ALABAMA STATE COMMITTEE OF PUBLIC HEALTH
DIVISION OF LICENSURE AND CERTIFICATION
ADMINISTRATIVE CODE

CHAPTER 420-5-10
NURSING FACILITIES

420-5-10-.21 Infection Control.

(1) The facility must establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection.

(a) Infection Prevention and Control Program. The facility must establish an infection control program that must include, at a minimum, the following elements:

1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 420-5-10-.19 and following accepted national standards.

2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

a. A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility.

b. When and to whom possible incidents of communicable disease or infections should be reported.

c. Standard and transmission-based precautions to be followed to prevent spread of infections.

d. When and how isolation should be used for a resident; including but not limited to:

(i) The type and duration of the isolation, depending upon the infectious agent or organism involved.

(ii) A requirement that isolation should be the least restrictive possible for the resident under the circumstances.

e. The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

f. The hand hygiene procedures to be followed by staff involved in direct resident contact.

g. A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

3) Linens. Personnel must handle, store, process, and transport linens to prevent the spread of infection.

4) Annual Review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

(2) IPCP. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

(3) Infection Preventionist (IP). The facility must designate one or more individual(s) as the IP who is responsible for the facility's IPCP. The IP must:

(a) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field.

(b) Be qualified by education, training, experience or certification.

(c) Work at least part-time at the facility.

(d) Have completed specialized training in infection prevention and control.

(4) Tuberculosis (TB) Screening:

(a) Resident Screening.

1) As part of the resident admission procedure, a two-step tuberculin (PPD-Mantoux) skin test shall be administered prior to or upon admission to all new residents unless there is documentation of a previous positive reaction. The two-step method should detect the boosting phenomenon that might be misinterpreted as a skin test conversion. Testing administered prior to admission shall be within 30 days of admission date. Results shall be recorded in the permanent records of the facility.

2) History of Bacille Calmetta Guerin (BCG) vaccination does not preclude an initial screening test, and a reaction of 10 mm or more indurations shall be managed as a tuberculous infection.

3) At the time of admission, any resident found to have a significant tuberculin skin test reaction (10 mm or greater) or with symptoms suggestive of TB shall be evaluated for active TB disease by clinical examination and chest roentgenogram. Sputum specimen, if obtainable, shall be collected and sent to the state Health Department Laboratory for smear and culture studies. Routine chest roentgenogram at admission remains an option at the discretion of the nursing facility. In the absence of clinical symptoms, annual chest roentgenograms are not recommended.

4) Sputum of acid-fast smear and mycobacterial culture shall be obtained promptly on any tuberculin reactor who develops a persistent cough or fever or manifests an abnormal chest roentgenogram compatible with TB. Any resident, regardless of skin test results, with a persistent cough or fever or other symptoms suggestive of TB shall first have sputum collected and submitted immediately to the state Health Department Laboratory for smear and culture studies, followed by a clinical examination and chest roentgenogram.

5) Residents who have a documented history of a positive (greater than 10 mm induration) PPD tuberculin test, adequate treatment for disease, or adequate preventive therapy for infection shall be exempt from further screening unless they develop signs or symptoms suggestive of TB.

6) Routine annual TB skin testing of residents is not recommended for every nursing facility. The Infection Control Plan for each facility shall establish the need and frequency of repeat or annual TB skin testing based upon the risk of transmission of TB infection in that facility and the surrounding community.

7) All residents with a documented negative tuberculin test shall be retested within 7 working days after notice of exposure to a suspected or diagnosed case, using the single-step Mantoux method. Contacts having a tuberculin skin test with a 5 mm or greater induration, and tuberculin converters should have follow-up examinations including a chest roentgenogram and clinical evaluation. Converters are defined as newly infected persons, without documented exposure information, whose tuberculin skin test increases as follows:

a. For persons under age 35 the skin test must increase by at least 10 mm from most recent test results.

b. For persons aged 35 and older the skin test must increase by at least 15 mm from most recent test results.

(b) Employee Screening.

1) As part of the pre-employment procedure, a two step tuberculin (PPD-Mantoux) skin test shall be administered to all new employees as soon as employment begins unless there is documentation of a previous positive reaction or documentation of a negative skin test within the past 12 months. A single-step skin test is sufficient for new employees with documented negative test within the previous 12 months. The two-step tuberculin skin testing should detect the boosting phenomenon that might be misinterpreted as a skin test conversion. Results shall be recorded in the permanent records of the facility.

2) A history of BCG vaccination does not preclude an initial screening test, and a reaction of 10 mm or more indurations shall be managed as a TB infection.

a. Any healthcare worker (HCW), at the time of employment, found to have a significant tuberculin

skin test reaction (10 mm or greater) or with symptoms suggestive of TB shall be evaluated by clinical examination and chest roentgenogram. Sputum specimen, if obtainable, shall be collected and sent to the State Health Department Laboratory for smear and culture.

b. HCWs who have a documented history of a positive PPD test, adequate treatment for disease, or adequate preventive therapy for infection shall be exempt from further screening unless they develop signs or symptoms suggestive of TB.

c. Routine annual TB skin testing of HCWs is not recommended for every nursing facility. PPD-negative HCWs shall undergo repeat PPD testing at regular intervals as determined by the nursing facility's risk assessment. The Infection Control Plan for each facility should establish the need and frequency of repeat or annual TB skin testing based upon the risk of transmission of TB in that facility and surrounding community.

d. All HCWs with documented negative tuberculin test shall be retested using the single-step Mantoux method within 7 working days after notice of exposure to a suspected or diagnosed case of TB if appropriate precautions were not in place at the time of exposure. All HCWs with newly recognized positive PPD test results shall be evaluated promptly for active TB. Contacts having a tuberculin skin test with a 5 mm or greater induration, and tuberculin converters shall have follow-up examinations including a chest roentgenogram and clinical evaluation. Sputum specimen, if obtainable, should be sent to the State Health Department Laboratory for smear and culture. Converters are defined as newly infected persons, without documented exposure information, whose tuberculin test increases as follows:

(i) For persons under age 35, the test must increase by at least 10 mm within the past 2 years.

(ii) For persons aged 35 and older, the skin test must increase by at least 15 mm within the past 2 years.

e. Routine chest radiographs are not required for asymptomatic, PPD- negative HCWs. HCWs with positive PPD test results shall have chest radiographs as part of the initial evaluation of their PPD test; if negative, repeat chest radiographs are not needed unless symptoms develop that could be attributed to TB. However, more frequent monitoring for symptoms of TB may be considered for recent converters and other PPD-positive HCWs who are at increased risk for developing active TB (e.g., HIV- infected or otherwise severely immunocompromised HCWs).

(c) Treatment of Latent Infection.

1) Infected employees and residents with no current disease, who are 34 years of age and under, shall be offered preventive therapy (isoniazid) in accordance with the American Thoracic Society, Centers for Disease Control and Prevention, American College of Chest Physicians, and the Alabama State TB Control Program Guidelines. Employees and residents aged 35 and over who have significant skin tests may be offered preventive therapy depending upon each individual's complete evaluation.

(d) Role of the Health Department.

1) Any employee or resident with suspected or diagnosed TB disease must be reported to the local health department immediately.

2) Epidemiologic investigation will be performed by trained health department staff on all employees and residents with diagnosed or suspected disease.

3) Further information regarding TB screening of employees and residents may be obtained by contacting the local county health department or the Division of TB Control of the State Health Department.

(e) Two-Step Testing.

1) Nursing homes may choose to use either of the methods outlined below when administering the two-step (test-retest) tuberculin skin test. The Infection Control Plan for each facility shall designate which method is more appropriate for the facility and that method must be consistently utilized. The use of the two-step tuberculin skin test should detect the boosting phenomenon that might be misinterpreted as a skin test conversion. The process is particularly important when repeat testing is likely.

a. Method 1:

(i) Apply first test.

(ii) Read result in 7 days.

(iii) If result is positive (greater than 10 mm of induration), follow recommendation for appropriate follow-up of positive skin test.

(iv) If result is negative (0-9 mm of induration), apply second test (same day).

(v) Read result of second test 48-72 hours later.

(vi) Use result of second test as baseline.

b. Method 2:

(i) Apply first test.

(ii) Read test in 48-72 hours.

(iii) If result is positive (greater than 10 mm of induration), follow recommendation for appropriate follow-up of positive skin test.

(iv) If result is negative (0-9 mm of induration), apply second test 1-3 weeks later.

(v) Read result of second test 48-72 hours later.

(vi) Use result of second test as baseline.

(5) Influenza and Pneumococcal Immunizations.

(a) Influenza. The facility must develop policies and procedures to ensure that:

1) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization.

2) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period;

3) The resident or the resident's representative has the opportunity to refuse immunization.

4) The resident's medical record includes documentation that indicates, at a minimum, the following:

a. That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization.

b. That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(b) Pneumococcal Disease. The facility must develop policies and procedures to ensure that:

1) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization.

2) Each resident
is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized.

3) The resident or the resident's representative can refuse immunization.

4) The resident's medical record includes documentation that indicates, at a minimum, the following:

a. That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization.

b. That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

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