Guidance and responses were provided based on information known on 6/11/2020 and may become out of date.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 11, 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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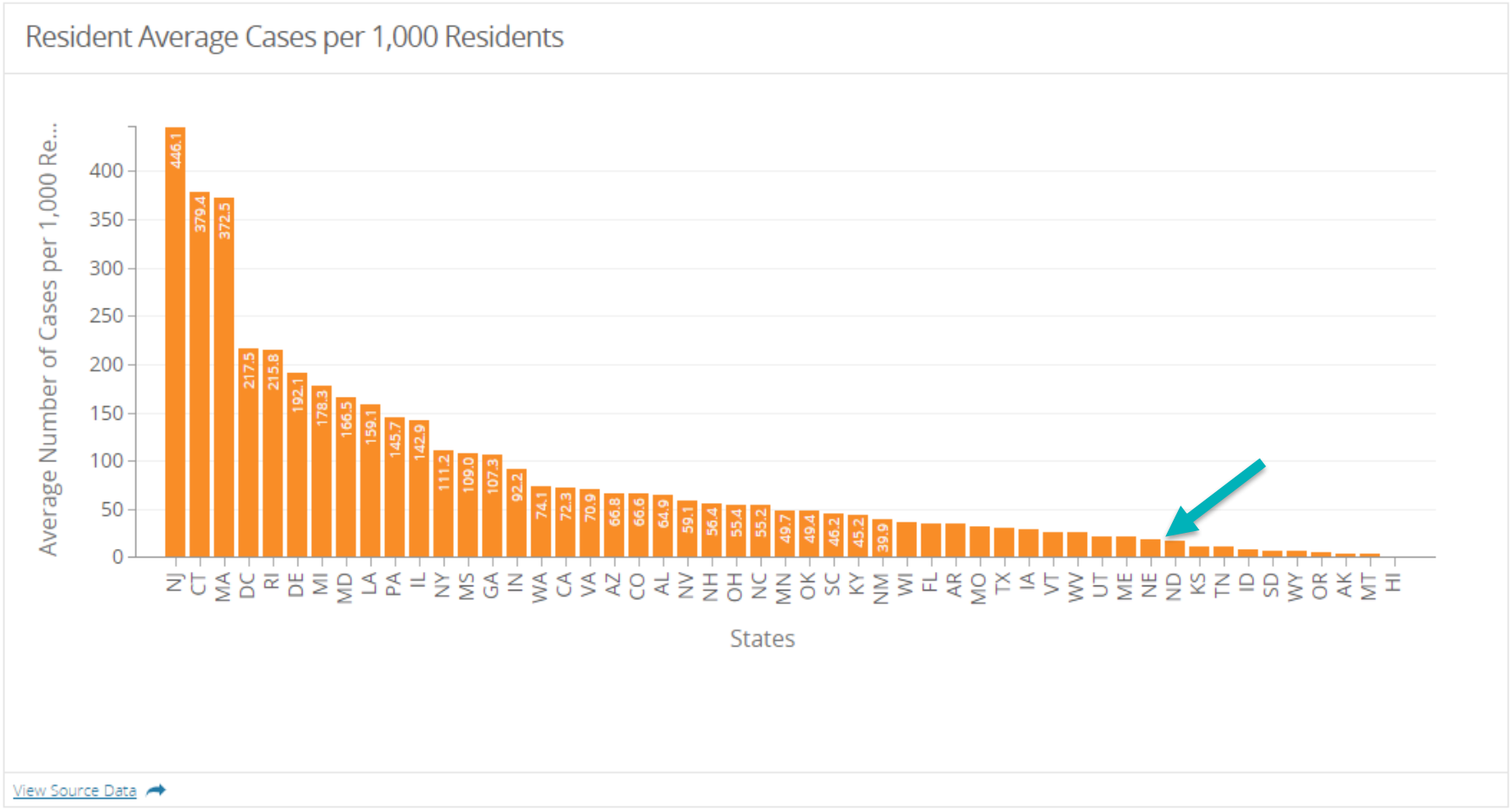
Resident Cases and Deaths per 1,000 Residents



Data.CMS.gov COVID-19 Nursing Home Data https://data.cms.gov/stories/s/bkwz-xpvg

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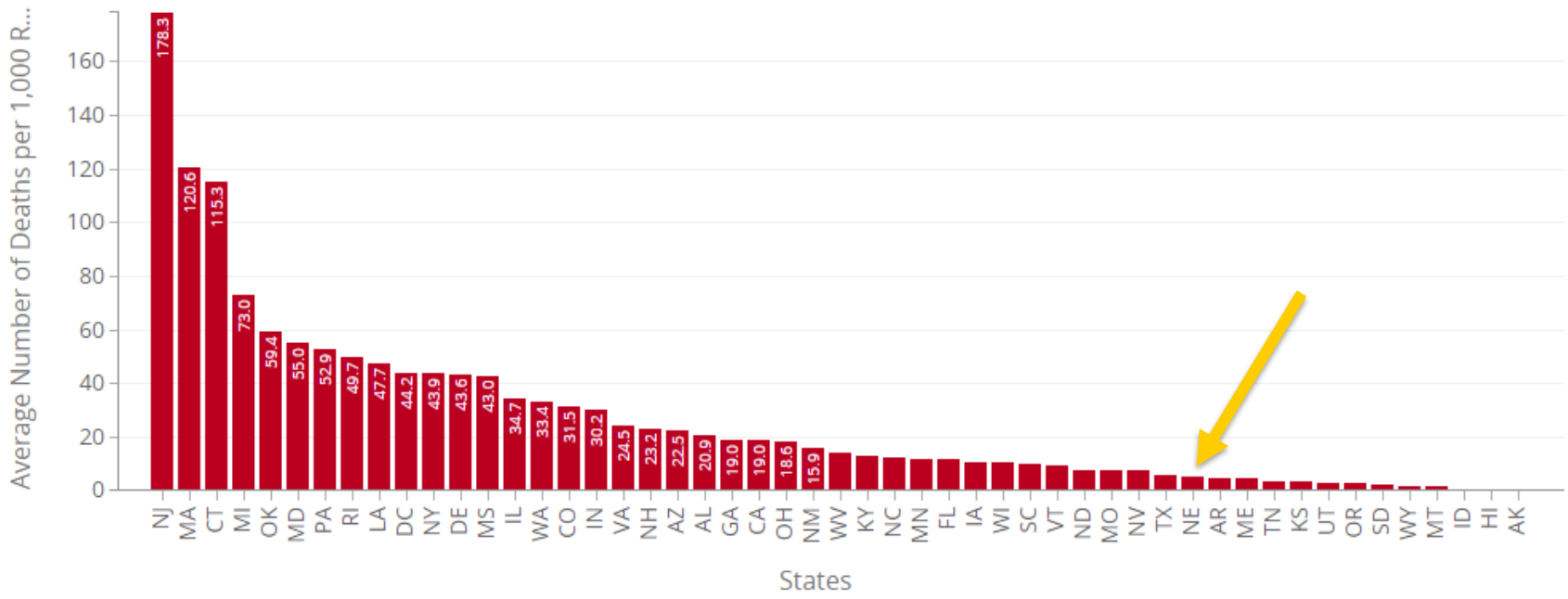
Resident Average Deaths per 1,000 Residents



View Source Data

Data.CMS.gov COVID-19 Nursing Home Data https://data.cms.gov/stories/s/bkwz-xpvg

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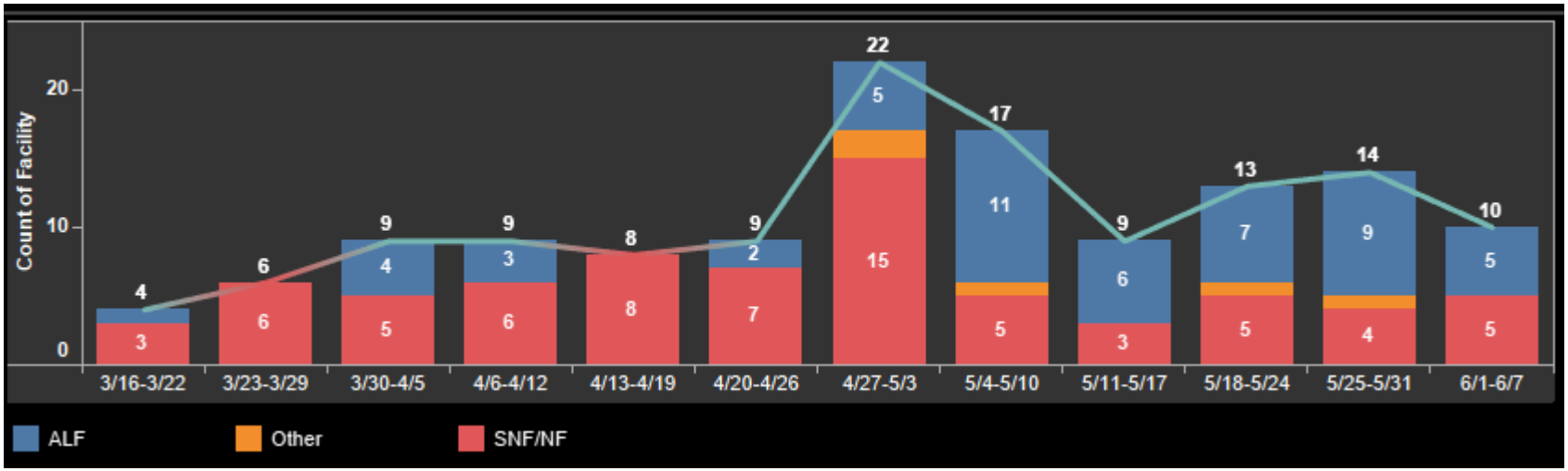
New LTCFs with COVID-19 Positive Resident/Staff By Week in Nebraska



Source: Unofficial Counts Compiled by Nebraska ICAP; Actual Numbers may vary slightly

Infection Control Recommendations and Considerations related to testing for COVID-19 in Long-term Care and Assisted Living Facilities

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Testing Guidance for Nursing Homes

Viral testing in nursing homes is an important addition to other infection prevention and control (IPC) recommendations aimed at:

Keeping COVID-19 out

Detecting cases quickly

Stopping transmission

Testing conducted at nursing homes should be implemented *in addition to* recommended IPC measures.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

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Detecting Cases Quickly

When one case is detected in a nursing home, there are often other residents and HCP who are infected with SARS-CoV-2 and can continue to spread the infection, even if they are asymptomatic.

Testing all residents and HCP as soon as there is a new confirmed case in the facility will identify infected individuals quickly to allow rapid implementation of IPC interventions (e.g., isolation, cohorting, use of personal protective equipment).

Stopping Transmission

After testing **all** residents and HCP in response to a new case, CDC recommends follow-up testing to ensure transmission has been terminated as follows:

- Immediately test any resident or HCP who subsequently develops fever or symptoms consistent with COVID-19
- Follow-up testing of previously negative residents may need to be considered.

At the current time, antibody test results should not be used to diagnose someone with an active SARS-CoV-2 infection and should not be used to inform IPC action.

Considerations for Facility-wide Testing

Some Questions to ask . . .

- *Will facility staff collect specimens on residents, staff or both?*
- *If yes, what will facility staff need to know to prepare for specimen* collection?

Training materials to review:

How does one collect specimens?

NP specimen collection video NE MED https://www.youtube.com/watch?v=J7lLZEZ6u_w.

Collection infographic NE MED https://www.nebraskamed.com/sites/default/files/documents/covid-19/np-only-specimen-collection-for-covid-19-final.pdf?date=04172020.

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What PPE should be worn?

NETEC COVID 19 PPE video, flyer and competency checklist https://repository.netecweb.org/exhibits/show/ncov/item/697.

- N95 or higher-level respirator (or facemask if a respirator is not available) and eye protection. A single pair of gloves and a gown should also be worn for specimen collection or if contact with contaminated surfaces is anticipated.
- Extended use of respirators (or facemasks) and eye protection is permitted. However, care must be taken to avoid touching the necessary face and eye protection. If extended use equipment becomes damaged, soiled, or hard to breathe or see through, it should be replaced. Hand hygiene should be performed before and after manipulating PPE.
- Gloves should be changed and hand hygiene performed between each person being swabbed.
- Gowns should be changed when there is more than minimal contact with the person or their environment. The same gown may be worn for swabbing more than one person provided the HCP collecting the test minimizes contact with the person being swabbed. Gowns should be changed if they become soiled.

Guidance on testing

- *What guidance on conducting testing should be followed?*

CDC - Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes

https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-facility-wide-testing.html

•The number of people present during specimen collection should be limited to only those essential for care and procedure support.

- Visitors or other bystanders should not be present for specimen collection.

•Swabbing of multiple individuals should not be performed in the same room at the same time, unless appropriate separation between swabbing stations can be maintained (see below).

Guidance on testing

Residents:

Specimen collection should be performed one at a time in each resident's room with the door closed. An airborne infection isolation room is not required. Ideally for rooms with multiple residents, specimen collection should be performed one individual at a time in a room with the door closed and no other individuals present.

Staff:

•Ideally, specimen collection should be performed one individual at a time in a room with the door closed and no other individuals present. If individual rooms are not available, other options include:

- Large spaces (e.g., gymnasiums) where sufficient space can be maintained between swabbing stations (e.g., greater than 6 feet apart).
- An outdoor location, weather permitting, where other individuals will not come near the specimen collection activity.

•Considerations for multiple HCP being swabbed in succession in a single room:

- Consider the use of portable HEPA filters to increase air exchanges and to expedite removing infectious particles.
- Minimize the amount of time the HCP will spend in the room. HCP awaiting swabbing should not wait in the room where swabbing is being done. Those swabbed should have a face mask or cloth cover in place for source control throughout the process, only removing it during swabbing.

•Minimize the equipment kept in the specimen collection area. Consider having each person bring their own prefilled specimen bag containing a swab and labeled sterile viral transport media container into the testing area from the check-in area.

Cleaning and disinfection

•Surfaces within 6 feet of where specimen collection was performed should be cleaned and disinfected using an Environmental Protection Agency-registered disinfectant from List N if visibly soiled and at least hourly.

•Terminal cleaning and disinfection of all surfaces and equipment in the specimen collection area should take place at the end of each day. Resident rooms should be cleaned and disinfected in accordance with Implementing Environmental Infection Control in the Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings.

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Lab results

- Laboratories that can quickly process large numbers of tests with rapid reporting of results (e.g., within 48 hours) should be selected for facility-wide testing intended to inform infection prevention initiatives to prevent and limit transmission.
    - Ideally, one laboratory should be selected to process specimens from both HCP and residents to facilitate data collection and analysis.

- If the designated laboratory sends results directly to the nursing home, the nursing home and health department should coordinate how all results will be shared with the health department.

Documenting and reporting Results

•Nursing homes should maintain records of HCP and residents who have positive tests; those records can facilitate reporting aggregate data into the National Healthcare Safety Network (NHSN) COVID-19 Module for LTCF.

•Data collection tools, which may include baseline epidemiologic information, developed by health departments should be shared with a responsible point of contact at each nursing home. The facility point of contact should be trained on how to collect and submit such data to ensure consistency across nursing homes.

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Common Questions This Week…

As we look at widespread testing, should we include or exclude residents and staff that have a history of COVID-19?

If you are testing with a goal of identifying new cases, it does not make sense to include staff or residents that are known to be positive. We are looking for hidden cases, so exclude folks (residents and staff) with a history of a positive test.

Testing to get a specific resident out of isolation is different, and these are one-off testing cases.

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Are N95 respirators required in the grey zone?

N95 are preferred. If your facility has access to them, they should be used in grey zone.

CDC: All recommended COVID-19 PPE should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown.

From: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html

Long-term care facilities should ensure all staff are using appropriate PPE when they are interacting with patients and residents, to the extent PPE is available and per CDC guidance on conservation of PPE.

https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf

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Review of Zones and PPE

Red Zone (Isolation zone)	**Dark Red**	**Residents with Positive COVID-19 test**	**Gown, Gloves, Eye protection and N95 mask (N95 preferred, if no N95, then surgical mask with face shield)**
	Light Red	**Symptomatic residents suspected of having COVID-19**	**Gown, Gloves, Eye protection and N95 mask (N95 preferred, if no N95, then surgical mask with face shield)**
Yellow Zone (Quarantine zone)		Asymptomatic residents who may have been exposed to COVID-19	Gown, Gloves, Eye protection and N95 mask (N95 preferred, if no N95, then surgical mask with face shield)
Green Zone (COVID-19 free zone)		Asymptomatic residents without any exposure to COVID-19	Surgical mask and PPE per standard precautions
Gray Zone (Transitional zone)		Residents who are being transferred from the hospital/outside facilities (but have no known exposure to COVID-19) are usually kept in this zone for 14 days and if remains asymptomatic at the end of 14 day will be moved to Green zone	Gown, Gloves, Eye protection and N95 mask (N95 preferred, if no N95, then surgical mask with face shield)

https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/06/Review-of-Isolation-Zones-and-PPE-2020.pdf

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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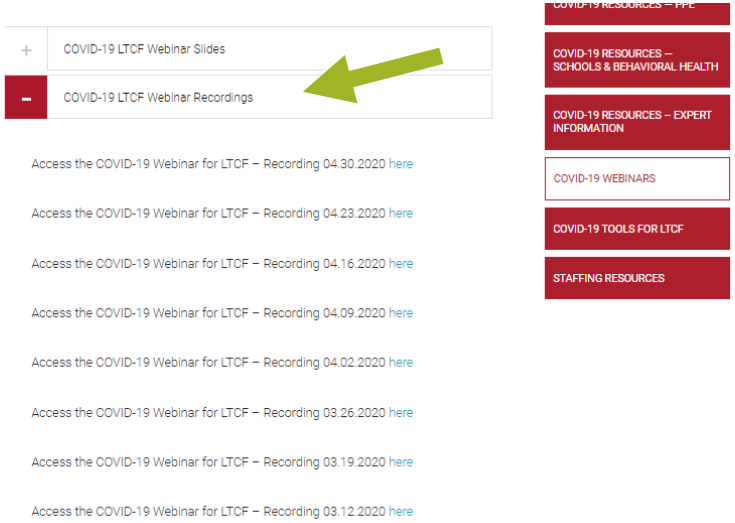
Dr. Tom Safranek, NE DHHS

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 6/11/2020

1. **We have an Assisted Living AND an Independent living under one roof. If we allow the Independent living residents to come and go as they choose, with a mask...can the assisted AND independent living eat in the same dining room (one per table, spaced out) and participate in activities together. We are in Hall County, so we are in phase I.**
   If this is a question related to planning for upcoming phases of relaxation (since there are no visitors and leaving the facility is currently allowed), you have to perform risk assessments for your facility. The answer will be based on how you are going to mitigate your risks. That will be part of the planning document we talked about. As you move through the phases of reopening, you want to be able to implement practices and policies where you can have safety measures in place to limit the transmission of COVID-19 between residents (6 feet between people at dining tables, limited amount of contact, etc.). IF they are under one roof and normally use the same dining, when you are reopening it will be fine for the independent living residents and long-term care residents to be together as long as safety measures are in place.

2. **Is nasopharyngeal testing and or antibody testing specific to COVID-19 or just coronavirus in general?**
   This was discussed in a different webinar presented by Dr. Trevor VanSchooneveld last week: (slides: https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/06/COVID-19-CAH-Slides-w-QA-6.2.2020.pdf). Testing for the common cold is not the same as COVID-19 testing, which is specific. The antibody test is also specific to COVID-19, but is not recommended at this time, it is not helpful right now.

3. **When a resident goes out for an appointment, and the community/hospital/clinic has not had COVID for weeks, the environment they are in is controlled by cleaning and masks, do those residents have to be isolated for 14 days?**
   As we move forward with the phased relaxation of our restrictions, you will want to address this in your plans for phased relaxation. In those phases, you will use your community data in making plans. You want to look at your community at that time. During those later phases, if the community does not have COVID-19, you could send residents to low-risk appointments (podiatry, wound care, etc. where it is not likely there will be sick patients there) it makes sense that there is limited chance of COVID-19 exposures in those clinics. In your Phase 2 plans, based in those data, there might be enough risk to put avoid putting someone going out for those appointments into 14-day quarantine. However, if they are going out for hospitalization, where there will be more chance to be around sick people who might have COVID-19, it makes sense to make those patients into the 14-day quarantine when they return to the facility. You want to differentiate between clinic visits (higher risk – general practice clinic versus lower risk – specialty clinics) in your plan. When the plan comes out from the state, it will allow you to make some of those risk assessments yourself, based on local factors, so that you maintain

patient safety. I understand that in the state plan that hospitalization will require the 14-day quarantine (grey zone).

4. **What is the rationale for testing staff and residents for COVID for reopening purposes? Being negative on Monday doesn't ensure being negative on Friday. Since we mask and screen all staff, what is the need to test for reopening purposes?**
   You are right, we don't rely on one day testing sometimes. But if you are testing the entire staff, for example 100 staff and they all come back negative, at least it tells you that there is no widespread problem in your facility. It gives you the confidence in planning phases of reopening, loosening restrictions. However, if you test those 100 staff members and 5 come back positive, you do have the potential of having more come back positive a couple of days later, but at least then you know you have a problem in your facility. You can take measures to resolve that problem first with containment, before going into other phases. It gives you a picture of the overall situation on that one day. It doesn't mean you know everything about every single staff member, but at least you have an overall picture.

5. **What is the latest guidance for pet visits? Can dogs come into the facility?**
   The CDC guidance is until we know how this virus affects animals, we should follow the same protective guidance we use for people. We don't want to have pets in the facility, just as we don't allow human visitors. Here is the link to the CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/faq.html#COVID-19-and-Animals

6. **Is it acceptable to allow staff to self-screen prior to reporting to work area versus staffing a "screener" IF they have demonstrated competency of taking temperature and understanding of screening questions? We currently have nurse signatures required to clear employee to report to work area.**
   We encourage someone to oversee the screening questions. Early on, we knew of facilities that were counting on self-screening, and some staff felt pressured to "not report" mild illnesses because of staffing shortages. This can cause delays in containment. Best practices we have seen so far have a good practice in place of screening by a nurse who is very good about asking the correct questions, and enough questions. It is possible to provide the adequate training to see it done in small facilities where staff is well educated, but it becomes more difficult in larger facilities where there are large numbers of people coming in for the next shift. Normally, if people are well-trained, they will be calling in ahead of a shift when they have even mild symptoms and not enter the facility at all. Individual facilities would need to audit and understand to see if the staff is competent to do this. Auditing processes are key to make sure everything works correctly.

7. **Can we cover the N95 masks with a surgical mask in the gray zone to save the N95 masks?**
   You could use a face shield over the N95 masks to keep them from being soiled. Face shields can be disinfected and used again. However, a surgical mask being used over an N95 mask would be a waste of PPE. The surgical mask would make it more difficult to breathe through the N95. A face shield is better. As part of a phasing document, you will want to get to a point where we are no longer at crisis level measures of PPE. We want to get to the point either

where staff are wearing the PPE for fewer shifts, because there is more available or because it is working to do the UV light disinfection of N95s. If we are that short of N95s, it needs to be elevated and talked about at a state level, because it should be a consideration for phased reopening.

8. **Can KN95 masks be used in gray, yellow, and/or red zones? We received some of these from county and need to know if they are considered proper protection.**
   Nebraska DHHS says the KN95 masks coming through the state for allocation through local health departments meet the standards. You do NOT want to use the vented N95 masks as these are not safe. Also, facilities should not consider buying their own KN95 masks as not all of the ones on the market are safe (the ones coming through the DHHS system are considered safe).

9. **We have just received negative test results on June 9th for residents and staff. Will this information be enough for public health to consider our building tested so we do not have to retest?**
   There is no reason to retest if everyone was negative when you tested your entire facility, at least in the next 14 days. After 14 days, if you have not gone into Phase 2 and that is not happening for another month, you may need to retest later. It also depends whether you have seen cases inside your facility and that may come into play in deciding on your reopening plan in Phase 2.

10. **Can I alternate between two N-95s--using one for one shift and then storing it in a proper paper bag and using my second N-95 and then going back to my first N-95 for my next shift? We are essentially alternating between the two N-95s to preserve PPE.**
    That is a good strategy in crisis-level PPE availability. It is a stopgap. We think facilities should be looking ahead to the next phase, because it shouldn't be the practice forever. We encourage facilities to be thinking about reprocessing those if that is available in your region (send off for reprocessing between uses; maybe have 3 of them for each staff member to cycle through). As we move forward we hope to get to a point where the N95 masks can be used for one shift and then discard them if reprocessing is not available to you.

    One effective strategy to mitigate the contact transfer of pathogens from the respirator to the wearer could be to issue each HCP who may be exposed to COVID-19 patients a minimum of five respirators. Each respirator will be used on a particular day and stored in a breathable paper bag until the next week. This will result in each worker requiring a minimum of five N95 respirators if they put on, take off, care for them, and store them properly each day. This amount of time in between uses should exceed the 72 hour expected survival time for SARS-CoV2 (the virus that caused COVID-19).3 HCP should still treat the respirator as though it is still contaminated and follow the precautions outlined in CDC's re-use recommendations.
    https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

11. **Will all future new hires need base line testing?**
    If the new hires are coming in before reopening, they will need baseline testing. If they are coming in after reopening, they would be subject to the same daily screening and self-reporting

asked of other workers, who are coming in and out of the facility and going out into the community and facing the same risks as the new hire.

12. **What are recommendations for family visiting folks when we send them out to hospital and they are admitted (and then are returning to our facility)?**
    That is why you will readmit those residents into the grey zone; because you cannot control what happens in the hospital. If you keep them in quarantine for 14 days, you avoid spreading into the rest of your facility. That way, no matter who they came in contact with in the hospital, you still have a measure in place in your facility to quarantine them, so if there was an exposure outside in the hospital, you can still protect others inside your facility.

13. **It is mandatory that the residents wear a mask when out of room when there are no visitors allowed?**
    Yes, they need to wear a mask if they can. It is not just about visitors. Once they are outside their rooms, they can come into contact with other visitors and other residents. It is for the resident's protection that they wear a mask when outside their own rooms.

14. **if staff refuse the test and they are off 14 days, then what needs done when they come back? We have at least 1/3 of our staff refusing to test.**
    If they were off work and quarantined for 14 days, they are fine to come back to work. That is where you need a very robust discussion with your staff about the role they have in making sure the residents are protected. The residents are also being tested, so that we identify the cases and we can protect the staff as well. If we can't test 1/3 of the population, it might not give a good picture of what is going on in the facility. The state won't have any specific guidance on what to do on staff members who decline testing, but the facility will need their own plans about how to make their residents safe. The facility takes on a lot of burden when staff refuses testing, as the facility tries to prepare for reopening. We hope that education and explanation of the reasoning for testing that the staff members will change their minds and allow testing.

15. **What is your recommendation for residents going out in the community to church? What is your recommendation for one resident to go with an employee to visit the cemetery?**
    Right now, we are still in Phase 1, which restricts any kind of visits into and outside a facility. If an employee takes a resident out to the cemetery, you still have to consider factors outside your control, whether there are other people in the cemetery at that time who would come up to the resident, etc. In Phase 1, CMS current guidance does not allow either of these. As we move forward into Phase 2, facilities will have a larger role to play in determining their own risk in some of these situations, and make their own decisions based on risk and put into place some safety measures to prepare for these activities. Based on which county you are living in and how many cases of COVID there are, you may be able to put some things into place to allow some of these activities to be done in a safe manner. That is Dr. Ashraf's understanding from his communications with the DHHS Licensure division.

16. **What is your recommendation regarding use of nebulizers and c-pap machines?**

Those are aerosol-generating procedures. This heightens the risk of transmission, especially if the resident has had COVID, is pre-symptomatic or even asymptomatic for COVID. In the gray zone, particularly, the door needs to be closed during the procedure. Staff doing the procedure need to be wearing N95 masks and face shield protection as part of their PPE outfit. The recommendation for this has not changed over time. If you are wearing an N95 mask and doing these procedures and the mask becomes dirty in the aerosol-generating process, you need to discard (not send for disinfection) the N95.

17. **Where can I find the recording of this webinar?**
    https://app.vidgrid.com/view/hvJgFMok1Mpc/?sr=0mfdTw