Guidance and responses were provided based on information known on 7/2/2020 and may become out of date.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

July 2, 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:

Dr. Salman Ashraf, MBBS	salman.ashraf@unmc.edu
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Map showing Counties Categorized by Days Last Tested Positive Cases

Updated: 7/2/2020 8:00AM CST
Source: Unofficial Counts Compiled by Nebraska ICAP based on date reported by facilities; Actual Numbers may vary slightly

Best Practices in Bathing

COVID-19 and the ‘new normal’

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Practical guidance for bathing residents, Updated:
Wherever it is possible, residents should get a bath.

- Asymptomatic, non-exposed residents may use the bath house. Mask these residents for transfer to the bath house/ tub room.
- Green zone residents can bathe in green zone spa
- If there is only 1 spa in the building, avoid taking red zone residents for bath in spa within the green zone
- Residents with COVID -19 should have baths in their room unless there is a dedicated bath house in the red zone itself.
- Consider scheduling any gray zone or yellow zone residents at the end of the bath schedule if they have to be moved to a green zone to get a bath.
- Gray zone or yellow zone resident should be able to go to the bathhouse any time during the day as long as:
    - the bath house is located in the same zone,
    - proper infection control measures are being taken between baths and during transfers
    - recommended air exchanges are being allowed between residents to clear the air in the bath house.

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Since resident will be without mask during the bath, even briefly, we must consider the air changes of the spa room

- Residents that are asymptomatic but exposed, should be regarded carefully.
    - Yellow Zone
    - Recent admission, transitional zone residents.
- PPE for the healthcare worker is essential

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175 NAC 12 12-007.04D1 for windowless toilets, baths, laundry HSP at least 10 ACH

Table B.1. Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency *

ACH § ¶	Time (mins.) required for removal 99% efficiency	Time (mins.) required for removal 99.9% efficiency
2	138	207
4	69	104
6+	46	69
8	35	52
10+	28	41
12+	23	35
15+	18	28
20	14	21
50	6	8

Content courtesy of Kate Boulter, MSN, RN NETEC

Guideline	Notes	
Staff member should don full set of clean PPE	Because the resident will be removing their mask in the tub, it is necessary to mitigate all risks	
Transfer the resident to and from the spa with a mask on	Cloth mask worn correctly is acceptable	Ensure mask is placed on a clean surface for reuse after the bath. Alternatively, have a clean mask for the resident to wear after the bath
Spa must be within the zone the resident resides in	Do not take a resident from a green zone to a spa in i.e. the yellow zone. Also don't take a resident from a yellow zone to a spa in the green zone	
Prepare the resident as much as possible in their room	To avoid having the resident's worn clothing placed on counters or other surfaces, transfer them in a robe	Alternatively, place clothing into a laundry hamper/ bag as soon as it's removed
Follow the tub manufacturer's guidance on products that can be used in the tub	If able to use other products use a disposable container to take only the amount required into the spa room	Do not share products between residents

Content courtesy of Kate Boulter, MSN, RN NETEC

Guideline	Notes	
Declutter the room	Make shelves and other surfaces easy to disinfect by removing all objects from them. If needed, items can be placed in containers with lids	
Any special ointments/ creams/ lotions should be kept in a locked cabinet	Do not share products between residents	
Disinfect after use and allow time between residents	Depending on air exchanges in the spa, let the room rest between residents.	Make sure staff understand how the room is to be disinfected including what the disinfectant contact time is, and how to apply it
Follow the tub manufacturer's instructions for tub disinfection between every resident	No exceptions	
Do not bring towel racks or carts into the spa room	Only take the towels that will be required for the resident into the room	After the bath, all laundry including towels should be bagged and sent to the laundry
Waste	Contain and remove waste between residents	Waste can be managed according to standard procedures

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We were cited for our employee screening process. Not sure what we did wrong.

Image: Pixabay

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Screening basics

Screen all staff at the beginning of their shift for fever and respiratory symptoms.

Actively take their temperature and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a facemask and self-isolate at home.

https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf

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

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

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Is temperature screening required?

Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19.

Actively take their temperature* and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.

*Fever is either measured temperature >100.0^{o}F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations.

HCP who work in multiple locations may pose higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases.

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

AHCA AMERICAN HEALTH CARE ASSOCIATION

NCAL NATIONAL CENTER FOR ASSISTED LIVING

COVID-19: Screening Checklist – for Visitors and Staff

On March 13, 2020, CMS and CDC updated guidance on restricting all SNF visitors and non-essential healthcare personnel, except for certain compassionate care situations. **ALL individuals** (staff, other health care workers, family, visitors, government officials, etc.) entering the building must be asked the following questions:

1. **Has this individual washed their hands or used alcohol-based hand rub (ABHR) on entry?**

   ☐ Yes ☐ No – please ask them to do so

2. **Ask the individual if they have any of the following respiratory symptoms?**

   ☐ Cough
   ☐ Shortness of breath

   OR at least **TWO** of these symptoms

   ☐ Fever
   ☐ Repeated shaking with chills
   ☐ Headache
   ☐ New loss of taste or smell
   ☐ Diarrhea
   ☐ Chills
   ☐ Muscle pain
   ☐ Sore throat
   ☐ Vomiting

   - If YES to any, restrict them from entering the building.
   - If NO to all, ~~proceed to **question #3 for staff** and~~ **question #4 for all others**.

3. **For Staff & Health Care Providers (HCP)** (e.g. agency staff, regional or corporate staff, health care workers such as hospice, EMS, dialysis technicians that provide care to residents):

   3A. Check temperature and document results: _____ ☐ Fever present?

   - If YES, restrict from entering the building.
   - If NO, proceed to step 3B.

   3B. Ask if they have worked in facilities or locations with recognized COVID-19 cases?

   ☐ If YES, ask if they worked with a person(s) with confirmed COVID-19?

   - If YES, require them to wear PPE including mask, gloves, gown before any contact with residents & proceed to step 4.
   - If NO, proceed to step 4.

4. **Allow entry to building and remind the individual to:**

   ☐ Wash their hands or use ABHR throughout their time in the building.
   ☐ Not shake hands with, touch or hug individuals during their visit.

Visitors permitted for compassionate care situation	**Staff**
☐ Must wear a facemask while in the building and restrict their visit to the resident's room or other location designated by the facility.	**When there are cases in the community but none in this facility:** ☐ Consider implementing universal use of facemasks for all HCP while in this facility. **When there are cases in this facility OR sustained transmission in the community:** ☐ Implement universal use of facemask for all HCP while in this facility. ☐ Consider having HCP wear all recommended PPE (gown, gloves, eye protection, N95 respirator or, if not available, a facemask) for the care of all residents, regardless of presence of symptoms. Implement protocols for extended use of eye protection & facemasks.

Note: Assisted Living Providers can use this checklist as feasible for their community. REVISED 4/8/2020

https://www.ahcancal.org/facility_operations/disaster_planning/Documents/COVID19-Screening-Checklist-SNF-Visitors.pdf

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What went wrong?

An employee reports new cough, on a screening form. No oversight of the process is in place. The employee completes several shifts, without exclusion.

That is a problem.

What is a better process?

An employee reports new cough, on a screening form.

A nurse is able to pull this employee aside and further assess. Document findings and recommendations.

Employee is taken off shift today, and recommended for testing. Results are documented.

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Monitoring residents and staff

- Use extended list of signs and symptoms for screening/monitoring of residents.
- Even one new symptom, such as loss of taste or smell, would be a trigger to test the resident for COVID.
- Have a low threshold for testing. If a fever spike, test. We have heard that facilities are not sure when to test, so we are telling you, at first sign, test.
- You can report to local health department with your first suspicious resident with symptom; they can help you coordinate getting test kits.
- NE ICAP can answer other questions – you do not have to guess, so please call. We always get back to all callers with our best recommendations.

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What do we do with employees with symptom that clearly are attributable to something else?

Runny nose and sore throat, consistent with usual allergy for employee

- Assess and test for COVID-19, document process. Reasonable to keep in place unless significant worsening
- If someone reports symptoms that may be consistent with COVID-19 but they think it is because of allergy, this person then should be referred for an evaluation under employee health program (consider setting up process to discuss the situation with medical director or a representative who can decide whether it is OK to work or not) and document rationale.

Talk about safety outside of work

- Avoid exposures outside of work, too.
- Report exposures that occur outside of work

A Virus Walks Into a Bar …

As communities open up, it's becoming increasingly clear that the indoor bar scene is uniquely suited to transmission of Covid-19.

Getty Images

https://www.nytimes.com/2020/06/25/well/live/coronavirus-spread-bars-transmission.html

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Screening for exposure:

Have you worked at any facility with COVID-19 cases?

Have you worked directly with COVID-19 positive residents?

Have you had unprotected exposure to someone known to have COVID-19?

Do you spend time with or live with someone with COVID-19?

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Important Information About Your Cloth Face Coverings

Print Resources Web Page: https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html

As COVID-19 continues to spread within the United States, CDC has recommended additional measures to prevent the spread of SARS-CoV-2, the virus that causes COVID-19. In the context of community transmission, CDC recommends that you:

Stay at home as much as possible

Practice social distancing (remaining at least 6 feet away from others)

Clean your hands often

In addition, CDC also recommends that everyone wear cloth face coverings when leaving their homes, regardless of whether they have fever or symptoms of COVID-19. This is because of evidence that people with COVID-19 can spread the disease, even when they don't have any symptoms. Cloth face coverings should not be placed on young children under age 2, anyone who has trouble breathing, or is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

How cloth face coverings work

Cloth face coverings may prevent the person wearing the mask from spreading respiratory droplets when talking, sneezing, or coughing. If everyone wears a cloth face covering when out in public, such as going to the grocery store, the risk of exposure to SARS-CoV-2 can be reduced for the community. Since people may spread the virus before symptoms start, or even if people never have symptoms, wearing a cloth face covering may protect others around you. Face coverings worn by others may protect you from getting the virus from people carrying the virus.

General considerations for the use of cloth face coverings

When using a cloth face covering, make sure:

- The mouth and nose are fully covered
- The covering fits snugly against the sides of the face so there are no gaps
- You do not have any difficulty breathing while wearing the cloth face covering
- The cloth face covering can be tied or otherwise secured to prevent slipping

Wash your cloth face covering after each use in the washing machine or by hand using a bleach solution Allow it to completely dry.

For more information, go to: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/how-to-make-cloth-face-covering.html

CDC

cdc.gov/coronavirus

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https://www.cdc.gov/coronavirus/2019-ncov/downloads/fs-Important-information-cloth-face-covering.pdf

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Regarding healthcare workers returning to work: How long?

Image: Pixabay

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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

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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

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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.

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Considerations when restrictions are being relaxed include:

- **Allowing communal dining and group activities** for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate.

-**Allowing for safe, socially distanced outdoor excursions** for residents without COVID-19, including those who have fully recovered. Planning for such excursions should address:

- Use of cloth face covering for residents and facemask by staff (for source control) while they are outside
- Potential need for additional PPE by staff accompanying residents
- Rotating schedule to ensure all residents will have an opportunity if desired, but that does not fully disrupt other resident care activities by staff
- Defining times for outdoor activities so families could plan around the opportunity to see their loved ones

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

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Considerations for visitation when restrictions are being relaxed include:

- Permit visitation only during select hours and limit the number of visitors per resident (e.g., no more than 2 visitors at one time).
- Schedule visitation in advance to enable continued social distancing.
- Restrict visitation to the resident's room or another designated location at the facility (e.g., outside).

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

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Tune in next time!

Image: Pixabay FancyCrave1

PPE Donning and Doffing with the experts:
Frontline welcome!
July 9, 2020

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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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Questions and Answer Session

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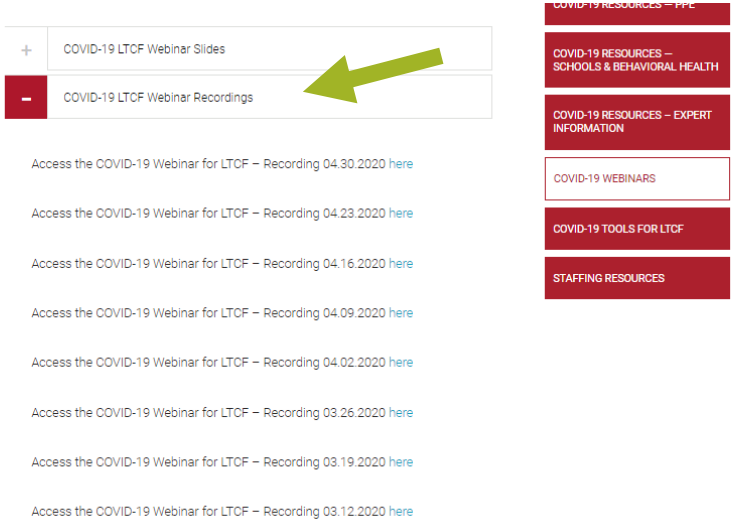
Panelists:
Dr. Salman Ashraf, MBBS
Kate Tyner, RN, BSN, CIC
Margaret Drake, MT(ASCP),CIC
Teri Fitzgerald, RN, BSN, CIC

Moderated by Mounica Soma, MHA

Supported by Sue Beach



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

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Responses were provided based on information known on 7/2/2020 and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates.

Nebraska DHHS HAI-AR and Nebraska ICAP
Long-term Care Facility Webinar on COVID-19 7/2/2020

1. **CDC says if we have a staff member who does NOT have symptoms but WAS exposed to Covid, the staff member should be quarantined in accordance with the following guidance:? Can you clarify was that guidance is?**
   If the staff member is asymptomatic but was exposed to COVID 19, that was the time basis strategy for 10 days that the CDC recommends. ICAP is recommending 14 days off work for long term care; the 10 days is more the rule for someone in the general population. Usually healthcare settings extend it to 14 days. The CDC has mentioned where there are people at higher risk, facilities can extend quarantine beyond 10 days. Nebraska Medicine recommends 14 days for their staff members and ICAP has recommended those same 14 days.

   Basically, for exposed persons, definitely 14 days from last exposure for healthcare worker restriction. Here is a link to the CDC recommendation, which shows how the guidance has changed over time: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html Originally (pre-COVID pandemic) CDC had said no one exposed could work (days before universal masking); as the pandemic progressed and we see so much exposure, the guidance changed. During the worst of the exposure, the guidance changed to allow for exceptions, but as we get farther out from the heaviest caseload, we return to more normal operations, a person who has had a legitimate exposure should not come back into the building. In Phase 3, in areas without COVID, the quarantine makes more sense for someone who has recently traveled. We encourage everyone to look at this link. Those are very defined terminology. Even with people exposed, not diagnosed, those healthcare workers, if they are essential to your service and there is no replacement for them, that person is exempt from the quarantine on that basis so long as they remain asymptomatic. But for most staff members who are exposed, they should be quarantined. See the table in the CDC link for guidance on who should be quarantined and how long they should be quarantined.

This guidance applies to HCP with potential exposure in a healthcare setting to patients, visitors, or other HCP with confirmed COVID-19. Exposures can also be from a person under investigation (PUI) who is awaiting testing. Work restrictions described in this guidance might be applied to HCP exposed to a PUI if test results for the PUI are not expected to return within 48 to 72 hours. Therefore, a record of HCP exposed to PUIs should be maintained. If test results will be delayed more than 72 hours or the patient is positive for COVID-19, then the work restrictions described in this document should be applied.

Exposure	Personal Protective Equipment Used	Work Restrictions
HCP who had prolonged[1] close contact[2] with a patient, visitor, or HCP with confirmed COVID-19[3]	• HCP not wearing a respirator or facemask[4] • HCP not wearing eye protection if the person with COVID-19 was not wearing a cloth face covering or facemask • HCP not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while performing an aerosol-generating procedure[1]	• Exclude from work for 14 days after last exposure[5] • Advise HCP to monitor themselves for fever or symptoms consistent with COVID-19[6] • Any HCP who develop fever or symptoms consistent with COVID-19[6] should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing. •
HCP other than those with exposure risk described above	• N/A	• No work restrictions • Follow all recommended infection prevention and control practices, including wearing a facemask for source control while at work, monitoring themselves for fever or symptoms consistent with COVID-19[6] and not reporting to work when ill, and undergoing active screening for fever or symptoms consistent with COVID-19[6] at the beginning of their shift. • Any HCP who develop fever or symptoms consistent with COVID-19[6] should immediately self-isolate and contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
HCP with travel or community exposures should inform their occupational health program for guidance on need for work restrictions.		

2. **If you have a resident in the gray/transitional zone but they have dementia and do have difficulty remaining in their room, would it be considered a contamination if they stepped outside of their room before we were able to get them back to their room even if we were able to get them to wear a mask?**
   That depends on the time frame of when they were out of the room. If they were wearing mask in the hallway and then we redirected them into the room, that is okay. We recommend facilities redirect those residents back into their own room; being out for a moment is not an exposure. However, if the residents come out longer and mingle with other residents that is a problem. But if they come out for a few seconds where you talk to them and get talk to them and get them back to a room, that is okay. We want to avoid that, but realistically we accept that risk and it is not an exposure.

3. **Do we still need to hold mail for 24 hours?**
   That was a soft recommendation early on, thinking postal mail could be contaminated. The 24-hour period might not be helpful. We want to talk to residents about using hand hygiene after they handle their mail. A hand hygiene intervention is preferred. If someone is doing a 24-hour hold, that is acceptable, but there is no solid recommendation on that. Your facility can either hold it or deliver it right away and ask residents to be vigilant about hand hygiene. Whatever practice you set up and can consistently follow in your facility is fine.

4. **In regard to employee screening: your AHCA form lists 2+ positives for the majority of symptoms on the screening. Can that be adopted in today's environment?**
   The AHCA form was released early on in the pandemic; Kate said this is information that is evolving. New guidance doesn't call for 2 symptoms. Just like our slide set, if you have one symptom, we want you to take those people out of service. That AHCA form is older and we definitely recommend having a low threshold of one symptom and then doing more testing and assessment. The two non-specific symptoms is one method, but the problem is that ICAP has seen that even staff with one vague symptom come back positive later on. Even one symptom means you need to do something. You can ask employee health for input or take them out of service right there and then. CDC has some criteria on their website as well. The regulation does not specify whether one or two symptoms are required. Remember that we recommend is based on our experience we have seen, but you need to follow the CDC-CMS guidance and base your policy on that. This discussion is a good reminder that if anyone in the audience is using the AHCA form they will want to update the information to only one symptom.

5. **This isn't a question, just a comment. It is hard to require tests when the results take 8 days. Is there a possibility that testing will get better?**
   The Nebraska Public Health Lab had been handing thousands of tests a day and did a superior job handling that volume. This is not a simple test like a glucometer test. It takes multiple steps and requires a lot of expertise. However, lately, there is a large Cyclospora outbreak that has affected capacity. Test Nebraska has stepped in and taken on a larger role. We are in a transition period and we fully anticipate that the results will be coming in at better turnaround

rate. The Cyclospora outbreak is related to the recalls of lettuce in Nebraska right now. Public health outbreaks like COVID-19 take a lot of effort, but there are other public health issues going on now as well.

6. **Staff have been unable to get a test scheduled with TestNebraska in Omaha. It keeps telling them to check back. Do you have any guidance or other options for baseline and healthcare worker testing options?**
   TestNebraska testing is being set up right now. Dr. Ashraf has heard from state DHHS leaders working on testing the staff. Twenty thousand test kits were set up for mailing last week and local health departments should be starting to see those delivered this week. We hope that if you have requested tests for baseline testing, those are being sent out to TestNebraska and if you requested them you should be receiving them. Check with your local health department to see if they have them now.

7. **In Phase 3, can we restart our outpatient physical therapies or occupational therapies that we offer our small community?**
   Yes, you can do that as long as you are taking all the infection control measures that need to be in place. That includes screening, cleaning and disinfection, social distancing and everything you need to do along with that. Phase 3 does not have any limitation on that. That is not a long-term care question, but based on what Dr Ashraf understands is that those should be allowed.

8. **For employee screening, our screen asks if staff has worked in facility or location with recognized COVID-19 cases as well as asking if the employee has been exposed to anyone confirmed to have COVID-19 or someone under investigation. What is the best timeframe to tie to these two questions?**
   The last 14 days is always important, because that is the incubation period for COVID-19. If someone is developing infection from the exposure, it happens in the last 14 days. If you are trying to figure out someone's exposure, it is always based on the last 14 days to figure it out. If you were exposed 14 days ago you should have it by now. Fourteen days is a good time frame.

9. **We have been going back and forth regarding PPE in the grey zone. Do we need a clean gown for each encounter, or can we reuse the same gown in the same room if the resident has tested negative and has no symptoms?**
   You cannot use the same gown from a yellow zone person who was exposed and is in a 14-day quarantine. Testing negative does not rule COVID-19 out, you still have to wait the 14 days. Somebody can develop symptoms any day up to 14 days and test negative on a particular day, or become asymptomatically positive. You need the yellow zone 14 days and in the yellow zone, you need to change your gowns on every entry. You cannot reuse the gowns. The reason you cannot reuse them is because there is no good way to doff a gown and put it back on without contaminating yourself. We have seen this happen to staff when they try to take off a gown and then put it back on, they cannot do it without contaminating themselves. That is the basic reason we recommend against using the gown once it is taken off. Disposable gowns need to be thrown away once they are doffed. If it is a reusable gown, once it is doffed, it needs to go to the laundry and then it can be reused.

A grey zone resident is handled the same way, because they are also in 14-day quarantine. In the yellow zone you are definitely sure someone was exposed to COVID-19. In the grey zone they may or may not have an exposure. Because of that element of uncertainty, there is still a possibility that the resident may have been exposed. In Phase 3 you are not required to have a grey zone; basically that is optional for Phase 3. You will have to decide if you keep a grey zone or not. We recommend (not mandate) that you look at the community you are in. If you are in a community where there are still significant transmission of COVID-19; if your hospitals are admitting patients with COVID-19, it will make sense for your facility to keep the grey zone for new admissions and for residents who are leaving for outpatient appointments who may be exposed from other at those appointments. should be put into the grey zone. But if you are living in a community that does not see COVID-19 transmission; if your hospitals aren't admitting COVID-19 patients, then you might not decide to put your residents coming back from those hospitals into a grey zone. One other thing to consider is even if your community does not have COViD-19 cases, you could still be admitting someone from a facility outside your area, where there is community transmission; from other hospitals which are admitting COVID-19 patients; or from outpatient appointments outside your community. In those kind of scenarios you may still want to have a grey zone. You put residents into an area not because you know they have been exposed, but rather that you fear there has been an exposure. In that grey zone you do all the things you do in quarantine -- gowns, gloves, masks, and eye protection and the gowns can only be used once. If you are running low on gowns, in the grey or yellow gown, you may want to use the gowns only when you are doing a high contact activity (bathing, dressing), then use the gowns in those scenarios and not each time you enter the room. That is better strategy than saving the gowns and reusing them, because then you are at risk of contaminating yourself.

10. **It doesn't make sense that after baseline testing for our facility that the recommendation is if you end up with an asymptomatic staff member who doesn't have a known exposure and tests positive they can still work with PPE if you are saying the other. Can you explain?**
    There might be a misunderstanding of what was said in the slides. If staff members who test positive for COVID-19, even if they are asymptomatic, they cannot return to work. That is where you use the time-based, symptom-based or test-based strategy to return to work. There are rules on that. We were talking about a person who may have a known exposure; the clarification is that they are known exposure and have not had a positive test. Dr. Ashraf agrees that after baseline testing, anyone who tests positive should not return to work for 14 days. That is the recommendation as of this point, even though they are asymptomatic, they cannot work. The people who can work are only if they are essential healthcare workers, known exposure, asymptomatic and have not tested positive. But not if they have tested positive and the only way with someone with a known exposure can return to work is in crisis level strategy, the CDC may allow that person to work in an area with COVID-positive residents, and that it still ONLY as a crisis level strategy.

11. **Please clarify. If there has never been a resident COVID-19 case in my long term care facility, no staff positives or symptomatic staff; none in our local hospital, and low prevalence in the**

county, can I admit new residents into a green zone if they are testing negative for COVID-19 at admission?

You can admit them into the green zone, because in Phase 3 it is observe and monitor. It does not require you to put someone into quarantine on admission. If the patient is coming from your community and not somewhere elsewhere there is higher levels of COVID-19, you can definitely put them into the green zone on admission. You may want to have each shift monitor vitals on the newly admitted resident (who is coming from your community) as there is no grey zone, based on you're the Phase 3 guidance, based on your own risk factors

If the facility is following old ICAP cohorting strategy, they may want to call it something different than the old grey zone. They will want to revise that policy guidance in their facility for the purposes of presenting the information to surveyors. You have to say you are not using a transition zone, not a quarantine unit. They can have an observation unit and not a grey zone unless someone is coming in from a high-risk county or area. No one will be admitted into the grey zone, but into the COVID-free facility. You will want to put them under close observation based on the guidance. Don't call it a grey zone unless you are quarantining. You need documentation that you are doing what you meant to do and that you are following your own policy and procedures.