post-exposure evaluation and follow-up, including prophylaxis as appropriate, is available.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

1. D.7 If the hospital has had HCP infection exposure events, the hospital evaluates HCP infection exposure event data and develops/ implements corrective action plans to reduce the incidence of such events.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756)		
1. D.8 The hospital system for identifying, reporting, and investigating infection control incidents includes providing Hepatitis B vaccine and vaccination series to all employees who have occupational exposure and conducting post-vaccination screening after the third vaccine dose is administered.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation		
1. D.9 The hospital system for identifying, reporting, and investigating infection control incidents includes provisions that all HCP (paid and unpaid) who have potential for exposure to TB are screened for TB upon hire and annually (if negative).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation		
1.D.10 The hospital system for identifying, reporting, investigating, and controlling infections includes provision that ensure HCP with TB test conversions are provided with appropriate follow-up.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		
1. D.11 Aggregated rates of TB-test conversion are periodically reviewed by the ICO to determine the need for corrective action plans.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(1) (Tag A-0756)		
1. D.12 The hospital system for identifying, reporting, investigating, and controlling infections includes provisions that ensure the facility has a respiratory protection program that details required worksite-specific procedures and elements for required respirator use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		

1. D.13 The hospital system for identifying, reporting, investigating, and controlling infections includes provisions that ensure that respiratory fit testing is provided at least annually to appropriate HCP.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		
1. D.14 The hospital system for identifying, reporting, and investigating infection control incidents includes provisions that ensure that all HCP are offered annual influenza vaccination.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
No citation		
1. D.15 ICO has written protocols for handling job-related and community-associated infectious diseases exposures in HCP.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)		

Module 2: General Location Module

Section 2. A Hand Hygiene				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
2. A.1 Soap, water, and a sink are readily accessible in patient care areas including but not limited to direct care areas (such as food and medication preparation areas).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. A.2 Hand hygiene is performed in a manner consistent with hospital infection control practices, policies, and procedures to maximize the prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. A.3 Alcohol-based hand rub (ABHR) is readily accessible and placed in appropriate locations.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. A.4 Does the hospital have policies and documented training that demonstrates HCP are educated regarding appropriate indications for hand washing with soap and water versus hand rubbing with alcohol-based hand rub? *Note: Soap and water must be used when bare hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected infectious diarrhea (e.g., *C. difficile* or norovirus). In all other situations, alcohol-based hand rub may be used.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2.A.5 HCP perform hand hygiene: • Before contact with the patient or their immediate care environment (even if gloves are worn) • Before exiting the patient's care area after touching the patient or the patient's immediate environment (even if gloves are worn) • Before performing an aseptic task (e.g., insertion of IV or urinary catheter, even if gloves are worn) • After contact with blood, body fluids or contaminated surfaces, (even if gloves are worn)	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2. A.1 through 2. A.5), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
2. A.6 The hospital ICO has developed and implemented policies and procedures for hand hygiene that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 2. B Injection Practices and Sharps Safety (Medications, Saline, Other Infusates)

Elements to be assessed		Manner of Assessment Code (check all that apply) & Surveyor Notes		Manner of Assessment Code (check all that apply) & Surveyor Notes
Injections are given and sharps safety is managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. B.1 Injections are prepared using aseptic technique in an area that has been cleaned and free of visible blood, body fluids, or contaminated equipment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. B.2 Needles are used for only one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2. B.3 Syringes are used for only one patient (this includes manufactured prefilled syringes and insulin pens).	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
2. B.4 The rubber septum on a medication vial is disinfected with alcohol prior to piercing.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
2. B.5 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 patients. If a surveyor sees needles or 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.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
2. B.6 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 patients. If a surveyor sees needles or 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.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
2. B.7 Single dose (single-use) medication vials are used for only one patient.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
2. B.8 Bags of IV solution are used for only one patient (and not as a source of flush solution for multiple patients).	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5

2. B.9 Medication administration tubing and connectors are used for only one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. B.10 Multi-dose 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: this 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 hospital policies and procedures, so long as it is clear what the date represents and the same policy is used consistently throughout the hospital.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. B.11 If multi-dose vials are used for more than one patient, they do not enter the immediate patient treatment area (e.g., operating room, patient room, anesthesia carts) . Note: if multi-dose vials are found in the patient care area they must be dedicated for single patient use and discarded after use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. B.12 All sharps are disposed of in a puncture-resistant sharps container.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. B.13 Sharps containers are replaced when the fill line is reached.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. B.14 Filled sharps containers are disposed of in accordance with State medical waste rules.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.B.1 through 2.B.14), cite at 42 CFR 482.42(a)(1) (Tag A-749)) *See notes on 2.B.5 and 2.B.6 if "no" is checked.				

2.B.15 The hospital ICO has developed and implemented policies and procedures for injection practices and sharps safety that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 2. C Environmental Cleaning/Disinfection				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Environmental cleaning/ disinfection is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including:				
2. C.1 Cleaners and EPA-registered hospital disinfectants are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. C.2 High touch environmental surfaces in procedure rooms are cleaned and disinfected between patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. C.3 Reusable noncritical items (e.g., blood pressure cuffs, oximeter probes) are cleaned and disinfected between patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. C.4 Single use devices are discarded after use and not used for more than one patient. If no, do not cite and go to question 2.C.5.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2.C.5 If the hospital elects to reuse single-use devices, these devices are reprocessed by an entity or a third party reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital must have documentation from the third party reprocessor confirming this is the case.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.C.1 through 2.C.5), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
Laundry is processed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. C.6 HCP handle soiled textiles/linens in a manner that ensures segregation of dirty from clean textiles/linens and ensure that there is not cross contamination of clean textiles/linens prior to use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. C.7 Soiled textiles are bagged at the point of collection and kept in a covered leak-proof container or bag at all times until they reach the laundry facility.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. C.8 There is clear separation of soiled laundry space from clean laundry areas and soiled laundry is maintained.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.C.6 through 2.C.8), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
2. C.9 The hospital ICO has developed and implemented policies and procedures for environmental cleaning and disinfection that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 2. D Personal Protective Equipment				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Personal protective equipment is utilized in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. D.1 Supplies for adherence to Standard and Transmission-based Precautions (e.g., gloves, gowns, mouth, eye, nose, and face protection) are available and located near point of use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. D.2 HCP wear gloves for procedures/activities where contact with blood, body fluids, mucous membranes, or non-intact skin is anticipated.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. D.3 HCP change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. D.4 Gowns are worn to prevent contamination of skin and clothing during procedures/activities where contact with blood, body fluids, secretions, or excretions are anticipated.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. D.5 Gowns and gloves are removed and hand hygiene is performed immediately before leaving the patient's environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. D.6 Appropriate mouth, nose, eye protection is worn for aerosol-generating procedures and/or procedures/activities that are likely to generate splashes or sprays of blood or body fluids.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.D.1 through 2.D.6), cite at 42 CFR 482.42(a)(1) (Tag A-749)				

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2. D.7 The hospital ICO has developed and implemented policies and procedures for the use of personal protective equipment that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 2. E Point of Care Devices (e.g. Blood Glucose Meter, INR Monitor)

Elements to be assessed		Manner of Assessment Code (check all that apply) & Surveyor Notes		Manner of Assessment Code (check all that apply) & Surveyor Notes
Point of care devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. E.1 Hand hygiene is performed before the procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. E.2 Gloves are worn by HCP when performing the finger stick procedure to obtain the sample of blood.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. E.3 Finger stick devices are not used for more than one patient. Note: This includes both the lancet and the lancet holding device.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. E.4 Sharps are disposed of in a puncture-resistant sharps container.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2. E.5 If used for more than one patient, the point-of-care device 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 patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. E.6 Gloves are removed and hand hygiene is performed following the procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.E.1 through 2.E.6), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
2. E.7 The hospital ICO has developed and implemented policies and procedures for cleaning and disinfecting point of care devices that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 2. F Reprocessing of Non Critical Items				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Reprocessing of non-critical items is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. F.1 The facility has and follows policies and procedures* to ensure that reusable patient devices are cleaned and reprocessed appropriately before use on another patient. *This would include clear delineation of responsibility among HCP.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. F.2 Manufacturers' instructions for cleaning noncritical medical equipment are followed.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

If no to any of the above (2.F.1 through 2.F.2), cite at 42 CFR 482.42(a)(1) (Tag A-749)		
2. F.3 The hospital ICO has developed and implemented policies and procedures for infection control related to reprocessing of non-critical items that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 2. G Single Use Devices (SUDs)				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Single use devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. G.1 Single use devices are discarded after use and not used for more than one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, do not cite and go to 2.G.2				
2. G.2 If the hospital elects to reuse single-use devices, these devices are reprocessed by an entity or a third party reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital must have documentation from the third party reprocessor confirming this is the case.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)				
2. G.3 The hospital ICO has developed and implemented policies and procedures for the use of single use devices that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 2. H Urinary Catheter Tracer				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Urinary catheters are inserted, accessed, and maintain in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Insertion:				
2. H.1 The hospital has guidelines for appropriate indications for urinary catheters.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. H.2 Hand hygiene performed before insertion.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. H.3 Catheter placed using aseptic technique and sterile equipment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. H.4 Catheter secured properly after insertion.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. H.5 Catheter insertion and indication documented.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.H.1 through 2.H.4), cite at 42 CFR 482.42(a)(1) (Tag A-749) If no to 2.H.5, cite at 42 CFR 482.24(C)(2)(vi)				
Accessing/Maintenance:				
2. H.6 Hand hygiene performed before manipulating catheter.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2. H.7 Catheter and collecting tubing are not disconnected (irrigation avoided).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. H.8 Urine bag emptied using aseptic technique.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. H.9 Urine samples obtained aseptically (via needless port for small volume).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. H.10 Urine bag kept below level of bladder at all times.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. H.11 Catheter tubing unobstructed and free of kinking.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. H.12 Need for urinary catheters reviewed daily with prompt removal of unnecessary urinary catheters.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.H.6 through 2.H.12), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
2. H.13 The hospital ICO has developed and implemented infection control policies and procedures related to the insertion, accession, and maintenance of urinary catheters that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
Do not cite unless the lack of a specific urinary catheter protocol is one of a number of protocol failures that indicate the absence of an active program to control infections and communicable disease. If so, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 2. I Central Venous Catheter Tracer				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Central venous catheters are inserted, accessed and maintained in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Insertion:				
2. I.1 Hand Hygiene performed before insertion.	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. I.2 Maximal barrier precautions used for insertion (includes use of cap, mask, sterile gown, sterile gloves, and a sterile full body drape).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. I.3 >0.5% chlorhexidine with alcohol used for skin antisepsis prior to insertion (If contraindicated, tincture of iodine, an iodophor, or 70% alcohol can be used as alternatives).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. I.4 Sterile gauze or sterile, transparent, semi permeable dressing used to cover catheter site (may not apply for well-healed tunneled catheters).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. I.5 Central line insertion and indication documented.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.I.1 through 2.I.4), cite at 42 CFR 482.42(a)(1) (Tag A-749) If no to 2.I.5, cite at 42 CFR 482.24(C)(2)(vi)				
Accessing/Maintenance:				
2. I.6 Hand hygiene performed before manipulating catheter (even if gloves worn).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

2. I.7 Dressings that are wet, soiled, or dislodged are changed promptly.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. I.8 Dressing changed with aseptic technique using clean or sterile gloves.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. I.9 Access port is scrubbed with an appropriate antiseptic (chlorhexidine, povidone iodine, an iodophor, or 70% alcohol) prior to accessing.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. I.10 Catheter accessed only with sterile devices.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. I.11 Need for central venous catheters reviewed daily with prompt removal of unnecessary lines.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.I.6 through 2.I.11), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
2. I.12 The hospital ICO has developed and implemented infection control policies and procedures related to the insertion, access, and maintenance of central venous catheters that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
Do not cite unless the lack of a specific central venous catheter protocol is one of a number of protocol failures that indicate the absence of an active program to control infections and communicable disease. If so, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 2. J Protective Environment (e.g. Bone Marrow patients)				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
For patients requiring a Protective Environment _ the hospital ensures:				
2. J.1 Positive pressure [air flows out to the corridor].	○ Yes ○ No ○ N/A		○ Yes ○ No ○ N/A	
2. J.2 12 ACH (air changes per hour).	○ Yes ○ No ○ N/A		○ Yes ○ No ○ N/A	
2. J.3 Supply air is HEPA filtered.	○ Yes ○ No ○ N/A		○ Yes ○ No ○ N/A	
2. J.4 Well sealed rooms so that there are no penetration spaces in walls, ceilings, or windows.	○ Yes ○ No ○ N/A		○ Yes ○ No ○ N/A	
2. J.5 Self closing door that fully close on all room exits.	○ Yes ○ No ○ N/A		○ Yes ○ No ○ N/A	
2. J.6 Documentation and demonstrates that failures are addressed.	○ Yes ○ No ○ N/A		○ Yes ○ No ○ N/A	
If no to any of the above (2.J.1 through 2.J.6) cite at 42 CFR 482.42(a)(1) (Tag A-749)				

2. J.7 For patients requiring a Protective Environment, the hospital ensures that ventilation specifications are monitored using visual methods (e.g. flutter strips smoke tubes) and observations documented daily.	○ Yes ○ No ○ N/A		○ Yes ○ No ○ N/A	
If no, cite at 42 CFR 482.42(b)(2) (Tag A-756)				

Section 2. K Isolation: Contact Precautions				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Patients requiring contact isolation are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. K.1 Gloves and gowns are available and located near point of use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. K.2 Signs indicating patient is on Contact Precautions are clear and visible.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. K.3 Patients on contact precautions are housed in single-patient rooms when available or cohorted based on a clinical risk assessment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. K.4 Hand hygiene is performed before entering patient care environment. Note: Soap and water must be used when bare hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected infectious diarrhea (e.g., *C. difficile* or norovirus). In all other situations, ABHR may be used.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2. K.5 Gloves and gowns are donned before entering patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. K.6 Gloves and gowns are removed and discarded, and hand hygiene is performed before leaving the patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. K.7 Dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs) is used or if not available, then equipment is cleaned and disinfected prior to use on another patient according to manufacturers' instructions.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. K.8 Facility has policy limiting movement of patients on Contact Precautions outside of their room.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. K.9 If a patient on Contact Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and policies and procedures to prevent transmission of infectious disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. K.10 Objects and environmental surfaces in patient care areas that are touched frequently (e.g., bed rails, side table, call button) are cleaned and then disinfected when visibly soiled and at least daily with an EPA-registered disinfectant.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. K.11 For terminal cleaning (i.e., after patient discharge), all surfaces are thoroughly cleaned and disinfected and all textiles are replaced with clean textiles including privacy curtains.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2. K.12 Cleaners and disinfectants are labeled and used in accordance with hospital policies and procedures and manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.M.1 through 2.M.12), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
2.K.13 The hospital ICO has developed and implemented policies and procedures for addressing contact isolation that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 2. L Isolation: Droplet Precautions

Elements to be assessed		Manner of Assessment Code (check all that apply) & Surveyor Notes		Manner of Assessment Code (check all that apply) & Surveyor Notes
Patients requiring Droplet Precautions are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. L.1 Surgical masks are available and located near point of use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. L.2 Signs indicating patient is on Droplet Precautions are clear and visible.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. L.3 Patients on Droplet Precautions are housed in single-patient rooms when available or cohorted based on a clinical risk assessment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. L.4 Hand hygiene is performed before entering patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

2. L.5 HCP don surgical masks before entering the patient care environment or private room.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. L.6 Mask is removed and discarded, and hand hygiene is performed upon leaving the patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. L.7 Facility has policy limiting movement of patients on Droplet Precautions outside of their room (note policy should address that patient wear surgical mask when transported).	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. L.8 If a patient on Droplet Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and policies and procedures to prevent transmission of infectious disease (note policy should address that patient wear surgical mask when transported).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. L.9 Objects and environmental surfaces in patient care areas that are touched frequently (e.g., bed rails, side table, call button) are cleaned and then disinfected when visible soiled and at least once a day with an EPA-registered disinfectant.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. L.10 During terminal cleaning (i.e., after patient discharge), all surfaces are thoroughly cleaned and disinfected and all textiles are replaced with clean textiles including privacy curtains.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. L.11 Cleaners and disinfectants are labeled and used in accordance with hospital policies and procedures and manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.L.1 through 2.L.11), cite at 42 CFR 482.42(a)(1) (Tag A-749)				

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

2. L.12 The hospital ICO has developed and implemented policies and procedures for addressing droplet isolation that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 2. M Isolation: Airborne Precautions				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Patients requiring Airborne Precautions are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
2. M.1 NIOSH-approved particulate respirators (N-95 or higher) are available and located near point of use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. M.2 Signs indicating patient is on Airborne Precautions are clear and visible.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. M.3 Patients on Airborne Precautions are housed in airborne infection isolation rooms (AIIR).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2.M.4 The AIIR meets generally accepted specifications: • 6 air changes per hour and; • direct exhaust of air to outside, if not possible air returned to air handling system or adjacent spaces if directed through HEPA filters and; • when AIIR is in use for a patient on Airborne Precautions, documentation that monitoring of air pressure is done daily with visual indicators (smoke tubes, flutter strips), regardless of differential pressure sensing devices (i.e. manometers): and • AIIR door kept closed when not required for entry and exit.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. M.5 Hand hygiene is performed before entering patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. M.6 HCP wear a NIOSH-approved particulate respirator (N95 or higher) upon entry into the AIIR.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2.M.7 Respirator is removed and discarded, (respirator used to provide care for patients with M tuberculosis may be reused by HCP if not soiled or damaged, and user fit check is not compromised per facility policy and in accordance with manufacturer's directions) and hand hygiene is performed upon leaving the patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
2. M.8 Facility has policy limiting movement of patients on Airborne Precautions outside of their room to medically-necessary purposes (note policy should address that patient wear surgical mask).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2. M.9 If a patient on Airborne Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and policies and procedures to prevent transmission of infectious disease (note policy should address that patient wear surgical mask when transported).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (2.M.1 through 2.M.9), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
2. M.10 The hospital ICO has developed and implemented policies and procedures for addressing Airborne Precautions that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Module 3: Critical Care Module

Section 3. A Hand Hygiene				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
3. A.1 Soap, water, and a sink are readily accessible in patient care areas including but not limited to direct care areas (such as food and medication preparation areas).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. A.2 Hand hygiene is performed in a manner consistent with hospital infection control practices, policies, and procedures to maximize the prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. A.3 Alcohol-based hand rub (ABHR) is readily accessible and placed in appropriate locations.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. A.4 Does the hospital have policies and documented training that demonstrates HCP are educated regarding appropriate indications for hand washing with soap and water versus hand rubbing with alcohol-based hand rub. *Note: Soap and water must be used when bare hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected infectious diarrhea (e.g., *C. difficile* or norovirus). In all other situations, alcohol-based hand rub may be used.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3.A.5 HCP perform hand hygiene: • Before contact with the patient or their immediate care environment (even if gloves are worn). • Before exiting the patient's care area after touching the patient or the patient's immediate environment (even if gloves are worn). • Before performing an aseptic task (e.g., insertion of IV or urinary catheter, even if gloves are worn). • After contact with blood, body fluids or contaminated surfaces, (even if gloves are worn).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.A.1 through 3.A.5), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
3. A.6 The hospital ICO has developed and implemented policies and procedures for hand hygiene that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 3. B Injection Practices and Sharps Safety (Medications, Saline, Other Infusates)				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Injections are given and sharps safety is managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. B.1 Injections are prepared using aseptic technique in an area that has been cleaned and free of visible blood, body fluids, or contaminated equipment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.2 Needles are used for only one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. B.3 Syringes are used for only one patient (this includes manufactured prefilled syringes and insulin pens).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.4 The rubber septum on a medication vial is disinfected with alcohol prior to piercing.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.5 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 patients. If a surveyor sees syringes or needles being reused to enter a vial to obtain additional medication, even for the same patient, they must follow-up to determine what happens with the vial and assure that it is discarded.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.6 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 patients. If a surveyor sees syringes or needles being reused to enter a vial to obtain additional medication, even for the same patient, they must follow-up to determine what happens with the vial and assure that it is discarded.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.7 Single dose (single-use) medication vials are used for only one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. B.8 Bags of IV solution are used for only one patient (and not as a source of flush solution for multiple patients).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.9 Medication administration tubing and connectors are used for only one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.10 Multi-dose 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: this 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 hospital policies and procedures, so long as it is clear what the date represents and the same policy is used consistently throughout the hospital.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.11 If multi-dose vials are used for more than one patient, they do not enter the immediate patient treatment area (e.g., operating room, patient room, anesthesia carts). Note: if multi-dose vials are found in the patient care area they must be dedicated for single patient use and discarded after use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.12 All sharps are disposed of in a puncture-resistant sharps container.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. B.13 Sharps containers are replaced when the fill line is reached.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. B.14 Filled sharps containers are disposed of in accordance with state medical waste rules.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.B.1 through 3.B.14), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
3. B.15 The hospital ICO has developed and implemented policies and procedures for injection practices and sharps safety that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 3. C Environmental Cleaning/Disinfection

Elements to be assessed		Manner of Assessment Code (check all that apply) & Surveyor Notes		Manner of Assessment Code (check all that apply) & Surveyor Notes
Environmental cleaning/ disinfection is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including:				
3. C.1 Cleaners and EPA-registered hospital disinfectants are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. C.2 High touch environmental surfaces in procedure rooms are cleaned and disinfected between patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. C.3 Reusable noncritical items (e.g., blood pressure cuffs, oximeter probes) are cleaned and disinfected between patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. C.4 Single use devices are discarded after use and not used for more than one patient. If no, do not cite and go to question 3.C.5.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. C.5 If the hospital elects to reuse single-use devices, these devices are reprocessed by an entity or a third party reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital must have documentation from the third party reprocessor confirming this is the case.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.C.1 through 3.C.5), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
Laundry is processed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. C.6 HCP handle soiled textiles/linens in a manner that ensures segregation of dirty from clean textiles/linens and ensure that there is not cross contamination of clean textiles/linens prior to use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. C.7 Soiled textiles are bagged at the point of collection and kept in a covered leak-proof container or bag at all times until they reach the laundry facility.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. C.8 There is clear separation of soiled laundry space from clean laundry areas and soiled laundry is maintained.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.C.6 through 3.C.8), cite at 42 CFR 482.42(a)(1) (Tag A-749)				

3. C.9 The hospital ICO has developed and implemented policies and procedures for environmental cleaning and disinfection that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 3. D Personal Protective Equipment				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Personal protective equipment is utilized in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following				
3. D.1 Supplies for adherence to Standard and Transmission-based Precautions (e.g., gloves, gowns, mouth, eye, nose, and face protection) are available and located near point of use.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. D.2 HCP wear gloves for procedures/activities where contact with blood, body fluids, mucous membranes, or non-intact skin is anticipated.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. D.3 HCP change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. D.4 Gowns are worn to prevent contamination of skin and clothing during procedures/activities where contact with blood, body fluids, secretions, or excretions are anticipated.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. D.5 Gowns and gloves are removed and hand hygiene is performed immediately before leaving the patient's environment.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. D.6 Appropriate mouth, nose, eye protection is worn for aerosol-generating procedures and/or procedures/activities that are likely to generate splashes or sprays of blood or body fluids.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
If no to any of the above (3.D.1 through 3.D.6), cite at 42 CFR 482.42(a)(1) (Tag A-749)				

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

3. D.7 The hospital ICO has developed and implemented policies and procedures for the use of personal protective equipment that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 3. E Point of Care Devices (e.g. Blood Glucose Meter, INR Monitor)				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Point of care devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. E.1 Hand hygiene is performed before the procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. E.2 Gloves are worn by HCP when performing the finger stick procedure to obtain the sample of blood.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. E.3 Finger stick devices are not used for more than one patient. Note: This includes both the lancet and the lancet holding device.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. E.4 Sharps are disposed of in a puncture-resistant sharps container.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. E.5 If used for more than one patient, the point-of-care device 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 patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. E.6 Gloves are removed and hand hygiene is performed following the procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.E.1 through 3.E.6), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
3. E.7 The hospital ICO has developed and implemented policies and procedures for cleaning and disinfecting point of care devices that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 3. F Reprocessing of Non Critical Items				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Reprocessing of non-critical items is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. F.1 The facility has and follows policies and procedures* to ensure that reusable patient devices are cleaned and reprocessed appropriately before use on another patient. *This would include clear delineation of responsibility among HCP.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. F.2 Manufacturers' instructions for cleaning noncritical medical equipment are followed.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

If no to any of the above (3.F.1 through 3.F.2), cite at 42 CFR 482.42(a)(1) (Tag A-749)		
3. F.3 The hospital ICO has developed and implemented policies and procedures for infection control related to reprocessing of non-critical items that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 3. G Single Use Devices (SUDs)				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Single use devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. G.1 Single use devices are discarded after use and not used for more than one patient.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
If no, do not cite and go to 3.G.2				
3. G.2 If the hospital elects to reuse single-use devices, these devices are reprocessed by an entity or a third party reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital must have documentation from the third party reprocessor confirming this is the case.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)				
3. G.3 The hospital ICO has developed and implemented policies and procedures for the use of single use devices that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 3. H Urinary Catheter Tracer				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Urinary catheters are inserted, accessed, and maintain in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Insertion:				
3. H.1 The hospital has guidelines for appropriate indications for urinary catheters.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. H.2 Hand hygiene performed before insertion.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. H.3 Catheter placed using aseptic technique and sterile equipment.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. H.4 Catheter secured properly after insertion.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. H.5 Catheter insertion and indication documented.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
If no to any of the above (3.H.1 through 3.H.4), cite at 42 CFR 482.42(a)(1) (Tag A-749) If no to 3.H.5, cite at 42 CFR 482.24(C)(2)(vi)				
Accessing/Maintenance:				
3. H.6 Hand hygiene performed before manipulating catheter.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

3. H.7 Catheter and collecting tubing are not disconnected (irrigation avoided).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. H.8 Urine bag emptied using aseptic technique.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. H.9 Urine samples obtained aseptically (via needless port for small volume).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. H.10 Urine bag kept below level of bladder at all times.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. H.11 Catheter tubing unobstructed and free of kinking.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. H.12 Need for urinary catheters reviewed daily with prompt removal of unnecessary urinary catheters.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.H.6 through 3.H.12), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
3. H.13 The hospital ICO has developed and implemented infection control policies and procedures related to the insertion, accession, and maintenance of urinary catheters that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
Do not cite unless the lack of a specific urinary catheter protocol is one of a number of protocol failures that indicate the absence of an active program to control infections and communicable disease. If so, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 3. I Central Venous Catheter Tracer				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Central venous catheters are inserted, accessed and maintained in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Insertion:				
3. I.1 Hand Hygiene performed before insertion.	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. I.2 Maximal barrier precautions used for insertion (includes use of cap, mask, sterile gown, sterile gloves, and a sterile full body drape).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. I.3 >0.5% chlorhexidine with alcohol used for skin antisepsis prior to insertion (If contraindicated, tincture of iodine, an iodophor, or 70% alcohol can be used as alternatives).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. I.4 Sterile gauze or sterile, transparent, semi permeable dressing used to cover catheter site (may not apply for well-healed tunneled catheters).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. I.5 Central line insertion and indication documented.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.I.1 through 3.I.4), cite at 42 CFR 482.42(a)(1) (Tag A-749)		**If no to 3.I.5, cite at 42 CFR 482.24(C)(2)(vi)**		
Accessing/Maintenance:				
3. I.6 Hand hygiene performed before manipulating catheter (even if gloves worn).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

3. I.7 Dressings that are wet, soiled, or dislodged are changed promptly.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. I.8 Dressing changed with aseptic technique using clean or sterile gloves.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. I.9 Access port is scrubbed with an appropriate antiseptic (chlorhexidine, povidone iodine, an iodophor, or 70% alcohol) prior to accessing.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. I.10 Catheter accessed only with sterile devices.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. I.11 Need for central venous catheters reviewed daily with prompt removal of unnecessary lines.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.I.6 through 3.I.11), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
3. I.12 The hospital ICO has developed and implemented infection control policies and procedures related to the insertion, access, and maintenance of central venous catheters that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
Do not cite unless the lack of a specific central venous catheter protocol is one of a number of protocol failures that indicate the absence of an active program to control infections and communicable disease. If so, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 3. J Protective Environment (e.g. Bone Marrow patients)				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
For patients requiring a Protective Environment _ the hospital ensures:				
3. J.1 Positive pressure [air flows out to the corridor].	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. J.2 12 ACH (air changes per hour).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. J.3 Supply air is HEPA filtered.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. J.4 Well sealed rooms so that there are no penetration spaces in walls, ceilings, or windows.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. J.5 Self closing door that fully close on all room exits.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. J.6 Documentation and demonstrates that failures are addressed.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.J.1 through 3.J.6) cite at 42 CFR 482.42(a)(1) (Tag A-749)				

3. J.7 For patients requiring a Protective Environment, the hospital ensures that ventilation specifications are monitored using visual methods (e.g. flutter strips smoke tubes) and observations documented daily.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(b)(2) (Tag A-756)				

Section 3. K Isolation: Contact Precautions				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Patients requiring contact isolation are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. K.1 Gloves and gowns are available and located near point of use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. K.2 Signs indicating patient is on Contact Precautions are clear and visible.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. K.3 Patients on contact precautions are housed in single-patient rooms when available or cohorted based on a clinical risk assessment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. K.4 Hand hygiene is performed before entering patient care environment. Note: Soap and water must be used when bare hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected infectious diarrhea (e.g., *C. difficile* or norovirus). In all other situations, ABHR may be used.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. K.5 Gloves and gowns are donned before entering patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. K.6 Gloves and gowns are removed and discarded, and hand hygiene is performed before leaving the patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. K.7 Dedicated or disposable noncritical patient-care equipment (e.g., blood pressure cuffs) is used or if not available, then equipment is cleaned and disinfected prior to use on another patient according to manufacturers' instructions.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. K.8 Facility has policy limiting movement of patients on Contact Precautions outside of their room.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. K.9 If a patient on Contact Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and policies and procedures to prevent transmission of infectious disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. K.10 Objects and environmental surfaces in patient care areas that are touched frequently (e.g., bed rails, side table, call button) are cleaned and then disinfected when visibly soiled and at least daily with an EPA-registered disinfectant.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. K.11 For terminal cleaning (i.e., after patient discharge), all surfaces are thoroughly cleaned and disinfected and all textiles are replaced with clean textiles including privacy curtains.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. K.12 Cleaners and disinfectants are labeled and used in accordance with hospital policies and procedures and manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.K.1 through 3.K.12), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
3.K.13 The hospital ICO has developed and implemented policies and procedures for addressing contact isolation that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 3. L Isolation: Droplet Precautions

Elements to be assessed		Manner of Assessment Code (check all that apply) & Surveyor Notes		Manner of Assessment Code (check all that apply) & Surveyor Notes
Patients requiring Droplet Precautions are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. L.1 Surgical masks are available and located near point of use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. L.2 Signs indicating patient is on Droplet Precautions are clear and visible.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. L.3 Patients on Droplet Precautions are housed in single-patient rooms when available or cohorted based on a clinical risk assessment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. L.4 Hand hygiene is performed before entering patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. L.5 HCP don surgical masks before entering the patient care environment or private room.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. L.6 Mask is removed and discarded, and hand hygiene is performed upon leaving the patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. L.7 Facility has policy limiting movement of patients on Droplet Precautions outside of their room (note policy should address that patient wear surgical mask when transported).	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. L.8 If a patient on Droplet Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and policies and procedures to prevent transmission of infectious disease (note policy should address that patient wear surgical mask when transported).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. L.9 Objects and environmental surfaces in patient care areas that are touched frequently (e.g., bed rails, side table, call button) are cleaned and then disinfected when visible soiled and at least once a day with an EPA-registered disinfectant.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. L.10 During terminal cleaning (i.e., after patient discharge), all surfaces are thoroughly cleaned and disinfected and all textiles are replaced with clean textiles including privacy curtains.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. L.11 Cleaners and disinfectants are labeled and used in accordance with hospital policies and procedures and manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

If no to any of the above (3.L.1 through 3.L.11), cite at 42 CFR 482.42(a)(1) (Tag A-749)		
3. L.12 The hospital ICO has developed and implemented policies and procedures for addressing droplet isolation that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 3. M Isolation: Airborne Precautions				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Patients requiring Airborne Precautions are identified and managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. M.1 NIOSH-approved particulate respirators (N-95 or higher) are available and located near point of use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. M.2 Signs indicating patient is on Airborne Precautions are clear and visible.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. M.3 Patients on Airborne Precautions are housed in airborne infection isolation rooms (AIIR).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.M.4 The AIIR meets generally accepted specifications: • 6 air changes per hour and; • direct exhaust of air to outside, if not possible air returned to air handling system or adjacent spaces if directed through HEPA filters and; • when AIIR is in use for a patient on Airborne Precautions, documentation that monitoring of air pressure is done daily with visual indicators (smoke tubes, flutter strips), regardless of differential pressure sensing devices (i.e. manometers): and • AIIR door kept closed when not required for entry and exit.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. M.5 Hand hygiene is performed before entering patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. M.6 HCP wear a NIOSH-approved particulate respirator (N95 or higher) upon entry into the AIIR.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.M.7 Respirator is removed and discarded, (respirator used to provide care for patients with M tuberculosis may be reused by HCP if not soiled or damaged, and user fit check is not compromised per facility policy and in accordance with manufacturer's directions) and hand hygiene is performed upon leaving the patient care environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. M.8 Facility has policy limiting movement of patients on Airborne Precautions outside of their room to medically-necessary purposes (note policy should address that patient wear surgical mask).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. M.9 If a patient on Airborne Precautions must leave their room for medically necessary purposes, there are methods followed to communicate that patient's status and policies and procedures to prevent transmission of infectious disease (note policy should address that patient wear surgical mask when transported).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.M.1 through 3.M.9), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
3. M.10 The hospital ICO has developed and implemented policies and procedures for addressing Airborne Precautions that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

Section 3. N Ventilator/Respiratory Therapy Tracer				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Respiratory procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
General respiratory therapy practices (apply to patients with and without ventilators):				
3. N.1 Hand hygiene is performed before and after contact with patient or any respiratory equipment used on patient.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. N.2 Gloves are worn when in contact with respiratory secretions and changed before contact with another patient, object, or environmental surface.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. N.3 Only sterile water is used for nebulization.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. N.4 Single-dose vials for aerosolized medications are not used for more than one patient.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. N.5 If multi-dose vials for aerosolized medications are used, manufacturers' instructions for handling, storing, and dispensing the medications are followed.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. N.6 If multi-dose vials for aerosolized medications are used for more than one patient, they are restricted to a centralized medication area and do not enter the immediate patient treatment area.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5

3. N.7 Nebulizers (e.g., mask/mouthpiece, cup) are rinsed with sterile water (or with tap water followed by isopropyl alcohol) and dried thoroughly between uses on the same patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.N.1 through 3.N.7), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
Ventilators:				
Ventilators are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. N.8 Ventilator circuit is changed if visibly soiled or mechanically malfunctioning.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. N.9 Sterile water is used to fill bubbling humidifiers (if applicable).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. N.10 Condensate that collects in the tubing of a mechanical ventilator is periodically drained and discarded, taking precautions not to allow condensate to drain toward the patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. N.11 If single-use open-system suction catheter is employed, a sterile, single-use catheter is used.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. N.12 If multi-use closed-system suction catheter is employed, only sterile fluid is used to remove secretions upon reentry into the respiratory tract.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. N.13 Sedation is lightened daily in eligible patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

3. N.14 Spontaneous breathing trials are performed daily in eligible patients.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
If no to any of the above (3.N.8 through 3.N.12), cite at 42 CFR 482.42(a)(1) (Tag A-749) No citation for 3.N.13-14				
3.N.15 The hospital ICO has developed and implemented infection control policies and procedures related to respiratory therapy and (if applicable) ventilator use that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5		
Do not cite unless the lack of a specific infection control respiratory therapy/ventilator protocol is one of a number of protocol failures that indicate the absence of an active program to control infections and communicable disease. If so, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 3. O Spinal Injection Procedures				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Spinal injection procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
3. O.1 Hand hygiene performed prior to the procedure.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. O.2 The spinal injection procedure is performed using aseptic technique and sterile equipment, including use of sterile gloves.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
3. O.3 Surgical masks are worn by HCP when placing a catheter or injecting materials into the epidural or subdural space.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5

3. O.4 Gowns are worn to prevent contamination of skin and clothing during procedures if contact with blood, body fluids, secretions, or excretions is anticipated.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3. O.5 Gloves and gowns are removed and hand hygiene is performed following the procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.O.1 through 3.0.5), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
3. O.6 The hospital ICO has developed and implemented policies and procedures for spinal injection procedures that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
Do not cite unless the lack of a specific spinal injection protocol is one of a number of protocol failures that indicate the absence of an active program to control infections and communicable disease. If so, cite at 42 CFR 482.42(a) (Tag A-0748)				

Module 4: Invasive Procedures Module

Section 4. A Hand Hygiene				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
4. A.1 Soap, water, and a sink are readily accessible in patient care areas including but not limited to direct care areas (such as food and medication preparation areas).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. A.2 Hand hygiene is performed in a manner consistent with hospital infection control practices, policies, and procedures to maximize the prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. A.3 Alcohol-based hand rub (ABHR) is readily accessible and placed in appropriate locations.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. A.4 Does the hospital have policies and documented training that demonstrates HCP are educated regarding appropriate indications for hand washing with soap and water versus hand rubbing with alcohol-based hand rub? *Note: Soap and water must be used when bare hands are visibly soiled (e.g., blood, body fluids) or after caring for a patient with known or suspected infectious diarrhea (e.g., *C. difficile* or norovirus). In all other situations, alcohol-based hand rub may be used.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4.A.5 HCP perform hand hygiene: • Before contact with the patient or their immediate care environment (even if gloves are worn). • Before exiting the patient's care area after touching the patient or the patient's immediate environment (even if gloves are worn). • Before performing an aseptic task (e.g., insertion of IV or urinary catheter, even if gloves are worn). • After contact with blood, body fluids or contaminated surfaces, (even if gloves are worn).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.A.1 through 4.A.5), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
4. A.6 The hospital ICO has developed and implemented policies and procedures for hand hygiene that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 4. B Injection Practices and Sharps Safety (Medications, Saline, Other Infusates)				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Injections are given and sharps safety is managed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4. B.1 Injections are prepared using aseptic technique in an area that has been cleaned and free of visible blood, body fluids, or contaminated equipment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. B.2 Needles are used for only one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. B.3 Syringes are used for only one patient (this includes manufactured prefilled syringes and insulin pens).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. B.4 The rubber septum on a medication vial is disinfected with alcohol prior to piercing.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. B.5 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 patients. If a surveyor sees syringes or needles being reused to enter a vial to obtain additional medication, even for the same patient, they must follow-up to determine what happens with the vial and assure that it is discarded.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.B.6 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 patients. If a surveyor sees syringes or needles being reused to enter a vial to obtain additional medication, even for the same patient, they must follow-up to determine what happens with the vial and assure that it is discarded.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. B.7 Single dose (single-use) medication vials are used for only one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. B.8 Bags of IV solution are used for only one patient (and not as a source of flush solution for multiple patients).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. B.9 Medication administration tubing and connectors are used for only one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. B.10 Multi-dose 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: this 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 hospital policies and procedures, so long as it is clear what the date represents and the same policy is used consistently throughout the hospital.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. B.11 If multi-dose vials are used for more than one patient, they do not enter the immediate patient treatment area (e.g., operating room, patient room, anesthesia carts). Note: if multi-dose vials are found in the patient care area they must be dedicated for single patient use and discarded after use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. B.12 All sharps are disposed of in a puncture-resistant sharps container.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. B.13 Sharps containers are replaced when the fill line is reached.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. B.14 Filled sharps containers are disposed of in accordance with state medical waste rules.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4. B.1 through 4. B.14), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
4.B.15 The hospital ICO has developed and implemented policies and procedures for injection practices and sharps safety that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 4. C Environmental Cleaning/Disinfection				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Environmental cleaning/ disinfection is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including:				
4. C.1 Cleaners and EPA-registered hospital disinfectants are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. C.2 High touch environmental surfaces in procedure rooms are cleaned and disinfected between patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. C.3 Reusable noncritical items (e.g., blood pressure cuffs, oximeter probes) are cleaned and disinfected between patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. C.4 Single use devices are discarded after use and not used for more than one patient. If no, do not cite and go to question 4.C.5.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.C.5 If the hospital elects to reuse single-use devices, these devices are reprocessed by an entity or a third party reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital must have documentation from the third party reprocessor confirming this is the case.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.C.1 through 4.C.5), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
Laundry is processed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4. C.6 HCP handle soiled textiles/linens in a manner that ensures segregation of dirty from clean textiles/linens and ensure that there is not cross contamination of clean textiles/linens prior to use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. C.7 Soiled textiles are bagged at the point of collection and kept in a covered leak-proof container or bag at all times until they reach the laundry facility.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. C.8 There is clear separation of soiled laundry space from clean laundry areas and soiled laundry is maintained.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.C.6 through 4.C.8), cite at 42 CFR 482.42(a)(1) (Tag A-749)				

4. C.9 The hospital ICO has developed and implemented policies and procedures for environmental cleaning and disinfection that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 4. D Personal Protective Equipment				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Personal protective equipment is utilized in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4. D.1 Supplies for adherence to Standard and Transmission-based Precautions (e.g., gloves, gowns, mouth, eye, nose, and face protection) are available and located near point of use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. D.2 HCP wear gloves for procedures/activities where contact with blood, body fluids, mucous membranes, or non-intact skin is anticipated.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. D.3 HCP change gloves and perform hand hygiene before moving from a contaminated body site to a clean body site.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. D.4 Gowns are worn to prevent contamination of skin and clothing during procedures/activities where contact with blood, body fluids, secretions, or excretions are anticipated.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. D.5 Gowns and gloves are removed and hand hygiene is performed immediately before leaving the patient's environment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. D.6 Appropriate mouth, nose, eye protection is worn for aerosol-generating procedures and/or procedures/activities that are likely to generate splashes or sprays of blood or body fluids.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.D.1 through 4.D.6), cite at 42 CFR 482.42(a)(1) (Tag A-749)				

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

4. D.7 The hospital ICO has developed and implemented policies and procedures for the use of personal protective equipment that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 4. E Point of Care Devices (e.g. Blood Glucose Meter, INR Monitor)				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Point of care devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4. E.1 Hand hygiene is performed before the procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. E.2 Gloves are worn by HCP when performing the finger stick procedure to obtain the sample of blood.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. E.3 Finger stick devices are not used for more than one patient. Note: This includes both the lancet and the lancet holding device.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. E.4 Sharps are disposed of in a puncture-resistant sharps container.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. E.5 If used for more than one patient, the point-of-care device 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 patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. E.6 Gloves are removed and hand hygiene is performed following the procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.E.1 through 4.E.6), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
4. E.7 The hospital ICO has developed and implemented policies and procedures for cleaning and disinfecting point of care devices that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 4. F Reprocessing of Non Critical Items				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Reprocessing of non-critical items is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4. F.1 The facility has and follows policies and procedures* to ensure that reusable patient devices are cleaned and reprocessed appropriately before use on another patient. *This would include clear delineation of responsibility among HCP.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. F.2 Manufacturers' instructions for cleaning noncritical medical equipment are followed.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

If no to any of the above (4.F.1 through 4.F.2), cite at 42 CFR 482.42(a)(1) (Tag A-749)		
4. F.3 The hospital ICO has developed and implemented policies and procedures for infection control related to reprocessing of non-critical items that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 4. G Single Use Devices (SUDs)				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Single use devices are used in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4. G.1 Single use devices are discarded after use and not used for more than one patient.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, do not cite and go to 3.G.2				
4. G.2 If the hospital elects to reuse single-use devices, these devices are reprocessed by an entity or a third party reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital must have documentation from the third party reprocessor confirming this is the case.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a)(1) (Tag A-749)				
4. G.3 The hospital ICO has developed and implemented policies and procedures for the use of single use devices that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 4. H Urinary Catheter Tracer				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Urinary catheters are inserted, accessed, and maintain in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Insertion:				
4. H.1 The hospital has guidelines for appropriate indications for urinary catheters.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. H.2 Hand hygiene performed before insertion.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. H.3 Catheter placed using aseptic technique and sterile equipment.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. H.4 Catheter secured properly after insertion.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. H.5 Catheter insertion and indication documented.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.H.1 through 4.H.4), cite at 42 CFR 482.42(a)(1) (Tag A-749)		**If no to 4.H.5, cite at 42 CFR 482.24(C)(2)(vi)**		
Accessing/Maintenance:				
4. H.6 Hand hygiene performed before manipulating catheter.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. H.7 Catheter and collecting tubing are not disconnected (irrigation avoided).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. H.8 Urine bag emptied using aseptic technique.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. H.9 Urine samples obtained aseptically (via needless port for small volume).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. H.10 Urine bag kept below level of bladder at all times.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. H.11 Catheter tubing unobstructed and free of kinking.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. H.12 Need for urinary catheters reviewed daily with prompt removal of unnecessary urinary catheters.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.H.6 through 4.H.12), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
4. H.13 The hospital ICO has developed and implemented infection control policies and procedures related to the insertion, accession, and maintenance of urinary catheters that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
Do not cite unless the lack of a specific urinary catheter protocol is one of a number of protocol failures that indicate the absence of an active program to control infections and communicable disease. If so, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 4. I Central Venous Catheter Tracer				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Central venous catheters are inserted, accessed and maintained in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
Insertion:				
4. I.1 Hand Hygiene performed before insertion.	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. I.2 Maximal barrier precautions used for insertion (includes use of cap, mask, sterile gown, sterile gloves, and a sterile full body drape).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. I.3 >0.5% chlorhexidine with alcohol used for skin antisepsis prior to insertion (If contraindicated, tincture of iodine, an iodophor, or 70% alcohol can be used as alternatives).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. I.4 Sterile gauze or sterile, transparent, semi permeable dressing used to cover catheter site (may not apply for well-healed tunneled catheters).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.I.5 Central line insertion and indication documented	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.I.1 through 4.I.4), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
Accessing/Maintenance:				
4. I.6 Hand hygiene performed before manipulating catheter (even if gloves worn).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

4. I.7 Dressings that are wet, soiled, or dislodged are changed promptly.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. I.8 Dressing changed with aseptic technique using clean or sterile gloves.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. I.9 Access port is scrubbed with an appropriate antiseptic (chlorhexidine, povidone iodine, an iodophor, or 70% alcohol) prior to accessing.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. I.10 Catheter accessed only with sterile devices.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. I.11 Need for central venous catheters reviewed daily with prompt removal of unnecessary lines.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.I.6 through 4.I.11), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
4. I.12 The hospital ICO has developed and implemented infection control policies and procedures related to the insertion, access, and maintenance of central venous catheters that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
Do not cite unless the lack of a specific central venous catheter protocol is one of a number of protocol failures that indicate the absence of an active program to control infections and communicable disease. If so, cite at 42 CFR 482.42(a) (Tag A-0748)				

Section 4. J Surgical Procedure Tracer				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Surgical procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4. J.1 Healthcare personnel perform a surgical scrub before donning sterile gloves for surgical procedures (in OR) using either an antimicrobial surgical scrub or an FDA-approved alcohol-based antiseptic surgical hand rub. Note: If hands are visibly soiled, they should be prewashed with soap and water before using an alcohol-based surgical scrub.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
4. J.2 After surgical scrub, hands and arms are dried with a sterile towel (if applicable), and sterile surgical gown and gloves are donned in the OR.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
4. J.3 Surgical attire (e.g., scrubs) and surgical caps/hoods covering all head and facial hair are worn by all personnel in semi restricted and restricted areas. Note: Restricted area includes ORs, procedure rooms, and the clean core area. The semi restricted area includes the peripheral support areas of the surgical suite.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
4. J.4 Surgical masks are worn (and properly tied, fully covering mouth and nose) by all personnel in restricted areas where open sterile supplies or scrubbed persons are located.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5
4. J.5 Sterile drapes are used to establish sterile field.	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5	O Yes O No O N/A	O 1 O 2 O 3 O 4 O 5

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

4. J.6 Sterile field is maintained and monitored constantly. Ensure that: • Items used within sterile field are sterile. • Items introduced into sterile field are opened, dispensed, and transferred in a manner to maintain sterility. • Sterile field is prepared in the location where it will be used and as close as possible to time of use. • Movement in or around sterile field is done in a manner to maintain sterility.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. J.7 Traffic in and out of OR is kept to minimum and limited to essential staff.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. J.8 Surgical masks are removed when leaving the sterile areas and are not reused when returning.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (3.J.1 through 3.J.8), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
4. J.9 The hospital ICO has developed and implemented infection control policies and procedures that ensure a surgical environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748) and 42 CFR 482.51(b) (Tag A-0951)				

Section 4. K Spinal Injection Procedures				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Spinal injection procedures are performed in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:				
4. K.1 Hand hygiene performed prior to the procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. K.2 The spinal injection procedure is performed using aseptic technique and sterile equipment, including use of sterile gloves.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. K.3 Surgical masks are worn by HCP when placing a catheter or injecting materials into the epidural or subdural space.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. K.4 Gowns are worn to prevent contamination of skin and clothing during procedures if contact with blood, body fluids, secretions, or excretions is anticipated.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. K.5 Gloves and gowns are removed and hand hygiene is performed following the procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.K.1 through 4.K.5), cite at 42 CFR 482.42(a)(1) (Tag A-749)				

4. K.6 The hospital ICO has developed and implemented policies and procedures for spinal injection procedures that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
Do not cite unless the lack of a specific spinal injection protocol is one of a number of protocol failures that indicate the absence of an active program to control infections and communicable disease. If so, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 4. L Reprocessing of Semi Critical Equipment				
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
High-Level Disinfection of Reusable Instruments and Devices is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including:				
4. L.1 All reusable semi-critical items receive at least high-level disinfection.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.2 High-level disinfection is performed on-site. Continue if "yes." If "no," skip to U.15. If the response is No, no citation is made in response to this question.	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.3 Flexible endoscopes are inspected for damage and leak tested as part of each reprocessing cycle.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. L.4 Items are thoroughly pre-cleaned according to manufacturer instructions and visually inspected for residual soil prior to high-level disinfection. Note: for lumened instruments (e.g., endoscopes), pre-cleaning must include all device channels and lumens with cleaning brushes appropriate for size of instrument channel or port.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.5 Enzymatic cleaner or detergent is used and discarded according to manufacturer's instructions (typically after each use).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.6 Cleaning brushes are disposable or cleaned and high-level disinfected or sterilized (per manufacturer's instructions) after each use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.L.7 For chemicals used in high-level disinfection, manufacturer's instructions are followed for: • preparation • testing for appropriate concentration • replacement (e.g., prior to expiration or loss of efficacy).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.8 If automated reprocessing equipment is used, proper connectors are used to assure that channels and lumens are appropriately disinfected.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.9 Devices are disinfected for the appropriate length of time as specified by manufacturer's instructions.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

4. L.10 Devices are disinfected at the appropriate temperature as specified by manufacturer's instructions.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.11 After high-level disinfection, devices are rinsed with sterile water, filtered water, or tap water followed by a rinse with 70% - 90% ethyl or isopropyl alcohol.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.12 Devices are dried thoroughly prior to reuse. Note: for lumened instruments (e.g., endoscopes) this includes flushing channels with alcohol and forcing air through the channels.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.13 Routine maintenance procedures for high-level disinfection equipment conform to manufacturer's instruction; confirm maintenance records are available.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.14 After high-level disinfection, devices are stored in a manner to protect from damage or contamination (Note: endoscopes must be hung in a vertical position).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4. L.15 The facility has a system in place to identify which instrument (e.g., endoscope) was used on a patient via a log for each procedure.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (4.L.1 and/or 4.L.3 through 4.L.15), cite at 42 CFR 482.42(a)(1) (Tag A-749)				
4. L.16 The hospital ICO has developed and implemented policies and procedures for high level disinfection of reusable instruments and devices that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5		
If no, cite at 42 CFR 482.42(a) (Tag A-0748)				

Module 5: Environmental Services and Sterile Reprocessing Module

Section 5. A Environmental Services		
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Environmental service are provided in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		
5. A.1 Facility has written policies and procedures for environmental cleaning and disinfection, including identification of personnel responsible for each activity.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. A.2 Environmental services has documented evidence that individual HCP receive job-specific training and competency validation at hire and when procedures/policies change.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. A.3 The hospital can provide evidence that there is training and equipment to ensure that HCP wear appropriate PPE to preclude exposure to infectious agents or chemicals (PPE can include gloves, gowns, masks, and eye protection).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. A.4 Objects and environmental surfaces in patient care areas that are touched frequently (e.g., bed rails, side table, call button) are cleaned and then disinfected when visibly contaminated or at least daily with an EPA-registered disinfectant.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. A.5 For terminal cleaning (i.e., after patient discharge), all surfaces are thoroughly cleaned and disinfected and textiles/linens are replaced with clean textiles. Privacy curtains should be changed when isolation precautions are in place (e.g., Contact, Airborne, and Droplet); whenever a MDRO in a patient is identified; and whenever there is visible soiling with blood or body fluids.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

5. A.6 Cleaners and disinfectants, including disposable wipes, are used in accordance with manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. A.7 Clean, (laundered if not disposable), cloths are used for each room or corridor.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. A.8 Mop heads and cleaning cloths are laundered at least daily using appropriate laundry techniques (e.g., following manufacturer instructions when laundering microfiber items).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. A.9 The facility decontaminates spills of blood or other body fluids according to its policies and procedures.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.A.10 Facility has established and follows a cleaning schedule for areas/equipment to be cleaned/serviced regularly (e.g., HVAC equipment, refrigerators, ice machines, eye wash stations, scrub sinks, aerators on faucets).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (5.A.1 through 5.A.10), cite at 42 CFR 482.42(a)(1) (Tag A-749)		
5.A.11 The hospital ICO has developed and implemented policies and procedures for infection control practices related to environmental service that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 5. B Environmental Infection Control in the Operating Room		
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Processes ensuring infection control in the OR are accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		

5. B.1 Cleaners and EPA-registered hospital disinfectants are used in accordance with hospital policies and procedures and manufacturer's instructions (e.g., dilution, storage, shelf-life, contact time).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. B.2 Cleaners and EPA-registered disinfectants, when in use, are labeled, diluted according to manufacturer's instructions, and are dated.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. B.3 All horizontal surfaces (e.g., furniture, surgical lights, booms, equipment) are damp dusted before the first procedure of the day using a clean, lint-free cloth and EPA-registered hospital detergent/disinfectant.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. B.4 High touch environmental surfaces are cleaned and disinfected between patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. B.5 Anesthesia equipment is cleaned and disinfected between patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. B.6 Reusable noncritical items (e.g., blood pressure cuffs, tourniquets, oximeter probes) are cleaned and disinfected between patients.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. B.7 ORs are terminally cleaned after last procedure of the day (including weekends) and each 24-hour period during regular work week. Terminal cleaning includes wet-vacuuming or mopping floor with an EPA-registered disinfectant.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. B.8 All surfaces, including but not limited to floor, walls, and ceilings have cleanable surfaces, are visibly clean, and there is evidence that all surfaces are cleaned regularly in accordance to hospital policies and procedures.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

5. B.9 Single use devices are discarded after use and not used for more than one patient. If no, do not cite and go to question 5.B.10	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. B.10 If the hospital elects to reuse single-use devices, these devices are reprocessed by an entity or a third party reprocessor that is registered with the FDA as a third-party reprocessor and cleared by the FDA to reprocess the specific device in question. The hospital must have documentation from the third party reprocessor confirming this is the case.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. B.11 Internal components of anesthesia machine breathing circuit are cleaned regularly according to manufacturer's instructions.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.B.12 Ventilation requirements meet the following : • Positive pressure, 15 air exchanges per hour (at least 3 of which are fresh air) • 90% filtration (HEPA is optional), air filters checked regularly and replaced according to hospital policies and procedures • Temperature and relative humidity levels are maintained at required levels • Doors are self-closing • Air vents and grill work are clean and dry.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (5.B.1 through 5.B.12), cite at 42 CFR 482.42(a)(1) (Tag A-749)		
5. B.13 The hospital ICO has developed and implemented policies and procedures for environmental infection control in the operating room that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 5. C Reprocessing of Critical Equipment Sterilization of Reusable Instruments and Devices		
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
Sterilization of reusable instruments and devices is accomplished in a manner consistent with hospital infection control policies and procedures to maximize the prevention of infection and communicable disease including the following:		

Interview = 1 Observation = 2 Infection Control Document Review = 3 Medical Record Review = 4 Other Document Review = 5

5. C.1 Items are thoroughly pre-cleaned according to manufacturer instructions and visually inspected for residual soil prior to sterilization. Note: for lumened instruments, pre-cleaning must include all device channels and lumens with cleaning brushes appropriate for size of instrument channel or port.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.2 All reusable critical instruments and devices are sterilized on site. If No, no citation is issued and skip to 5.C.3	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.3 Enzymatic cleaner or detergent is used and discarded according to manufacturer's instructions (typically after each use).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.4 Cleaning brushes are disposable or cleaned and high-level disinfected or sterilized (per manufacturer's instructions) after each use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.5 After pre-cleaning, instruments are appropriately wrapped/packaged for sterilization (e.g., package system selected is compatible with the sterilization process being performed, hinged instruments are open, and instruments are disassembled if indicated by the manufacturer).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.6 A chemical indicator (process indicator) is placed correctly in the instrument packs in every load.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.7 A biological indicator is used at least weekly for each sterilizer and with every load containing implantable items.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.8 For dynamic air removal-type sterilizers, a Bowie-Dick test is performed each day the sterilizer is used to verify efficacy of air removal.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

5. C.9 Sterile packs are labeled with the sterilizer used, the cycle or load number, and the date of sterilization.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.10 Logs for each sterilizer cycle are current and include results from each load.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.11 Routine maintenance for sterilization equipment is performed according to manufacturers instructions (confirm maintenance records are available).	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.12 After sterilization, medical devices and instruments are stored so that sterility is not compromised.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.13 The hospital has policies and procedures and documentation that sterile packages are inspected for integrity and compromised packages are reprocessed prior to use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.14 Immediate-use steam sterilization, if performed, is only done in circumstances in which routine sterilization procedures cannot be performed, unless the hospital can document that it is following guidelines from a nationally recognized organization that supports routine use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.15 Instruments that are subject to immediate use sterilization procedures are actually used immediately and not stored.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5. C.16 Policies and procedures are in place outlining facility response (i.e., recall of device and risk assessment) in the event of a reprocessing error/failure that could result in the transmission of infectious disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of the above (5.C.1 through 5.C.16), cite at 42 CFR 482.42(a)(1) (Tag A-749)		

5. C.17 The hospital ICO has developed and implemented policies and procedures for sterilization of reusable instruments and devices that ensure an environment minimizing risk for spread of infection and maximizing prevention of infection and communicable disease.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR 482.42(a) (Tag A-0748)		

Section 5. D Hydrotherapy Equipment		
Elements to be assessed		**Manner of Assessment Code (check all that apply) & Surveyor Notes**
T.3 Hydrotherapy equipment (e.g., Hubbard tanks, tubs, whirlpools, spas, birthing tanks) are drained, cleaned, and disinfected using an EPA-registered disinfectant according to manufacturer's instructions after each patient use.	○ Yes ○ No ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no cite at 42 CFR 482.42(a)(1) (Tag A-749)		

DRAFT Instructions

Acute Care Hospital

Infection Control Tool for Surveyors

42 CFR 482.42 Condition of Participation: Infection control

The hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases. There must be an active program for the prevention, control, and investigation of infections and communicable diseases.

(a) Standard: Organization and policies. A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases.

(1) The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.

(2) The infection control officer or officers must maintain a log of incidents related to infections and communicable diseases.

(b) Standard: Responsibilities of chief executive officer, medical staff, and director of nursing services. The chief executive officer, the medical staff, and the director of nursing services must--

(1) Ensure that the hospital-wide quality assurance program and training programs address problems identified by the infection control officer or officers; and

(2) Be responsible for the implementation of successful corrective action plans in affected problem areas.

This Infection Control Tool provides a new survey structure for assessing hospital compliance with the Infection Control CoP. Use of the tool should not replace the important critical thinking skills that surveyors use in the full and comprehensive evaluation of each hospital's infection control program, and is not intended to limit survey process. If surveyor's observations raise concerns, they can widen scope, review medical records, review policies and procedures, and/or conduct additional interviews to deepen their level of inquiry in order to assess potential infection control deficiencies. Use of the tool can improve the CMS survey process by standardizing the approach, providing a consistent, evidence-based framework for focused surveyor observations, and standardizing and simplifying important survey documentation. The pretest period is intended to evaluate the efficacy and ease of use of the tool, use surveyor feedback and input to improve the tool, and determine its impact on the hospital's infection control efforts. Your participation in the pretest involves change that can be difficult and a new survey process that is structured. It does, however, provide an opportunity for you to give your opinion on how to make this tool a welcomed addition for your colleagues when it is finalized.

<u>Outline of Pretest Survey Agenda</u>

Entrance Conference (follow SOM, provide documentation list, identify key contact persons, etc.) and hospital tour:

During this initial part of the survey, request and identify patient "tracers" (based on list of services and eligible patients provided by the hospital) in order to begin selecting locations to survey (see tables below):

a. Patient undergoing surgical procedure in OR
b. Patients undergoing other invasive and non-invasive procedures
c. Patients with invasive devices (observe insertion and/or maintenance practices)
d. Patients on Isolation Precautions

Consider locations in which to survey (based on hospital complexity and services)

e. General locations (e.g., Medical/Surgical units, ICUs, ED)
f. Specialty locations (OR, Endoscopy, Invasive Radiology)
g. Environmental Services and Sterile Reprocessing

First surveyor will interview with Infection Control Officer, QAPI Director, Employee Health Nurse, and Director of Education (using Module 1, see sample "open ended "questions at end of this document).

Second surveyor will begin using Modules 2-5

Conduct additional observations, interview, and/or document review as needed based on any concerns identified in location modules and patient tracers

Surveyor conference

Exit conference

Facility list of procedures, specialty care locations, and eligible patients for tracers

During the entrance conference, surveyors will ask for and check all of the following services or departments that are available in the hospital:

Location(s) where procedure performed

- GI endoscopy (i.e., colonoscopy, EGD) _____
- Bronchoscopy _____
- Cystoscopy _____
- Invasive radiology _____
- Nuclear medicine procedures _____
- Angiograms _____
- Cardiac catheterization
- Ventilator/ Respiratory Therapy _____
- Spinal injection procedures (e.g., spinal tap, myelogram, spinal anesthesia)_____
- Sterilization _____
- High-level disinfection _____

Check whether the following locations are in the hospital:

- Neonatal intensive care unit (NICU)
- Medical Intensive Care Unit (MICU)
- Surgical Intensive Care Unit (SICU)
- Pediatric Intensive Care Unit (PICU)
- Cardiac Intensive Care Unit
- Burn Unit
- General Operating Room
- Cardiac Cath/Invasive Radiology
- Endoscopy

- Labor and Delivery
- Emergency Department
- Rehabilitation unit
- Bone marrow transplant unit

In addition, the surveyors will ask the ICO for a list of patients (during the time the survey team expects to remain on site) who are undergoing surgery or other procedures (including bedside procedures), and/or who are on isolation precautions, in order to select patients for survey tracer activities. The surveyor can use the following tables to organize these tracer activities.

Patient name	Procedure	Estimated time of procedure	Location

Patient name	Isolation Precautions	Pathogen	Location

Patient name	Device	Insertion or maintenance	Location

(Please note that if a patient does not give verbal consent for a surveyor to be present during a procedure, that wish must be respected.)

Modules and Sections

The CDC participated in the collaborative development of the evidence-based questions in this tool. The questions are organized into sections (e.g. hand hygiene) and the sections are organized into Modules (e.g. Critical Care Module). The modules and sections are designed and organized to assist surveyors in the assessment of compliance with the CMS infection prevention and control requirements. Some sections that are labeled "tracers" are meant to highlight specific procedures or activities that can cause infections. These "tracers" include questions concerning hospital prevention activities for CAUTI (catheter associated urinary tract infection), SSI (surgical site infection), CLABSI (central line associated blood stream infection), and VAP (ventilator associated pneumonia). This is not an exclusive list of HAIs (hospital acquired infections) that hospitals should address in their programs. Hospital infection prevention and control programs must also include provisions to address other infectious disease such as MRSA, CDI (Clostridia Difficile Infection), hepatitis, TB, and influenza.

Survey Tool Table of Contents

Survey Process

After the entrance conference and hospital tour, one surveyor begin the interview process using Module 1 (suggested "open ended" questions provided at the end of the instruction sheet) and the other begins to complete Modules 2-5. With guidance provided in Module 1 of the tool, surveyors evaluate the infection prevention and control program (based primarily on interview and review of documentation) including:

- Infection control/prevention program and resources
- Systems to Identify, Report, Investigate, and Control Communicable Disease and Infection
- Systems to Control Transmission of MDROs, Promote Antibiotic Stewardship, and Surveillance
- Personnel Education System/Infection Control Training

There are a few questions on antibiotic stewardship in Module 1 for which we are gathering data but will not issue any deficiency citations. Although the CDC recommends that hospitals have an antibiotic stewardship program, and many hospitals have implemented such a program, there is no regulatory requirement that hospitals develop or implement antibiotic stewardship programs. Antibiotic stewardship is essential for preventing further MDRO (multi drug resistant organism) formation and development of life threatening CDIs, but for now, is at the discretion of an individual hospital. There are a few other scattered questions that will not be cited for an answer of "no".

Based on the information on hospital services and patient procedures, devices, or isolation status obtained from the ICO, surveyors can begin to select locations in which to use Modules 2-4. Surveyors using Module 2-4 may, time permitting, use the same module for more than one location. The sections are meant to be general guides to key infection control and prevention requirements, and the first nine are repeated in each of these three modules. However, they are not inclusive of everything a surveyor might need to assess in a given location. For example, if blood glucose monitoring is performed prior to an endoscopy

procedure, surveyors should complete the section for blood glucose monitoring (point of care devices) in Module 4. If not, that section is non-applicable. Or, if an endoscope is sterilized instead of high-level disinfected, surveyors will complete the section for sterilization in Module 5 instead of the section on high-level disinfection included as part of Module 4. During the pretest phase, surveyors should try and complete as many sections as possible.

In keeping with the patient focus required to complete Modules 2-4, the surveyor should trace and observe patient care during an entire episode of care. During a surgical procedure or endoscopy, the surveyor should follow the patient through the pre-procedure holding area, into the operating room or endoscopy suite, and then into the post-procedure holding area. For a radiology test, such as a CT scan, the surveyor should be present at the patient's room when the patient is transported to the Radiology Department and then remain with the patient as they are returned to their room. If a patient on contact precautions must have a test done in a location other than their room, the surveyor should be present as the patient is taken for the test and as they are returned to their room. This allows the surveyor to assess infection control and prevention of infection transmission in all locations and by all HCP (health care personnel) involved in that episode of care.

When survey activities using Modules 2-5 reveal areas of concern, surveyors should conduct additional survey activities to "drill down" to assess manner, degree, and systems related to the concern. This might include widening scope, conducting additional staff or patient interviews, making additional observations, and/or reviewing policies, procedures, additional records or other pertinent documentation. For example, hand hygiene concerns noted while observing patient treatment or HCP activities should prompt the team to widen the scope of review related to hand hygiene. Is this a concern on other units? Are competencies related to infection control practice documented and up to date in personnel files? Do hospital policies and procedures reflect current practice in the hospital i.e. is the hand hygiene concern limited to one practitioner or broadly to hospital infection control processes and systems? Surveyors are not limited to the use of the tool and are encouraged to use their judgment and survey expertise in assessing infection control compliance. If the surveyor is unable to assess compliance with a given question or element in a module with a "yes" or "no" response, they should indicate "N/A" as appropriate.

During this pre-test phase, Modules 1-5 must be used at least once. This will allow surveyors to be able to give feedback and input on how to optimize the tool to improve effectiveness and ease of use. As time permits, Modules 2-4 should be used in more than one location. The layout of Modules 2-4 are designed to be able to use each module in two locations.

* Note that Modules 2, 3, and 4 include the same initial nine sections (hand hygiene, injection practices and sharps safety, environmental cleaning, personal protective equipment, point of

care devices, noncritical device reprocessing, single use device reprocessing, urinary catheter tracer, and central line tracer).

** Additional sections are added to Modules 2-4 for specific patient care tracers in specialty locations; some may be present in more than one module and some may be non-applicable during the time you are present at that location.

***Please ensure that Modules 1& 5 are completed in their entirety

Suggested Locations for Module Use

Module 1 Interview Questions

Module 2 General Location:

Suggested Locations where Module 1 might apply (not all-inclusive)

- Medical/Surgical inpatient units
- Pediatric and nursery units
- Rehab
- Psych
- Radiology
- Bone Marrow Transplant

Module 3 Critical Care:

Suggested Locations where Module 3 might apply:

- MICU
- SICU
- NICU
- CCU
- Burn Unit
- Emergency Department

Module 4 Invasive Procedure:

Suggested Locations where Module 4 might apply:

- Surgical Operating Room
- Endoscopy Suite
- Labor and Delivery
- Cardiac Catheterization

- Invasive Radiology

Module 5 Environmental Services and Sterile Reprocessing:

Suggested Locations where Module 5 might apply:

- Terminal cleaning of patient room
- Terminal cleaning of operating room
- Any common area of the hospital
- Daily cleaning of patient room
- Central sterile supply
- Hydrotherapy tub
- Rehab facility

List of all Sections:

- Hand hygiene
- Injection practices and sharps safety
- Environmental cleaning/disinfection (patient care area)
- Personal protective equipment
- Point of care devices
- Reprocessing of non-critical items
- Single-use devices
- Urinary catheter tracer
- Central venous catheter tracer
- Protective environment (bone marrow transplant)
- Isolation: contact precautions
- Isolation: droplet precautions
- Isolation: airborne precautions
- Ventilator/Respiratory therapy tracer
- Spinal injection procedure
- Surgical procedure tracer
- Reprocessing of semi-critical equipment
- Environmental services (any location)
- Environmental infection control in the operating room
- Reprocessing of critical equipment (central sterile supply)

Glossary for Infection Control Worksheet

Biologic indicators: provide the only direct measure of lethality of a sterilization cycle. Self-contained test composed of microorganisms that are commonly found on items being sterilized. Require incubation period.

Bowie-Dick test: diagnostic test of a sterilizer's ability to remove air from the chamber of a pre-vacuum steam sterilizer. The air-removal test or Bowie-Dick test is not a test for sterilization.

Chemical Indicators (CI): designed to respond to physical and or chemical conditions within the sterilization chamber. Allow for multiple location placement and immediate information. Placed externally differentiates processed versus non-processed items and placed internally demonstrates exposure to sterilant. The "pass" response of a chemical indicator does not prove the item accompanied by the indicator is necessarily sterile. CIs are intended to detect potential sterilization failures that could result from incorrect packaging, incorrect loading of the sterilizer, or malfunctions of the sterilizer.

Critical Care Items: From the Spaulding Classification System for patient care items or equipment that are used in sterile body sites generally during surgical procedures or that enter the vascular system. Critical care items must always be sterile.

Hand Hygiene: encompasses both hand washing with the use of soap and water in a sink, or use of a waterless alcohol-based hand rub.

High-level Disinfection (HLD): a chemical disinfection process that when following manufacturer's direction renders an item free of all vegetative bacteria and most spores. Used for reprocessing semi-critical items.

Low-level disinfectant (LLD): agent that destroys all vegetative bacteria (except TB bacilli), lipid viruses, some non-lipid viruses, and some fungi, but not bacterial spores. LLD is appropriate for disinfection of non-critical items.

Non-critical items: From the Spaulding Classification System for patient care items (i.e. BP cuff, stethoscope, HR monitor), and surfaces (i.e. bedrails, wheelchairs, walls, floors) that are designed for contact with a patient's intact skin only. These Items must be cleaned and disinfected using low-level disinfectants.

Physical monitors: provides real-time sterilization cycle assessment (i.e. time, temperature, pressure), provides permanent records and detect malfunctions on a real-time basis. Require periodic calibration.

Semi-critical Items: From the Spaulding Classification System for patient care devices and items that are used on intact mucous membranes (such as the lungs or GI tract), or non-intact skin. These items must be minimally high-level disinfected and include items such as thermometers, endoscopes. Cleaning should precede HLD.

Sterilization: validated process may be chemical or physical used to render a product free of all forms of viable microorganisms.

Suggested interview questions for the hospital tour and Module 1:

Hospital Tour

Objectives:

(1) Is the hospital environment sanitary?

(2) Is there an effective communications system throughout the hospital to identify and address infection prevention/control concerns?

(3) Is the infection prevention/control program hospital-wide?

In each unit or area that the surveyor walks through:

Observe if the area is clean and organized, and if it appears sanitary. Look very briefly at clean and dirty utility rooms, the med room, pantry, inside at least one refrigerator, and in at least one patient room.

- Ask one unit/area leadership staff member:
    - How does your unit interface with infection control and how often do you see or communicate with the ICO?
    - What are the infection control quality indicators in use on that unit or in that area?
    - How are infection control quality indicators selected for your unit or area?
    - How does staff get feedback about how they are doing on any given indicator that is being tracked?

  Ask one front line nurse:
    - What do you do when a patient develops a fever and you suspect they have developed an infection?
    - Tell me what you know about adverse events and hospital acquired infections.
    - To whom do you report hospital acquired infections?

Interview questions for the Infection Control Officer and QAPI Director

Objectives: Broadly assess the infection control program and systems in the facility; evaluate communications structure(s), program processes, supporting systems, and the integration between the Infection Prevention and Control program and other key hospital programs.

Questions

1. Please tell me about the IC program from a process perspective i.e. how do you learn about specific cases of hospital associated infections, patients needing isolation precautions, unsanitary conditions etc., and what processes do you follow to track and address these concerns?

2. Please tell me about the Infection Prevention and Control program structure.

3. How is your (ICO) time organized in a typical workweek?

4. Tell me about the process for development of the infection control plan including when and how often is it developed, is it based on a risk analysis, who participates in its development, who approves the plan, when is each plan effective?

5. Tell me about ongoing infection control activities that you monitor that are not linked to the QAPI program.

6. Who participates in the development of infection control program related policies and procedures and who approves new policies or updates?

7. How do you ensure that the hospital environment is sanitary?

8. What systems and processes does the hospital use to ensure each of the following:

- Prevention of infections and communicable diseases;

- Investigation of infections and communicable diseases;
- Control of infections and communicable diseases.

9. Tell me about the infection control log i.e. what goes into the log and how is it utilized within infection control program activities?

10. Tell me about the following systems dealing with infections and communicable diseases (whether hospital acquired or not):

- Systems for identifying infections and communicable diseases?
- Systems for reporting infections and communicable diseases?
- Systems for investigating infections and communicable diseases?
- Systems for containing and controlling infections and communicable diseases?
  - What is the screening process for patients presenting in the ED and for new admissions
  - What is the bed management process for patients placed on an isolation status?
  - What is the hand-off process to communicate isolation status and is that hand-off process consistent throughout the hospital?

11. How are HCP trained in infection control systems, processes, practices, strategies?

- How often
- Competency assessments?
- Documentation?

12. Tell me about the communications systems between the infection control program and QAPI?

13. Looking at the facility layout, which areas are not included in QAPI activities related to infection prevention and control? Ask as open ended first, and then ask about specific areas.

14. What are the infection control related QAPI indicators for select units and service areas? (Include outpatient services and contract services)

15. Is the hospital tracking the infection prevention/control quality indicators in contract areas (if applicable)?

16. Tell me about infection prevention/control patient safety activities.

17. What were the last two hospital acquired infections that were serious preventable adverse events in the hospital (i.e. patient harm or death following development of the infection).

18. What was done about each of the last two serious hospital acquired infections?

19. Describe the antibiotic stewardship program, if one exists, and efforts to prevent MDROs.

<u>Interview questions for Employee Health Nurse and Director of Education</u>

Objective: Evaluate the infection prevention/control program activities regarding prevention and control of infections and communicable disease related to HCP.

1. Tell me how HCP are trained in infection control systems, processes, practices, strategies?

    - How often
    - Competency assessments?
    - Documentation?

2. Tell me about the hospital system for identifying and addressing employee exposure events including blood-borne pathogen exposure events, needle-sticks, and other sharps incidents.

3. Tell me about the hospital system for addressing employee post exposure evaluation and follow up.

4. Tell me about the hospital system for tracking and trending HCP infection exposure events.

5. Tell me about the system in place for providing Hepatitis B vaccine to HCP? What HCP are excluded? Are non paid HCP screened?

6. Tell me about the system in place for screening and addressing TB.

7. Tell me about the system in place for respirator fit testing and storage/availability of respirator equipment.

8. Are HCP offered annual influenza vaccine and does the hospital track success rates for HCP who get the vaccine?

9. Tell me about infection prevention/control training process for non-paid staff, environmental staff, and clinical staff i.e. how often, how much is covered, and are competencies assessed and documented in personnel files or elsewhere?

After obtaining answers to a sample of the above broad questions, complete Module 1 while those interviewed remain available. Most of the questions in this module can be answered without additional input, but several may require additional input.

DRAFT #2: PRE-DECISIONAL SURVEYOR WORKSHEET

Assessing Hospital Compliance

With the Condition of Participation for

Quality Assessment & Performance Improvement (QAPI)

State Agency Name _____ _____

Instructions: The following is a list of items that must be assessed during the on-site survey, in order to determine compliance with the QAPI Condition of Participation. Items are to be assessed primarily by review of the hospital's QAPI program documentation and interviews with hospital staff. Direct observation of hospital practices plays a lesser role in QAPI compliance assessment, but may still be appropriate.

The interviews should be performed with the most appropriate staff person(s) for the items of interest (*e.g.*, unit/department staff should be asked how they participate in the hospital-wide QAPI program).

Citation instructions are provided throughout this instrument, indicating the applicable regulatory provision to be cited on the Form CMS-2567 when deficient practices are observed.

PART 1 – HOSPITAL CHARACTERISTICS

1.1 Hospital Name **(please print)** _____

1.2 Address, State and Zip Code
(please print)

_____
Address

_____
City State Zip

1.3 CMS Certification Number (CCN) | | | | | | |

1.4 Date of site visit:

		/			/					to			/			/			
m	m		d	d		y	y	y	y		m	m		d	d		y	y	y	y

PLEASE COMPLETELY FILL IN EACH BUBBLE USING A DARK PEN.

1.5 Does the hospital participate in Medicare via accredited "deemed" status?

- ○ YES
- ○ NO

1.5a If YES, which AO(s)? (Check all that apply)

- ○ American Osteopathic Association (AOA)/HFAP
- ○ DNV Healthcare (DNV)
- ○ The Joint Commission (TJC)

1.5b If YES, according to the hospital, what was the end date of the most recent accreditation survey?

		/			/				
m	m		d	d		y	y	y	y

1.5c What was the end date of the most recent previous State Agency Federal survey:

		/			/				

NOTE: PART 2 - NEW HOSPITAL WORKSHEET SECTION - PURPOSELY OMITTED FROM PRETEST

PART 3: DATA COLLECTION AND ANALYSIS - QUALITY INDICATOR TRACERS

Instructions for Part #3 Questions:
Select 3 quality indicators (not patient safety analyses) and trace them answering the following multipart question. Focus on indicators with related QAPI activities or projects. At least one of the indicators must have been in place long enough for most questions to be applicable.

Elements to be Assessed	Indicator #1	Indicator #2	Indicator #3
3.1 Write in indicator selected			
Indicator selection identified through	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.a Can the hospital provide evidence that each quality indicator selected is related to improved health outcomes? (e.g. based on QIO, guidelines from a nationally recognized organization, hospital specific evidence, peer-reviewed research, etc.)	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.b Is the scope of data collection appropriate to the indicator, e.g.,. an indicator related to labor and delivery might be appropriate to all areas of that unit and the ED, but indicators related to hand hygiene would be hospital-wide.)	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Elements to be Assessed	Indicator #1	Indicator #2	Indicator #3
3.1.c Is the method (e.g., chart reviews, monthly observations, etc.) and frequency of data collection specified?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.d Is there evidence that the data actually collected conforms to the methodology and frequency? E.g., Is there evidence of late, incomplete, or wrong data collection?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.e If unit staff play a role in data collection, is collection consistent with the methodology?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.f Is data aggregated in accordance with the hospital methodology for this indicator?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Elements to be Assessed	Indicator #1	Indicator #2	Indicator #3
3.1.g Is the collected data analyzed?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.h If data is aggregated quantitatively, are rates calculated for points in time and over time, and are comparisons made to performance benchmarks when available (e.g. established by nationally recognized organizations)?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.i Is aggregated data broken down into subsets that allow comparison of performance among hospital units covered by the indicator? For example, is it possible to compare hand hygiene in different inpatient units?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of 3.1.a through 3.1.i, cite at 42 CFR 482.21(a)(1), (a) (2), (b)(1), & (b)(3) (Tag A-273)			

Elements to be Assessed	Indicator #1	Indicator #2	Indicator #3
3.1.j Is there evidence that analysis that identifies areas needing improvement leads to interventions (activities and/or projects)? If not, can the hospital demonstrate that other improvement activities are more urgent, based on the regulatory criteria for prioritizing them?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.k Are interventions evaluated for success ?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.l If interventions taken were not successful, were new interventions developed?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
3.1.m If interventions were successful, did evaluation continue long enough to assess if success was sustained?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A
	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of 3.1.j through 3.1.m, cite at 42 CFR §482.21(b)(2), (c) (1), & (c) (3) (Tag A-283)			

PART 4 – APPLYING QUALITY INDICATOR INFORMATION - ACTIVITIES AND PROJECTS		
Elements to be Assessed		**Manner of Assessment Code (Enter all that apply) & Surveyor Notes**
4.1 Can the hospital provide evidence that its improvement activities focus on areas that are high risk (severity), high volume (incidence or prevalence), or problem-prone?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to 4.1, cite at 42 CFR §482.21(b)(2) (Tag A-283)		
4.2 Can the hospital provide evidence that it conducts distinct performance improvement projects?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.3 Is the number of projects proportional to the scope and complexity of the hospital's services and operations? No fixed ratio is required, but smaller hospitals with a smaller number of distinct services would be expected to have fewer projects than a large hospital with many different services.	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
4.4 Does the scope of projects reflect the scope and complexity of the hospital's services and operations? E.g., if the hospital offers more complex services, such as neonatal intensive care, or open heart surgery, has there been QAPI project(s) related to any complex service in the past three years?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any of 4.2 through 4.4, cite at 42 CFR §482.21(d)(1) (Tag A-297)		
4.5 Can the hospital provide evidence showing why each project was selected? *(NOTE: If the project is a QIO cooperative project or an IT project, such as computer ordered physician entry for medications or an electronic medical record, no rationale is required. Check N/A in these cases)*	○ YES ○ NO ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to 4.5, cite at 42 CFR §482.21(d)(3) (Tag A-297)		

PART 5 – PATIENT SAFETY – ADVERSE EVENTS AND MEDICAL ERRORS

Elements to be Assessed		Manner of Assessment Code (Enter all that apply) & Surveyor Notes
5.1 In this multipart question evaluate if the hospital's leadership sets expectations for patient safety? Specifically:		
5.1.a Is there evidence of widespread staff training in expectations for patient safety? (e.g. training related to steps to take in a situation that feels unsafe, how to report medical errors (including near misses/close calls) adverse events, etc.)	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.1.b Is there evidence that the hospital has adopted policies supporting a non-punitive approach to staff reporting of medical errors, (including near misses/close calls), adverse events, and situations they consider unsafe?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.1.c On each unit surveyed, can staff explain if/how they would intervene and/or report if they observed or learned of medical errors (including near misses/close calls), adverse events, or unsafe situations?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to 5.1.a, 5.1.b, or 5.1.c, cite at 42 CFR §482.21(e)(3)(Tag A-286)		
5.2. In this multipart question evaluate if the hospital has a systematic process to identify medical errors (including near misses/close calls)and adverse events on an ongoing basis? Specifically:		
5.2.a On each unit/program surveyed, can staff define medical errors (including near misses/close calls) and adverse events?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Elements to be Assessed		Manner of Assessment Code (Enter all that apply) & Surveyor Notes
5.2.b On each unit/program surveyed, can staff explain how and/or to whom they would report medical errors (including near misses/close calls) and adverse events?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.2.c Does the hospital employ methods, in addition to staff incident reporting, to identify possible medical errors (including near misses/close calls) and adverse events? (Examples of other methods include, but are not limited to, retrospective medical record reviews, review of claims data, unplanned readmissions, or patient complaints/grievances, interview or survey of patients, etc.)	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.2.d Can the hospital provide evidence of medical errors (including near misses/close calls) and adverse events identified through staff reports or other methods?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to any 5.2.a through 5.1.d, cite at 42 CFR §482.21(a)(2) (Tag A-286)		
5.3 Is there QAPI program collaboration with infection control officer(s) to identify and track avoidable healthcare-acquired infections?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.4 Is there evidence that problems identified by infection control officer(s) are addressed through QAPI program activities?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to 5.3 or 5.4, cite at 42 CFR §482.21(a)(2) and 42 CFR §482.42(b)(1) (Tags A-286 and A-756)		

Elements to be Assessed		Manner of Assessment Code (Enter all that apply) & Surveyor Notes
5.5 Does the QAPI program identify and track medication administration errors, adverse drug reactions, and drug related incompatibilities?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to 5.5, cite at 42 CFR §482.21(a)(2) and 42 CFR §482.25(b)6) (Tags A-286 and Tag A-508)		
5.6 Is there a QAPI program process for staff to report blood transfusion reactions, and reviews of reported blood transfusion reactions to identify medical errors (including near misses/close calls) and/or adverse events?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to 5.6, cite at 42 CFR §482.21(a)(2) and §482.23(c)(4) (Tags A-286 and A-410)		
5.7 Did the survey team have prior knowledge of, or identify while on-site, serious preventable adverse events that the hospital failed to identify?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If yes to 5.7, cite at 42 CFR §482.21(a)(2) (Tag A-286)		
5.8 Has the hospital conducted causal analyses of all serious preventable adverse events it identified in the period 12 months prior to the survey date? (Note: for events that occurred less than 2 months prior to the survey date, the hospital may have started, but not yet completed a causal analysis.)	○ YES ○ NO ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, and if the survey team has identified serious preventable adverse events for which no analyses were scheduled or planned, cite at 42 CFR §482.21(a)(2) (Tag A-286)		

Causal Analysis Tracers **Instructions for Question #5.9: Select three analyses the hospital has completed for adverse events or aggregated near misses (close calls) during the last 12 - 24 months, and answer the following questions. (For at least one analysis selected there should be sufficient time after implementation of preventive measures for the hospital to have evaluated the impact of those measures.) For initial certification surveys of new hospitals, this section may not apply, depending on whether any serious preventable adverse events have occurred and been identified.**				
If the hospital has had serious preventable adverse events but has not initiated any such analyses for events occurring in the previous 2 months, or has not completed analysis for events occurring in the previous 2 – 12 months, cite at 42 CFR §482.21(a)(2) (Tag A-286).				
Elements to be Assessed	**Analysis**			**Manner of Assessment Code (Enter all that apply) & Surveyor Notes**
	#1	**#2**	**#3**	
5.9 Has the hospital conducted any causal analyses in the 12 months prior to the survey date? If yes continue, if no, skip 5.10 and all 5.10 sub-questions				○ YES ○ NO
5.10.a Analyzed each event or aggregated events/near misses to identify potential underlying causes through qualitative or quantitative methods?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
Elements to be Assessed	**Analysis**			**Manner of Assessment Code (Enter all that apply) & Surveyor Notes**
	#1	#2	#3	
5.10.b Identified all parts of the hospital utilizing similar processes/at similar risk?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.10.c Developed and implemented preventive actions based on the analysis in at least one area of the hospital?	○ YES ○ NO	○ YES ○ NO	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.10.d Evaluated the impact of the preventive actions, including tracking reoccurrences of similar events/near misses?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Elements to be Assessed	Analysis			Manner of Assessment Code (Enter all that apply) & Surveyor Notes
	#1	#2	#3	
5.10.e If evaluation showed the intervention(s) did not meet goals, were revised interventions implemented and evaluated?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
5.10.f Implemented preventive actions found to be effective in all parts of the hospital utilizing similar processes/at similar risk, unless there are documented reasons for not doing so?	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ YES ○ NO ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no for any (5.10.a through 5.10.f) cite at 42 CFR §482.21(a)(1) & (a)(2) & (c)(2) (Tag A-286)				

PART 6 – BROAD QAPI REQUIREMENTS AND LEADERSHIP RESPONSIBILITIES		
Elements to be Assessed		**Manner of Assessment Code (Enter all that apply) & Surveyor Notes**
6.1 Is there evidence that the hospital has a formal QAPI program - including written policies and procedures, budgeted resources, and clearly identified responsible staff - approved by the governing body after input from the CEO and medical staff leadership?		
If no, for pre-test only cite at 42 CFR §482.21(e)(2)) (Tag A-309)		
6.2 In this multipart question evaluate if the hospital's QAPI program is hospital-wide. Specifically:		
6.2.a Using information on services offered from the Hospital/CAH Data Base Worksheet, can the QAPI manager provide evidence of QAPI monitoring related to each service?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR §482.21(e)(2)) (Tag A-309)		
6.2.b Using information from the hospital identifying services provided under arrangement (contract), can the QAPI manager provide evidence of QAPI monitoring for each service related to clinical care provided under arrangement? (Exclusively administrative contractual services, e.g., payroll preparation, are not required to be included in the QAPI program.)	○ YES ○ NO ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR §482.12(e) and §482.21(e)(2) (Tags A-083 and A-309)		
6.3 Is there evidence that the governing body, hospital CEO, Medical Staff leadership, and other senior administrative officials, e.g., Director of Nursing, each play a role in QAPI program planning and implementation?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR §482.21(e)(2) (Tag A-309)		

Elements to be Assessed		Manner of Assessment Code (Enter all that apply) & Surveyor Notes
6.4 Is there evidence, e.g. in minutes, that the hospital's governing body:		
6.4.a Approves QAPI program indicators selected and frequency of data collection?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR §482.21(b)(3) (Tag A-273)		
6.4.b Makes decisions on the number of distinct QAPI projects to be conducted annually?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
6.4.c Actively reviews the results of QAPI data collection, analyses, activities, projects and makes decisions based on such review?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no to either (6.4.b or 6.4.c) cite at 42 CFR §482.21(e)(2) (Tag A-309)		
6.4.d Holds the CEO accountable for the effectiveness of the QAPI program?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR §482.21(e)(2) and §482 .12(b) (Tags A-309 & A-057)		
6.5 Regarding resource allocation:		
6.5.a Is there evidence of the amount of resources (funding and personnel) dedicated to the hospital's QAPI program and the functions for which those resources are used?	○ YES ○ NO	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If no, cite at 42 CFR §482.21(e)(4) (Tag A-315)		

Elements to be Assessed		Manner of Assessment Code (Enter all that apply) & Surveyor Notes
6.5.b If there are condition-level QAPI program deficiencies, is there evidence that lack of QAPI resources are a significant contributing cause of these deficiencies?	○ YES ○ NO ○ N/A	○ 1 ○ 2 ○ 3 ○ 4 ○ 5
If *yes*, cite at 42 CFR §482.21(e)(4) (Tag A-315)		