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| **DEPARTMENT OF HEALTH SERVICES**  Division of Quality Assurance  F-02651 (10/2020) | | | **STATE OF WISCONSIN**  Page 1 of 2 | | |
| **NURSING HOME – COVID-19 CHANGE WORKSHEET** | | | | | |
| This worksheet is designed to assist nursing homes in planning for COVID-19 surge capacity. The Division of Quality Assurance (DQA) will utilize the information shared to determine whether nursing homes will be able to safely provide cares to residents under their plans, and work with the providers if concerns arise during review of the plans.  The information collected on this form will be used by the DQA to evaluate the provider’s plan to temporarily expand or transfer residents during the COVID-19 public health emergency. Complete this form and submit an electronic version of the completed form and any attachments to Elizabeth Laubenstein at [Elizabeth.Laubenstein@dhs.wisconsin.gov](mailto:Elizabeth.Laubenstein@dhs.wisconsin.gov).  DQA will review the form for completeness. If any sections are incomplete or need clarification, DQA will contact the provider.  **References**   * Wis. Stat. Chapter 50: <http://docs.legis.wisconsin.gov/statutes/statutes/50> * Wis. Admin. Code Ch. DHS 132: <https://docs.legis.wisconsin.gov/code/admin_code/dhs/110/132> | | | | | |
| Name – Provider | | | | Provider Type | License No. |
| Name – Administrator/Contact Person | | Provider Telephone No. | | Provider Email Address | |
| **Emergency Preparedness Plan** | | | | | |
| Yes  No | Do you have a written emergency preparedness plan? *If “No,” submit an emergency preparedness plan that includes potential COVID-19 concerns, including staffing and PPE*. | | | | |
| Yes  No | Do you have a plan for resident isolation? | | | | |
| Yes  No | Will this plan involve moving residents? | | | | |
| Yes  No | Will this mean internal moves or external moves out of the facility? | | | | |
|  | What are your resident notification and transfer plans? *Describe below.* | | | | |
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| **Staffing** | | | | | |
| Yes  No | Does the facility currently have sufficient staff to care for the patients/residents, including additional COVID-19 positive residents? | | | | |
| Yes  No | Do you have a plan for acquiring more? *If “Yes,”* d*escribe below.* | | | | |
|  |  | | | | |
| Yes  No | Do you have an emergency plan if/when staff start to contract the virus? *If “Yes,”* d*escribe below.* | | | | |
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| Yes  No | Do you have an emergency plan if/when the NHA, DON, or ICP contract the virus? *If “Yes,”* d*escribe below.* | | | | |
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| **Personal Protective Equipment (PPE)** | | | | | |
|  | Describe below how much PPE you have? | | | | |
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| Yes  No | Do you have plans for acquiring more? *If “Yes,”* d*escribe below.* | | | | |
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| Yes  No | Have you calculated a PPE burn rate that includes a census of C-19 positive residents? | | | | |

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| **Beds** | | | | |
| Yes  No | Do you plan to increase/decrease the number of beds? | | | |
|  | What is the number of private beds? |  |  | |
|  | What is the number of non-private beds? |  |  | |
|  | What is the total number of beds? |  |  | |
|  |  |  |  | |
| Yes  No | Are these additional beds for COVID-19 positive patients/residents? | | | |
|  | If “No,” why are you adding the beds? *Explain below.* | | | |
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|  | If “No,” where did/will the beds come from? *Explain below.* | | | |
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| Yes  No | Will the additional beds be added to the facility before COVID-19 positive residents are admitted to the facility or once there is a COVID-19 positive resident in the facility? | | | |
| **Environmental Controls** | | | | |
| Yes  No | Do occupied C-19 room doors stay closed per facility policy? | | | |
| Yes  No | Could you include a diagrammatic floor plan in your submission to the department that denotes the C-19 area? | | | |
| Yes  No | Is ventilation air from the C-19 area recirculated back to the remainder of the facility? | | | |
| Yes  No | Are high efficiency (HEPA) filters being used? *If “Yes,” indicate where.* | | | |
|  | Resident rooms  Corridors  Central air handling unit  Other: | | |  |
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