

Guidance and responses were provided based on information known on 5/28/2020 and may become out of date.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

May 28, 2020

NEBRASKA

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DEPT. OF HEALTH AND HUMAN SERVICES



**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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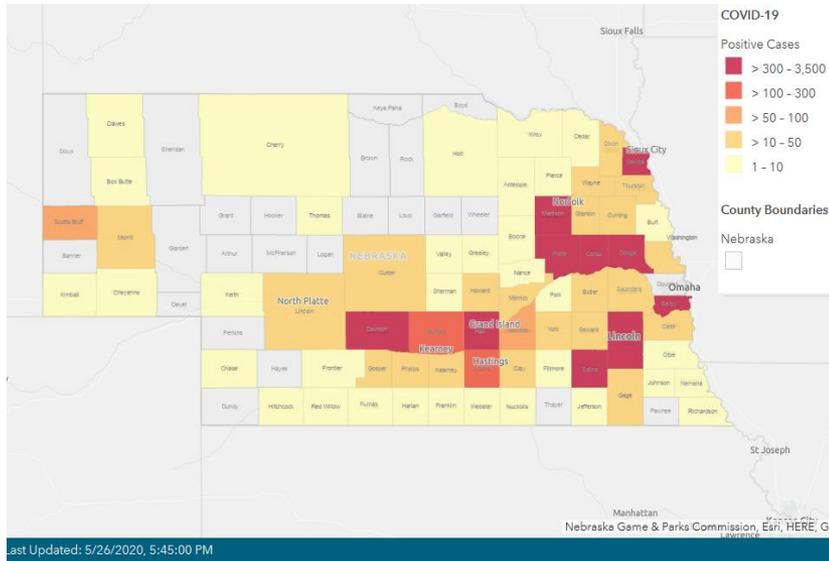
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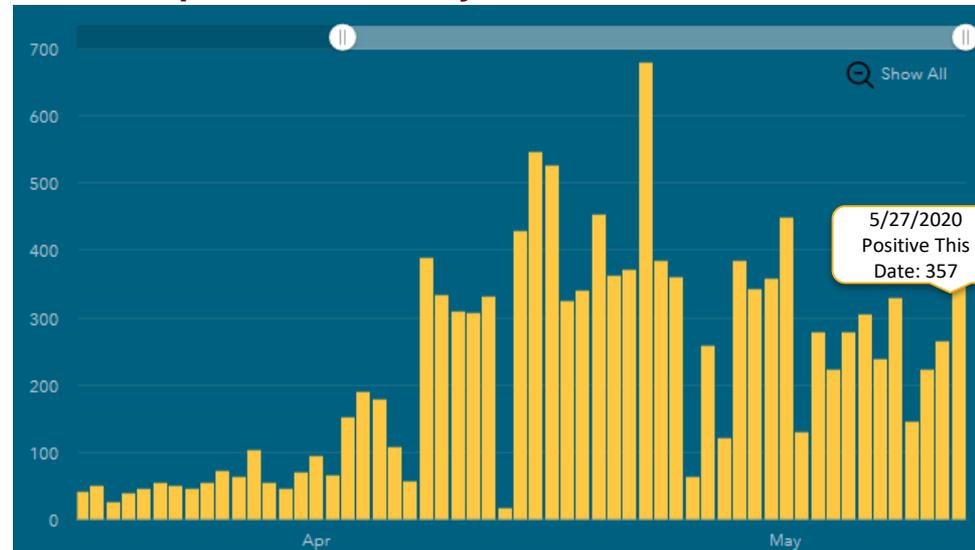


Nebraska Case Update

Coronavirus COVID-19 Nebraska Cases



New positive cases by date results were received



Total Positive Cases

12,976

Total Tested

93,347

Deaths

163

<https://nebraska.maps.arcgis.com/apps/opsdashboard/index.html#/4213f719a45647bc873ffb58783ffef3>

Frequently Asked Questions

Week of May 21- May 27

Regarding healthcare workers returning to work:
We are trying to use a test-based strategy, but
have some staff members where we cannot get a
negative test, even after 3 or 4 weeks!
Why is this?
Should we abandon the test based strategy?



Image: [Pixabay](#)

Return to Work Criteria for HCP with Suspected or Confirmed COVID-19

Symptomatic HCP with suspected or confirmed COVID-19

(Either strategy is acceptable depending on local circumstances):

Symptom-based strategy. Exclude from work until:

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 10 days have passed *since symptoms first appeared*

Test-based strategy. Exclude from work until:

- Resolution of fever without the use of fever-reducing medications **and**
- Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens)[1]. See Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus (2019-nCoV). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

Updated 4/30/2020 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>



HCP with laboratory-confirmed COVID-19 who have not had any symptoms

Time-based strategy. Exclude from work until:

- 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used. Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.

Test-based strategy. Exclude from work until:

- Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individual are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

Updated 4/30/2020 <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

CDC also points out:

While this strategy can apply to most recovered persons, CDC recognizes there are circumstances under which there is an especially low tolerance for post-recovery SARS-CoV-2 shedding and risk of transmitting infection. In such circumstances, employers and local public health authorities may choose to apply more stringent recommendations, such as a test-based strategy, if feasible, or a requirement for a longer period of isolation after illness resolution.

Therefore, ICAP team usually suggest long-term care facilities to either use test-based strategy for clearing healthcare workers to return to work or extend the duration to 14 days from time of onset or 5 days from resolution of fever and symptoms improvement (whichever one is longer).

<https://www.cdc.gov/coronavirus/2019-ncov/community/strategy-discontinue-isolation.html>.



We are screening all staff members coming into work. We want to do the right thing, but are having a hard time with the symptoms of headache and fatigue. These are so vague and common! Do we:
Send those employees home?
Do we test those employees?
Do the employees have to be off for 10 days, treating them like they “had” COVID-19?

Image: [Pixabay](#)



People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness

Symptoms may appear **2-14 days after exposure to the virus**. People with these symptoms may have COVID-19:

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

This list does not include all possible symptoms. CDC will continue to update this list as they learn more about COVID-19.

<https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html>

Yes, The staff with symptoms should get tested and should be sent home. If those vague symptoms resolves and the test come back negative than they can come back to work.

For how many shifts is ok to wear a single N95 without disinfecting it?



Image: [Pixabay](#)

N95 respirators - the manufacturer instructions for use dictate how many reuses are recommended for that respirator. You will need to follow that MIFU recommendation if you are not reprocessing, and ensure staff have either been fit-tested and/or can perform a seal check to ensure good fit of the respirator... also, ensure staff have been trained on reuse, and proper storage of N95 until next use.

Whenever possible, N-95 should be reprocessed after every shift.

UV Light box locations in Nebraska

City of Lincoln Transportation & Utilities Municipal Service Center

901 West Bond

Lincoln, NE 68521

CONTACTS: Dave Thurber 402-326-2507 or Rod Hendrickson 402-441-7701

Regional West Medical Center

4021 Ave. B

Scottsbluff, NE 69361

CONTACT: Robin Buchammer 308-630-1545

Avera St. Anthony's Hospital

300 North 2nd Street

O'Neill, NE 68763

CONTACT: Deb Tejral 402-336-5287 or 402-340-6718 debora.tejral@avera.org

CHI Good Samaritan Hospital

10 E 31 Street

Kearney, NE 68848

CONTACT: JasonTaylor@catholicealth.net

Nebraska Ortho Hospital

Oakview Medical Building

2727 S. 144 St.

Omaha, NE 68144

CONTACT: Lori Jensen 402-699-7074 lori.jensen@OrthoNebraska.com

Chase County Community Hospital

600 W. 12 Street

Imperial, NE 69033

CONTACTS: hlwheeler@ymail.com

Kay Schmidt 308-882-7217 kschmidt@chasecountyhospital.com

Abby Cyboron ACyboron@ChaseCountyHospital.com

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<https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/UV-Light-box-locations-in-Nebraska.pdf>



Image: [Pixabay](#)

Should we pursue the use of antibody tests or serologic testing for COVID-19 in residents or staff members?

Results from antibody testing should not be used to diagnose or exclude SARS-CoV-2 infections or to inform infection status. Negative results from antibody testing do not rule out SARS-CoV-2 infections, particularly for those individuals who have been exposed to the virus and are still within the estimated incubation period. Until the performance characteristics of antibody tests have been evaluated, it is possible that positive results from such testing may be due to past or present infections with a coronavirus other than SARS-CoV-2.

If a laboratory initially uses antibody testing for diagnostic purposes, follow-up testing using a viral test should be performed.

Read: [Important Information on the Use of Serological \(Antibody\) Tests for COVID-19: FDA Letter to Healthcare Providers external icon](#)

More: [FDA EUA Authorized Serology Test Performance external icon](#)

https://www.cdc.gov/coronavirus/2019-ncov/lab/lab-testing-faqs.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Flab%2Ftesting-laboratories.html

It has been a month since our resident was tested positive and he is still testing positive although asymptomatic for a week now. How long we should keep testing?



Image: [Pixabay](#)

Discontinuation of Isolation for Nursing Home Residents with COVID-19

- Consider retesting the resident after at least 10 days have passed since the onset of the illness and 3 days have passed since symptoms resolution (whichever is longer).
- Residents with COVID-19 will need 2 negative tests (obtained more than 24 hours apart) before they can come out of isolation.
- If one of the two tests come back positive then wait 5 to 7 days before obtaining additional tests (will still need two negative test >24 hours apart for discontinuation of isolation).
- If the residents with COVID-19 were being managed in an isolation (red) zone within a facility, then upon confirmation of the two negative tests, they may be moved back to their own rooms (as long as they remain asymptomatic).
- It should be noted that COVID-19 PCR-tests may continue to be positive for a prolonged period of time (> 4 to 6 weeks) in some residents. It remains unknown whether these PCR-positive samples represent the presence of infectious virus. Among recovered patients with detectable RNA in upper respiratory specimens, concentrations of RNA after 3 days are generally in ranges where virus has not been reliably cultured by CDC.
 - Therefore, it may be reasonable to discontinue isolation for those residents who have been positive for more than 28 days and has remained asymptomatic for at least 7 days even if they continue to test positive



One of our resident in north hall was positive for COVID-19 and was sent to hospital and one staff member was positive for COVID-19 in south hall and was sent home for isolation 2 weeks ago. Both halls are yellow zone currently and no one else have tested positive. How long should we continue quarantine/yellow zone?

Image: [Pixabay](#)

Quarantine zone will continue for 14 days from the last exposure.

- We consider a new exposure every time an employee has worked either 48 hours before or any time after the onset of symptoms (or test coming back positive if asymptomatic)
- Similarly we consider a unit/facility (depending on the scenario) to be exposed if a resident comes back positive and the facility has not already established a red or yellow zone 48 hours before the resident having symptoms (or testing positive if asymptomatic)
- A unit/facility (depending on the scenario) is also considered to be exposed if a resident comes back positive and the facility has established a red or yellow zone 48 hours before the resident having symptoms (or testing positive if asymptomatic) but the staff was not wearing all recommended PPE for that zone.

Have there been any statistically significant studies that you guys are following, discussing potential immunity after being positive with the virus vs. the ability to become reinfected?



Image: [Pixabay](#)

As of this point, we do not know for sure how long the immunity for COVID-19 last once someone already had an infection. However, there is no reliable evidence for human re-infections with SARS-CoV-2 at this point.

Furthermore, Korea CDC has released a report where they evaluated 285 cases who were re-positive after initial discontinuation of isolation. From monitoring of 790 contacts of the 285 re-positive cases, no case was found that was newly infected solely from contact with re-positive cases during re-positive period.

Reference:

Kirkcaldy RD et al. JAMA

2020 May 11.

doi: 10.1001/jama.2020.7869

<https://www.cdc.go.kr/board/board.es?mid=a30402000000&bid=0030>

Questions and Answer Session

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Dr. Tom Safranek, NE DHHS

Moderated by Mounica Soma, MHA



Access the COVID-19 Webinar for LTCF – Recording 04.30.2020 [here](#)

Access the COVID-19 Webinar for LTCF – Recording 04.23.2020 [here](#)

Access the COVID-19 Webinar for LTCF – Recording 04.16.2020 [here](#)

Access the COVID-19 Webinar for LTCF – Recording 04.09.2020 [here](#)

Access the COVID-19 Webinar for LTCF – Recording 04.02.2020 [here](#)

Access the COVID-19 Webinar for LTCF – Recording 03.26.2020 [here](#)

Access the COVID-19 Webinar for LTCF – Recording 03.19.2020 [here](#)

Access the COVID-19 Webinar for LTCF – Recording 03.12.2020 [here](#)



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



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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**Nebraska DHHS HAI-AR and Nebraska ICAP
Long-term Care Facility Webinar on COVID-19 5/28/2020**

1. There has been mention of facilities in Iowa for families to use a 3-sided Plexiglas device to communicate/visit with residents. What are your thoughts on this?

We have seen pictures of this. This will be need to approved by regulatory. There would be issues; someone needs to get the resident to the booth; you need to amplify sound in the booth; have a staff member present to make sure protocols are being followed; you need a system for appointments, but we have not seen approval for visits, even without good adaptive ideas like this. When the visitation starts, innovative ideas like this to reduce risk of transmission will be good. There will have to case-by-case evaluations of these plans. The process will need to be studied, including what is the room like, the airflow like, etc.?

2. I have not heard anymore regarding the task force that was going to be in place to set guidelines for LTCF for visitation and opening up, etc. Can you comment?

Visitation at long-term care facilities won't be opened at this moment. Even with CMS guidance, visitation doesn't happen until Phase 3. The task force working on reopening plans received comments last week from long-term care advocates including Nebraska Healthcare Association and LeadingAge. This week those comments were incorporated into the reopening guidance for the state. We expect this to be announced soon because it is in the final stages. It won't say when the visitation is reopening; rather it will say "what is your plan for when reopening when the CMS allows the visitation." I think facilities should begin working on this, to have plans in place for when reopening is allowed, how each facility will safely allow the visitation to happen.

3. If we have a resident move from home or a hospital to LTC and we admit to a gray zone and we test them and they come back negative, can they then move out of the gray zone? Or do they still have to quarantine for 14 days?

They still have to quarantine for 14 days. Sometimes, you can check on Day 14 before you take them out to test again and make sure they are still negative. That isn't a mandated requirement, but it is an option.

4. What other options are there for disinfecting N95 masks for reuse other than the ultra violet lighting?

There are different CDC-recommended methods, but I don't know of any other options in Nebraska for mask reprocessing other than ultraviolet light. The best option for Nebraska long-term care is to use ultraviolet lighting in the centers that have been established for reprocessing. Here are links from the ICAP website on mask reprocessing: Ultraviolet light box reprocessing centers in Nebraska: <https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/UV-Light-box-locations-in-Nebraska.pdf> ; Nebraska Medicine COVID-19 PPE Guidance Extended Use and Reuse of Facemasks, Respirators and Protective Eyewear For Healthcare Personnel (Updated 04/20/2020)

<https://www.nebraskamed.com/sites/default/files/documents/covid-19/COVID-Extended-Use-Reuse-of-PPE-and-N95.pdf?date=03182020>

5. We received a distribution of KN95 masks after a request to DHHS. Are those safe and effective to use in the yellow and red zones?

The state is no longer acquiring the KN95 masks and are phasing them out. We understand you can use them up (preferred in non-red zone areas). If you are having aerosol-generating procedures in either the yellow or red zones, use the regular N95 masks and not the KN95 masks.

6. Are we in Nebraska going to the 100% staff and resident testing as recommended by CDC? What do we do when staff refuse?

This is the situation as we understand it at ICAP. There might be a process of identifying facilities in high incidence counties (where there are a high number or rate of cases) and all facilities in those counties may be offered a process to have testing done for staff (not residents). This is not final, just under discussion, but the rationale is that the residents are in isolation, it is the staff who would introduce it. If you test the staff and there are no positive staff members, chances are that there will be no positive residents there. That is the rationale that will be followed. It doesn't make sense to test staff in counties where there is no COVID at all, at least not in the past 14-28 days. This is being discussed as part of the state's reopening plan, but Dr. Ashraf said he only has limited knowledge to share at this time and discussions are ongoing.

7. Can we talk more about gray zoning a resident in a room when all isolation beds are in use?

Gray zone residents when all isolation beds are in use can be done, but the resident must be housed by themselves (no roommate). They can be in their own room for 14 days and use all your PPE (gloves, gowns, masks, eye protection) while caring for the residents. It can be done if they are in their own room and staff uses the full PPE. Ideally, it would be in an units by themselves, but we understand there are limitations. If you have one CNA you could dedicate them, but we know that staffing that way could be a problem.

8. We are a COVID free facility. Do you have any suggestions for hiring an employee who was working at a facility that had COVID? Should we test them? Should they isolate 14 days before starting? What if they had tested positive in the past 2-4 weeks and show no symptoms?

If they have tested positive in the last 2-4 weeks and have no symptoms, (asymptomatic 5 days and 14 days past test or onset of illness, they are considered COVID free) they can start work now. If they were always negative and just worked in a facility that had COVID positive patients, you need to consider if they had an exposure there while they worked at the other facility. If there was an exposure, then definitely (worked with a resident who tested positive within 48 hours of their encounter, and the staff member was not wearing PPE at the time of the contact) they need to wait 14 days before they start again on any job. That is a high risk exposure. If you test them, that still does not 100% rule out that they are COVID-free, and the isolation for 14 days is needed. If they had no exposure, wearing PPE well and had no known exposures, they

can start working. The facility hiring can make that decision based on the exposure risk. There is always a chance that even if the staff member was wearing PPE, there is a chance if they did not don and doff properly there could have been an exposure. It needs to be a case-by-case decision, but if the person was trained well and was following the procedures, it would be assumed there was not an exposure and they should be able to work.

- 9. If you have a new admission coming from home, the plan is to quarantine for 14-days. As of late, we have also used full PPE. In light of not burning this with someone that is asymptomatic, would it be practical to request an order to test this new admit for COVID? And then, if they test negative, keep them in 14-day quarantine but just mask and glove vs. full PPE?**

The only relaxation we can suggest in PPE is that you may consider using the gowns only in high contact care (toileting, bathing, whenever your body can come into contact with the resident) with this new admission, but you need the rest of the PPE (mask, gloves, eye protection) in all other in all other situations. In the high contact care you wear the full PPE, including the gown. You could consider not wearing gowns in activity like passing trays. Masks in the gray zone are preferred to be N95; if they are not having aerosol-generating procedures it could be a surgical mask). N95 masks are preferable in the gray zone.

- 10. How can we send staff home with one of all these signs and symptoms and still care for our residents? How can we minimize the staff who go home? Our local health department is telling us that staff have to stay out for 14 days even if Co-VID test is negative.**

I understand there is a problem, but we have seen people who had those weak symptoms who have tested positive. You also need to consider what you are risking by letting them work, and then that staff member infects 3 or more other staff while they are working. That means instead of having one staff member go home now, you end up with 5 staff members who have to be out a few days later. All facilities need to plan for encountering these situations and try to have some cushioning in their staffing plan. We understand there are a lot of staffing shortages, but you need to plan that you will have staff who have some of the symptoms who have to stay home.

- 11. We have been hearing that many facilities are doing randomized testing such as every couple of weeks even if nobody is having any symptoms. Is that something you think a facility should do?**

If a facility is doing that, they are doing it on their own, not based on the state recommendation. They may be doing it based on the new CMS Guidance, which says states should consider it, but the state needs to decide based on their own data. Those kind of strategies need much more consideration before we recommend those practices. If there is a case identified in the facility and then the tests are being done every 7 to 14 days to help with plans to cohort the positive residents. We have seen cases where residents were placed in the yellow zone and first tested negative but then later tested positive and had to be moved to the red zone. If they are doing the tests to identify those residents who are becoming positive, then the testing makes sense. If you are just testing of staff members to identify any new case on a baseline in a high-incidence county, then that testing would make sense, too. How often you repeat those tests in that

situation depends on what is going on in the county in the next 14 days. At this point, the state is not recommending that everyone should do this testing.

12. We currently screen for going to "hot spots" including other counties/states. Should we continue this? Governor Ricketts spoke about only quarantining for international travel. Is it necessary to screen for travel to other counties in the state or even traveling to other states?

As of this point what makes the most sense is to follow the state recommendations, which means definitely quarantining after international travel. After that, you need to screen your staff members to find out if they have come into contact with someone who came into contact with COVID-19 or thought they could possibly have been exposed. The question is more about whether a staff member thinks they were exposed, even in the course of their normal activities without travel, rather than where they traveled to inside or outside Nebraska. That information will help facilities make the right decision.

13. What recommendations do you feel are appropriate when admitting a resident from the community and from a hospital? Do we need two negative COVID test results?

You don't need two negative tests, but it depends on whether you are admitting a resident who tested positive for COVID-19; then you definitely need 2 negative tests, unless you already have a unit set up that is caring for COVID-positive patients; you can admit those residents without 2 negative tests and admit them to the established red zone rooms. If you don't have the red zone in place, then you do need the 2 negative tests. However, if the resident was not in the hospital for COVID-19; was never symptomatic and never had any exposure to a COVID positive person, then that person can be admitted without 2 negative tests. If a resident shows some symptoms of COVID-19 (respiratory – cough, shortness of breath; that is assumed by hospital to be attributed to some other condition like COPD, you can get one negative test and then you can admit them. You don't need a negative test for an admission unless the person is showing respiratory symptoms. You can ask the hospital if they have tested for COVID-19 with a patient with respiratory symptoms. Two negative tests are used for ruling out COVID. Here is the Leading Age/Nebraska Healthcare Association/Nebraska Hospital Association resource/algorithm for testing and admissions: <https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Post-acute-transfer-form-updated4.13.20.pdf>

What about admissions from counties with high/active positive test results?

Even in counties with high numbers of positive test results, if a person does not have symptoms for COVID-19, testing is not recommended, but you want to put them in a gray zone on admission, because the test is just a snapshot of that one day and might not reflect cases that haven't become positive yet.

14. Can this call be viewed later by others that couldn't be on this call? If so, how?

Use this link on the ICAP webpage: <https://icap.nebraskamed.com/covid-19-webinars/> and find the listing for May 28, which should be added soon.