Guidance and responses were provided based on information known on 6/4/2020 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates.

COVID-19 and LTC

June 4, 2020

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ICAP
Infection Control Assessment and Promotion Program

Questions and Answer Session

Use the QA box in the webinar platform to type a question. Questions will be read aloud by the moderator
If your question is not answered during the webinar, please either e-mail it to NE ICAP or call during our office hours to speak with one of our IPs

A transcript of the discussion will be made available on the ICAP website
https://icap.nebraskamed.com/coronavirus/
https://icap.nebraskamed.com/covid-19-webinars/

Panelists today are:

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Reopening: Infection Prevention Considerations

LONG-TERM CARE COVID-19 RESPONSE PLANNING TOOL

Nursing and assisted living facilities can take steps to assess and improve their preparedness for responding to COVID-19. The following information should be used as one tool to develop a comprehensive COVID-19 response plan, including a plan for gradual return to standard practices of the facility based on meeting critical benchmarks including communal activities and allowing in-person visitors. The following information identifies key areas long-term care facilities should consider in developing their plans and can also be used to self-assess the strengths and weaknesses of current preparedness efforts.

Because staffing levels and access to supplies and testing may vary by facility and because the pandemic is affecting facilities and communities in different ways, decisions about relaxing restrictions in a facility should include the following considerations, as recommended by the Centers for Medicare and Medicaid Services (CMS) in QSO-20-30-NH:

- **Case status in community:** The level of community transmission. For example, a decline in the number of new cases, hospitalizations, or deaths (with exceptions for temporary outliers).
- **Case status in the nursing home(s)**: Absence of any new nursing home onset COVID-19 cases (resident or staff), such as a resident acquiring COVID-19 in the nursing home.
- **Adequate staffing**: No staffing shortages and the facility is not under a contingency staffing plan.

http://dhhs.ne.gov/licensure/Documents/LTCC19ResponsePlanningTool.pdf#search=LONG%2DTERM%20CARE%20COVID%2D19%20RESPONSE%20PLANNING%20TOOL

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Rolling-Back Re-opening

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Preparation to lock-back down

Triggers:

- Suspected or confirmed COVID case in resident or staff
- COVID cases increasing in community
- Increase in respiratory infections

Preparation (continued)

- PPE on-hand to do quarantine of all residents (if needed)
    - Yellow-Zone, use the PPE calculator and/or plan for about 18-26 room entries for each room
- Pick up disease early
    - Continue extended symptom screening of residents (3 times per day) and staff
- Dedicate staff to each unit
    - This contains disease

Visitation

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CDC Considerations for visitation when restrictions are being relaxed

CDC says:

Permit visitation only during select hours and limit the number of visitors per resident (e.g., no more than 2 visitors at one time).

Ideas:

- Consider staffing a team member to greet visitors, enforce the limit, educate about mask use and hand hygiene
- Consider reaching out to family to set up an appointment and describe the expectations
- Visitation oversight will be time consuming. Plan for staffing.
- Record the visit date, and keep record of resident and staff contacts with each visitor

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

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CDC says:

Schedule visitation in advance to enable continued social distancing.

Ideas:

- Consider reaching out to family to set up an appointment and describe the expectations
- Consider conducting a verbal symptom screening when setting appointment
- Schedule team members to educate and enforce social distancing.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

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CDC says: Restrict visitation to the resident's room or another designated location at the facility (e.g., outside).

Ideas:

- Identify meeting rooms in safe areas of the facility, such as patio, and private meeting rooms in the facility.
- Prevent visitor contact with resident roommate if possible
- Stage chairs 6 feet apart
- Consider identifying safe routes/pathways for visitors to minimize exposure to other residents
- Record the visit date, and keep record of resident and staff contacts with each visitor

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

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Communal Dining

Ensure clean dining room environment, and clean residents

Educate diners on need for social distancing

Arrange dining tables to accommodate social distancing

Only asymptomatic and negative-tested residents may go to dining room (symptomatic and isolated/cohorted should be served in room)

Still need to use social distancing

- Consider dividing asymptomatic residents into 3 groups for dining outings
- First group would go to breakfast, second would go to lunch, and third to dinner.
- Rotate the schedule for these groups so that residents are out to dining room for different meals.

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Indoor Activities

Consider taking advantage of social distancing at mealtimes, and plan activities that could be carried out in dining area

- Paper bingo that can be disposed of after game
- Sing-alongs
- Some chair exercises before or after meals

Locked unit groups (memory) need activities too, so consider masks for residents to participate in hallway activities with social distancing

- chair exercises, kicking the ball or bopping the balloon, etc.
- Any activities with shared objects – consider cleaning between residents, and use of PPE where appropriate.

Ill/Isolated residents must remain in their rooms for activities until their illness/isolation is over/discontinued.

Ensure residents can communicate with loved ones via phone or electronic devices, until visitation opens up again.

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Outdoor activities

Outdoor activities which allow for social distancing (small groups)

- walks,
- gardening activities,
- birdwatching, etc.

Transporting residents to appointments (asymptomatic, negative tested)

– will still need social distancing and masks for residents/staff.

*Do not transport residents in groups where social distancing cannot be kept.

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Personal Protective Equipment

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Preparing your PPE supply Plan

How much PPE do you need during “normal” operations

- PPE for MDRO
- PPE when resident or staff are either suspected or confirmed for COVID-19

Use PPE calculator-https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

Supply chain

Plan for continuing training and competencies for donning and doffing

Fit testing?

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PPE considerations

Increase par levels to accommodate visitors

What PPE will visitors wear?

Who will provide?

Who will monitor compliance with PPE

Therapy

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How Will You Provide Rehabilitation Therapy

Will you continue to do Therapy in room?

Need to bring residents to therapy gym?

Determine size of therapy gym

Possible to practice social distancing

Number of residents that could be accommodated at one time

What PPE – Residents? Therapists?

Safe to mask resident during therapy

Cleaning procedure

- Who, when, how long

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Therapy

Transport to therapy gym

- What steps do you need to take before a resident leaves their room?
- What needs to be done after therapy to return a resident to their room?

Hand sanitizer-

- How much do you have?
- Where is it placed?
- Are you encouraging residents to use it before and after therapy?

Auditing

- Hand hygiene
- PPE usage and technique
- Cleaning

Infection Prevention and Control Office Hours

Monday – Friday
7:30 AM – 9:30 AM Central Time
2:00 PM -4:00 PM Central Time
Call 402-552-2881

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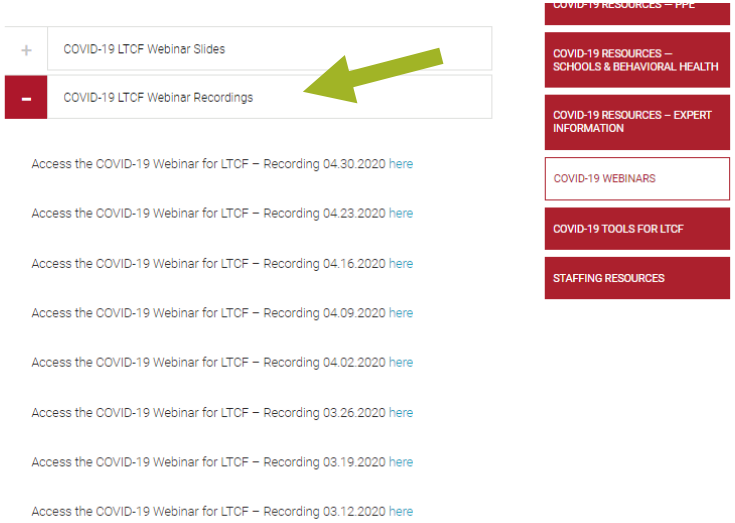
Moderated by Mounica Soma, MHA



https://icap.nebraskamed.com/resources/

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Nebraska DHHS HAI-AR and Nebraska ICAP
Long-term Care Facility Webinar on COVID-19 6/4/2020

1. **Regarding the Covid planning tool, which is due June 22. There are a few items I hope you can clarify.**
    a. **Access to adequate testing: Can you tell us what our steps are in identifying this answer?**
    You have to write a plan on what access you want to use. If you have a private lab, that is your access. If you will be working with the local health department, you need to check with them on what will be their process. If you have to set up an account with NPHL (Nebraska Public Health Lab) for testing, you will want to do that. Then, in the COVID planning tool, you will identify which process you plan to use. Also, you will want to identify who will do the test. You need a plan, listing who will do the testing, It can be a nurse from your own facility trained to do the test. For assisted living facilities that might not have a nurse on staff, you need to have a plan to use a contracted person or perhaps someone from the community or local hospital who could do the testing for you.
    b. **Other than the facility having a plan in place to do the testing themselves, is there a way to ensure that testing will be available through other vendors? We have had Bryan Mobile lab do testing at one of our communities a couple weeks ago but I don't feel this is a guaranteed service if we would have an outbreak.**
    If there an outbreak (or a case in your facility), you will have to notify the local health department and state licensure. When you notify the local health department, they usually do provide you some guidance on testing, whether by themselves or in cooperation with the ICAP team, they will usually supply you the test materials you need for outbreak containment. That will be the process in those cases (usually).
    c. **Local hospital capacity: Ability for the local hospital to accept transfers from nursing homes. How are we to ensure this?**
    Many health departments have developed some dashboards and are keeping tabs on the bed capacity in their local hospitals. Your local coalition or local health department should have this information. If you are seeing a an increase of cases that is overflowing your hospital capacity, your plan should be rolled back the restrictions. Even an increase in numbers should be enough to make you consider putting back some restrictions, because your staff could be exposed, too. You need to keep monitoring the situation.
    d. **PPE requests: Is there a way to know if county health department can keep up with our PPE requests?**
    We have heard from the state health department that they have enough PPE to fulfill the requirements right now. Since the state health department has it, the local health departments can reach out to them for PPE. We still have to know our burn rates, to keep the local health departments informed. We still have to fill out our PPE requests

and ask for the current two-week's PPE. A facility should be prepared with enough PPE on hand at least have enough PPE (obtained through your normal channels) if there is a positive case in your facility and you need to place everyone there in PPE (at least 2 days supply needed for that). Calculate the amount of PPE you would need to put everyone in the facility in an isolation gown for two days and make a request so you have that on hand. It might take that much time for the local health department fill your immediate needs in that case.

When you consider reopening; consider that the state has PPE on hand for outbreaks, etc. You should not plan on the state to have enough PPE on hand to take care of your reopening needs; that should be a facet of what you consider in when you can reopen and you want to be able to go to your regular vendors and sources to help you be ready for reopening for visitation. Look at what you have, your other supply chains, etc. You need to remember the state's system is not an "Amazon warehouse" and you shouldn't count on immediate delivery of PPE. It takes time. Plan for how much you PPE you have on hand, and how much of that you can allocate to visitors. That will help guide you on reopening plans. That should be a deciding factor on planning how many visitors you can accommodate in your facility. The state's supply is there for an outbreak, not day-to-day functions.

2. **We are wondering about the facility testing that needs to take place. What happens when asymptomatic staff and residents refuse to be tested? Will the facility be penalized if staff refuse to be tested? How should the facility deal with or cope with staff who will not be tested?**
   Explain the rationale to the staff about why testing is important. You can't force the staff to do it, so you need a plan in case staff refuses to be tested. That plan is how the facility can still be in a safe position. It depends on circumstances and statistical analysis (i.e., 148 of 150 staff members are tested and none of the 148 are positive, you can consider it a low-risk scenario). If the numbers of positives of the 148 staff was 60 positive, then you would need to more strongly encourage those 2 staff members to be tested because the chances that one of them is positive greatly increases. If they still refuse, the facility will need to decide if you ask them to stay at home, work in non-clinical areas, etc., but there is no penalty for staff who refuse testing, especially if they are asymptomatic.

3. **We completed mass testing and all residents were negative. One employee tested positive. 100% of staff and residents were tested. Do we need to retest everyone to establish an all negative.**
   It depends on when you did the testing. If the testing was very recent, you may not need to repeat now, but if it was two or three months ago, it may be of value to test gain. If you are working with the local health department and/or ICAP, you will want to follow their guidance on whether to retest now.

4. **Can residents and families visit outside in skilled nursing facilities? I have seen in other states facilities are allowing outside visits with the families and the residents. Families are getting very demanding about wanting to see their family member.**
   As of today, visitation is still not allowed. Whenever we are going to start loosening some restrictions, visitation still isn't allowed until Phase 3. We are just setting up the plans now and Phase 1 has not started. The DHHS licensure department will be giving guidance on that. Visitation by mandate is not allowed right now.

5. **Can ICAP develop a template for reopening and rolling back protocols and send out to facilities so we have something to work off of? It is very difficult to maneuver when we do not have guidance from DHHS Licensure yet.**
   There would be problems with ICAP presenting a template yet because even though a template would make it easy for a site, you really need to spend time thinking about your specific situations at your own facility – no "one size fits all". You need to include things in your plan based on what your daily flow of activities looks like; what are your challenges at your facility because of layout, etc. That is why ICAP only provided suggestions for your individual plans today. We have seen in the past that many people have infection control plans were tested in a corporate building and those might take into account making the plans fit the specific facility and that can cause problems. We agree this won't be easy to make a plan, but the idea is to put that thought process into the plan for your own facility. We want you to go slow on this process because there is still a huge amount of risk associated with reopening and thinking it through now will make you better prepared for Phase 3.

6. **When a resident goes to the ER or must go to an appointment, do we have to place them in the gray zone and do isolation x 14 days? Can that just be gloves and mask with good handwashing? Must they stay in their room for 14 days?**
   As of this point, this our recommendation: that the resident returns to the gray zone and staff working with them will wear full PPE for 14 days. When you are developing your plan for loosening restrictions, you may end up including guidelines for that type of event in your plan. We still highly recommend that anyone who is hospitalized or ED visit (even after loosening restrictions) will return to a grey zone. Outpatient appointments may vary by the type of outpatient (low risk, i.e. podiatry appointment where there won't be many sick people) or if they are going to a primary care visit where the risk of exposure to people with respiratory illness is higher. (Outpatient visits with low risk = no grey zone, outpatient visits with high risk = return to a grey zone). Your plans may want to have these risk levels listed in outpatient plans for loosening restrictions. One other factor could also be on the number/rate of community cases of COVID. If you are still seeing a lot of cases daily in your county, you may want to have anyone returning from any type of appointment going into a grey zone. There are multiple factors to consider when you are making plans for your grey zone as we start to loosen restrictions.
   Our recommendations are based on best recommendations and our desire to help facilities keep COVID out of their buildings, where it can be so difficult to control once it is inside a building/facility.

In short, as of now, we still recommend anyone who goes out should come back into the quarantine (grey) zone. Later you will want to look at the different factors of the type of appointment, community rate/spread of COVID and then come up with your plan on which patient goes into grey zones.

7. **What are your recommendations for residents who go out to medical appointments or to dialysis? Are we required to isolate them to a private room with dedicated staff using full PPE? We are concerned about space, staffing levels, and PPE burn.**
   This was answered for outpatients, and dialysis falls under the same outpatient rules. We have seen outbreaks related to dialysis patients who come in and out of the facilities. You are not required, but you want to handle any resident who leaves your facility and returns very cautiously. When you are developing your reopening plan these are things you want to consider and have a process in place. That plan can be made to take into account things like whether there is COVID in your community.

8. **Should it be expected that Assisted Livings follow these specific guidance in regards to exposures and isolation?**
   Yes, Assisted Living Facilities will also be making a plan (just like long-term care) for reopening specific to their buildings. Those plans will be for isolations, for exposures, and for what steps they will take if they have any exposures.

9. **At what point can we move forward with visitation, dining, activities? That is the biggest question of when can we move to this.**
   The licensure division of DHHS (state health department) will be making the announcement on this reopening. Right now they are waiting for facilities to develop a plan and then they will announce the criteria on when the loosening of restrictions can start.

10. **A number of facilities are developing homemade Plexiglas dividers for a visiting room close to the front entrance. What are your thoughts on using this to protect both residents and visitors?**
    Right now, visitation is still not allowed (even in reopening, not until Phase 3). If you are planning to use that in Phase 3 and are thinking this out ahead of time for visitation, it does make sense. Be sure to know it cannot be done right now. You have to consider airflow in the room, etc. Other things to consider are which residents can be scheduled for the visitation booth you propose. How will you get the resident to the booth? How do you make it so that there isn't a line of 20 families wanting to stand in line for the booth? Will you need to schedule a staff member to be there to make sure people are compliant with your visitation expectations? Could the residents be confused in the booth and want to hug their loved one? You could only do that in Phase 3 when you know how you will move residents safely around the facility; visitation can only happen when you don't have cases in the building; when the resident is wearing a mask; when you have the staff to designate for that. A cleaning also needs to be scheduled before reusing the booth. This is not the time to do it, but it is a good time to start planning for it so you have good infection control measures in place when you do it. The

process could be used after you have a plan in place and then when the licensure division at the state gives permission for this to start in Phase 3.

11. **When should we allow home health therapy back in our building?**
    Many facilities have already allowed home health care and hospice workers back into their building. The QSO memo in mid-March said that if those workers are essential to the care of their residents, they are allowed in the building. You need to screen them as you do with your own staff.

12. **Can we have less than 6 foot distancing in the dining room to accommodate 2 residents/table (that are roommates) if we have a Plexiglas barrier between those residents?**
    No, you cannot. Even if residents are roommates, in their room they have 6 feet of distance and usually have a curtain between them which provides source control. The Plexiglas solution can make sense, but it depends on whether it is high enough to provide good source control. If it appears to you it can block secretions from going from one person to another, it could work, but it depends on the barrier. If you can achieve source control, this would work, but otherwise it would not. You also might want to try other strategies, like having different residents come out in the dining rooms for different meals and that way they all get out of their rooms at least once a day for a meal.

13. **Where can we get copies of the slides for today? I missed the site address.**
    https://icap.nebraskamed.com/covid-19-webinars/