

Guidance and responses were provided based on information known on 9/17/2020 and may become out of date.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

## September 17, 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:

Dr. Salman Ashraf, MBBS

Kate Tyner, RN, BSN, CIC

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# Infection Prevention and Control Office Hours

Monday – Friday

8:00 AM – 10:00 AM Central Time

2:00 PM -4:00 PM Central Time

Call 402-552-2881

# NHSN Reporting Review



**Infection Control Assessment  
and Promotion Program**

# Common Reporting Errors

Error#1: Rolling Over Counts from Previous Day

Date	Admissions	Confirmed	Suspected	Total Deaths	COVID-19 deaths
5/8/2020	5	4	20	10	10
5/9/2020	6	4	20	10	10
5/10/2020	6	4	20	10	10
5/11/2020	6	6	20	10	10
5/12/2020	8	6	20	10	10
5/13/2020	8	7	20	10	10
5/14/2020	8	7	20	10	10

Error#2: Excluding COVID-19 Deaths from Total Death count

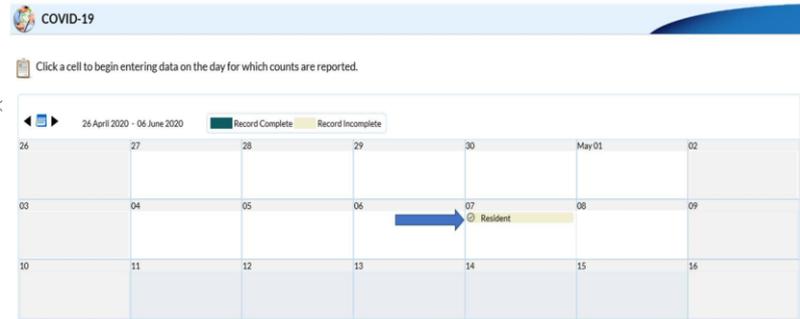
Date	Total Deaths	COVID-19 Deaths
5/8/2020	5	4
5/9/2020	0	5
5/10/2020	4	2
5/11/2020	1	1
5/12/2020	2	5
5/13/2020	4	4
5/14/2020	0	5

Error#3: Missing Data for Counts

0 = 0 Counts  
Blank = Missing data

Date	Admissions	Confirmed	Suspected	Total Deaths	COVID-19 deaths
5/8/2020	0	1	0	0	0
5/9/2020			0		
5/10/2020	1	0	2	3	

Error#4: Missing or Incomplete Reporting in one or more Pathways



Error#5: Missing or 0 for “Number of ventilators available” in facilities with ventilator dependent units and /or beds

Do you have ventilator dependent unit and/or beds in our facility?	Y
Number of Mechanical ventilators	✗ 0
Mechanical ventilators in use	0

# Common Reporting Errors

## Implications of Incorrect Data Entry

- Incorrect data shared with Centers Medicare and Medicaid Services (CMS)
  - Publicly reported and accessible
- Inaccurate assessment of resource needs
  - The Federal Emergency Management Agency (FEMA) – provisions of PPE supplies
  - White House Task force – providing of testing supplies
  - CDC Emergency Response – deployment of response teams
- Unreliable data for re-opening determinations

# Reporting Weekly Counts

## Surveillance Tips



**Maintain consistency in data collection and reporting**

A screenshot of an NHSN data collection form titled "COVID-19 Module Long Term Care Facility, Resident Impact and Facility Capacity". The form includes sections for "Resident Impact" and "Facility Capacity and Laboratory Testing".

**Use a line list or NHSN data collection forms to assist with data collection**

# Reporting Weekly Counts

## Case Study

### Worksheet for DHQP Skilled Nursing data – Week 2

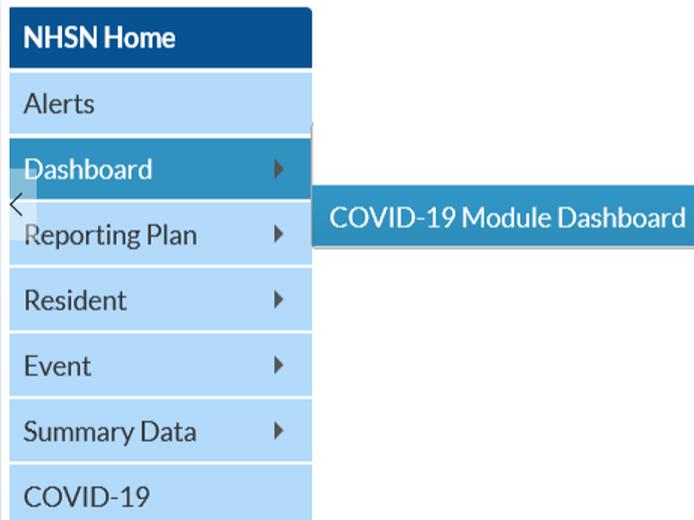
- Do not carry over cumulative cases from previous day.
- Choose to enter weekly or non-weekly not both
- Total deaths counts include all deaths including COVID-19 deaths
- Do not remove previously entered data if resident status changes

5/29 - 6/4	ADMISSIONS	CONFIRMED	SUSPECTED	TOTAL DEATHS	COVID-19 DEATHS
Friday 5/29	1	0	0	1	1
Saturday 5/30	0	3	4	2	1
Sunday 5/31	0	0	2	0	0
Monday 6/1	0	2	1	3	2
Tuesday 6/2	0	1	5	1	1
Wednesday 6/3	0	3	0	0	0
Thursday 6/4	2	1	0	3	1
<b>Weekly Total to be entered in NHSN*</b>	<b>3</b>	<b>10</b>	<b>12</b>	<b>10</b>	<b>6</b>

\*Only if data was not previously entered for that week.

# Viewing Reported Data

## NHSN LTCF COVID-19 Module Facility Dashboard



- Summary of the data entered in the COVID-19 Module
- Currently limited to the Resident Impact and Facility Capacity pathway
- The dashboard is best viewed using Microsoft Edge, Google Chrome, and Safari internet browsers

# Viewing Reported Data

## NHSN LTCF COVID-19 Module Facility Dashboard

**COVID-19 Module Dashboard**

Resident Impact and Facility Capacity | Staff and Personnel Impact

- Summary
- Confirmed COVID-19 and COVID-19 Deaths Among Residents

### Summary

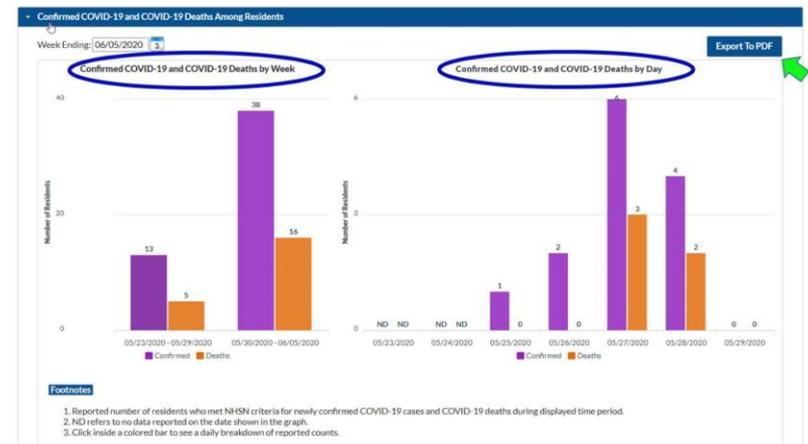
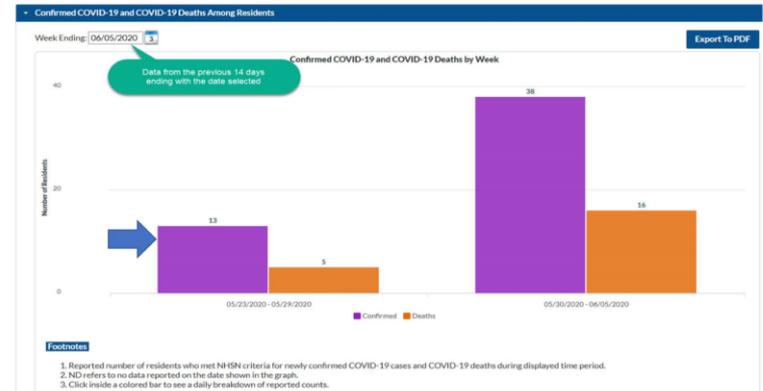
Resident Impact and Facility Capacity | Staff and Personnel Impact | Supplies and Personal Protective Equipment | Ventilator C...

Summary

Date From: 05/22/2020 To: 05/29/2020 Go

12 Admitted COVID-19 Residents	6 COVID-19 Suspected Residents	13 COVID-19 Confirmed Residents	5 COVID-19 Resident Deaths
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## Confirmed COVID-19 and COVID-19 Deaths among Residents



# Viewing Reported Data

## NHSN LTCF COVID-19 Module Dashboard

- Facility user guide for using LTCF COVID-19 dashboard:  
<https://www.cdc.gov/nhsn/pdfs/covid19/lpcf/fac-db-508.pdf>
- Group user guide for LTCF COVID-19 dashboard:  
<https://www.cdc.gov/nhsn/pdfs/covid19/lpcf/grp-db-508.pdf>

# Takeaways for NHSN Reporting

## Takeaways and reminders

- Facilities must report either once a week **OR** more than once a week but not both
- If reporting once a week facilities should report on the same day every week (if possible) and include only new counts since the last day counts were reported
- Use data from line list or NHSN data collection forms to document daily counts
  - Use NHSN data collection form instructions to understand case definitions for each category including non count (Y/N) categories

# Takeaways for NHSN Reporting

## Takeaways and reminders

- Enter only **new** counts since the last time data was reported
- Enter ZERO (0) if the answer is zero for questions requiring counts
  - Blank data element = missing data
- Complete data for all pathways

# Takeaways for NHSN Reporting

## Takeaways and reminders

- Total death counts must include deaths from all causes including COVID-19 related
- Do not remove previously entered data if resident status changes

# Takeaways for NHSN Reporting

## What if my Data are Showing as Incorrect on the Centers Medicare and Medicaid Services (CMS) Website?

- Make sure you are looking at the correct time frame
- Login to NHSN and verify the number with the dates from CMS website
- FAQ for CMS data: <https://www.cdc.gov/nhsn/pdfs/covid19/lctf/faq-cms-datarelease-508.pdf>
- Detailed information about how CMS processed NHSN data should be directed to :
  - <https://data.cms.gov/Covid19-nursing-home-data>
  - [NH\\_COVID\\_Data@cms.hhs.gov](mailto:NH_COVID_Data@cms.hhs.gov)

# Takeaways for NHSN Reporting



## FREQUENTLY ASKED QUESTIONS *COVID-19 DATA PUBLISHED BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES*

The Centers for Medicare and Medicaid Services (CMS) COVID-19 NHSN reporting requirements for nursing homes became effective on May 8, 2020. Data submitted to NHSN are shared with CMS on a weekly basis, enabling the agency to evaluate requirement compliance and publicly publish facility-level information. [CMS memo QSO-20-29-NH](#) provides additional information for nursing homes to meet COVID-19 reporting requirements.

Below you will find answers to questions you may have concerning your facility's NHSN data that were subsequently publicly published by CMS. Detailed information about how CMS processed NHSN data should be directed to <https://data.cms.gov/Covid19-nursing-home-data> or [NH\\_COVID\\_Data@cms.hhs.gov](mailto:NH_COVID_Data@cms.hhs.gov).

### Reporting Timelines:

#### **1. When does CDC send my data to Centers for Medicare and Medicaid Services (CMS)?**

COVID-19 data reported to NHSN by CMS-certified long-term care facilities (skilled nursing facilities (SNFs) and/or nursing facilities (NFs), also known as nursing homes) are captured from the system shortly after midnight EST every Monday morning and subsequently sent to CMS. All data that had been reported to NHSN by the CMS deadline of 11:59 p.m. on Sunday evening are shared with CMS and are identified by the unique CMS Certification Number (CCN).

# Takeaways for NHSN Reporting

## Comparison of CMS and NHSN Data:

### 2. Where are the data I submitted to NHSN this week?

The COVID-19 data submitted to NHSN this week is viewable in the NHSN online application. These data will be provided to CMS on Monday morning after the 11:59 p.m. Sunday deadline. CMS will process these data in preparation for the weekly update of their nursing home COVID-19 webpage. Therefore, there will be a delay (approximately 11 days) in viewing this week's data on CMS webpages.

Please ensure that the CCN used in the NHSN application matches the CCN assigned to the facility by CMS. If they do not match, your facility's data may not be included in data posted by CMS.

If your facility's data do not appear on the CMS website, please contact CMS at [NH\\_COVID\\_Data@cms.hhs.gov](mailto:NH_COVID_Data@cms.hhs.gov).

### 3. How can we compare our data in NHSN with what is presented on the CMS website?

To verify that your facility data on the CMS website is correct, login into NHSN and export your COVID-19 module data from NHSN. For more information on exporting your COVID-19 module data (please [How to export COVID-19 module data](#) below). Once you export your data, compare the data from NHSN to the CMS webpage by matching the time period for which the data were posted by CMS. Viewing the data by the correct time period is essential, since data on the NHSN online application are current and there is an approximate 11-day delay on the CMS website.

# UNMC ID Nursing Home Project ECHO



**Infection Control Assessment  
and Promotion Program**

# What is Unique About UNMC ID Nursing Home Project ECHO?

Many nursing home ECHO hubs across the country - Nursing homes may receive several recruitment offer.

Same core curriculum for training at each Hub.

Different group of facilitators and subject matter experts at each hub

**UNMC ID Nursing Home Project ECHO** hub provides the unique opportunity for Nebraska nursing homes as it provides them direct access to some of the leading infection prevention and control experts in the state during the training.

# UNMC ID Nursing Home Project ECHO - UPDATES

So far 138 Nebraska Nursing Homes have already applied for Project ECHO

Additional 18 nursing home outside Nebraska have also applied

Feel free to apply on the website if your nursing home has not yet applied. If UNMC ID Hub exceeded its capacity, we will try to link your nursing home to another ECHO Hub

The nursing homes that have already applied should have received a follow up email today with information on upcoming steps, including identifying team members that will be involved in the Nursing Home ECHO sessions. Please fill out the survey included in the email with the contact information for:

- Medical Director
- Nurse or Infection Preventionist
- Quality Program Representative
- Any additional staff member who is interested in quality improvement efforts

# Zoning Best Practices



**Infection Control Assessment  
and Promotion Program**

# Red Zone Workflow Review

- Plan for additional red zone space
  - What is the contingency plan if more residents are identified positive?
- Air flow and tissue tests
  - Hold a small piece of tissue in front of the door ~1” above the floor outside of the room.
    - In a negative pressure situation, the tissue should be pulled towards the room at all doors including the anteroom door/s  
GOOD, shows contaminated air is not escaping the room
    - Positive pressure is shown by tissue blowing away from room-  
BAD- work with maintenance staff to correct
    - Neutral Air flow indicated by no tissue movement
- Eating and Drinking in Red Zone
  - DON'T DO IT!
- Donning and Doffing locations are clearly separate

# Best Practices for Zoning

- Dedicated staff for Zones to prevent spread of COVID-19
  - Staff working in a any zone should be dedicated to that zone especially those who are working in the dark red zone (COVID-unit)
- Staff transitions between Zones
  - If the facility cannot dedicate staff to a zone, a hard stop should be completed between working in zones
  - Staff transitioning into different zones should work from Green to Yellow to Red Zone (clean to dirty method)
  - Hard stop consists of: Doffing, hand hygiene and some sort of break between entering new zone

# Best Practices for Zoning

- PPE extended use in Yellow Zone
  - Face shields and eyewear: May be worn between residents
  - N95 masks: May be worn between residents
  - Gowns: New gowns before entry to each room and doff before exiting the room
  - Gloves: Hand hygiene performed and new gloves between residents
- PPE extended use in Dark Red Zone
  - Face shields and eyewear: May be worn between residents
  - N95 masks : May be worn between residents
  - Gowns : May be worn between residents
  - Gloves: Hand hygiene performed and new gloves between residents

# After Hours Protocol



**Infection Control Assessment  
and Promotion Program**

# After Hours Protocol

- After hours phone protocol
  - Call State HAI Epidemiologist on-call phone number at: 531.207.4053
  - Also work with Local Health Department regarding new outbreaks
- What constitutes an after hours emergency?
  - New suspected or confirmed COVID-19 outbreak
  - Facility needing to request resident transfer to COVID-19 Unit because of inability to isolate properly
  - The need to move residents between units due to isolation and/or zoning
- Office Hours review
  - General Contact Tracing Questions (email okay)
  - General Infection Control questions (email okay)
  - General PPE questions (email okay)
  - Review or updates of existing cases (email okay)

# After Hours Protocol

- Things that can start immediately even before ICAP meeting
  - Initiating Red and Yellow Zones (Avoid moving residents between units before ICAP discussion)
  - Reporting to Local Health Department
  - Initiating the testing plan
- How to be prepared for any ICAP call so we can best help you with recommendations
  - Facility type and bed count in facility
  - Date of positive test
  - Date last worked if staff
  - Date of symptom onset if symptomatic
  - Was there a confirmed exposure with a positive individual?
  - Is the facility already implementing zoning (Red, Yellow, Green, Gray)
  - Resources to help facility gather this information are available on our website at: <https://icap.nebraskamed.com/covid-19-tools-for-ltcf/>



# We are on Facebook!

- This platform will be used to disseminate IPC training information to frontline staff.
- The staff will also be able to receive training certificates for participating in those programs when it is launched and announced on the Facebook.
- We will send you an email with information on the Facebook page. Please forward that to all healthcare staff in your facility.

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ICAP (Infection Control Assessment and Promotion Program) is supported by the Nebraska Medicine, Nebraska DHHS and the CDC. Our team includes experienced infection control practitioners, infectious disease epidemiologists, and professional educators.

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**Nebraska ICAP**  
18h · 🌐

Have you seen the latest MMWR article about how hospitals can help slow the spread within their facility? Check it out here:



# Questions and Answer Session

Use the QA box in the webinar platform to type a question. Questions will be read aloud by the moderator, in the order they are received

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Panelists:

Dr. Salman Ashraf, MBBS

Kate Tyner, RN, BSN, CIC

Margaret Drake, MT(ASCP),CIC

Teri Fitzgerald, RN, BSN, CIC

Sarah Stream, MPH, CDA

Jodi Scebold, EdD, MSN, RN

Moderated by Mounica Soma, MHA

Supported by Marissa Chaney and Margaret Deacy

+	COVID-19 LTCF Webinar Slides
-	COVID-19 LTCF Webinar Recordings

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](#)

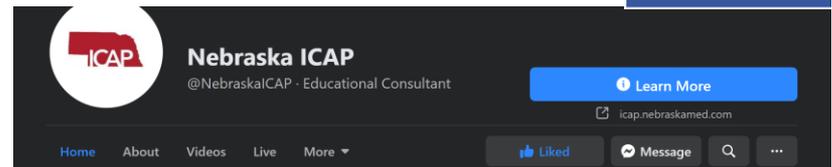
Access the COVID-19 Webinar for LTCF – Recording 03.19.2020 [here](#)

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



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

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**Nebraska DHHS HAI-AR and Nebraska ICAP  
Long-term Care Facility Webinar on COVID-19 9/17/2020**

**Q&A (recording time stamp 40:05)**

- 1. If we are in a Yellow Zone, can a staff member go room to room to drop off meal trays without changing their gown between each room if they do not have any patient contact?**

**Kate Tyner:**

I'll start this one and I'll ask other panelists to jump in. I think the thing in the Yellow Zone is if you have enough gowns, then staff should wear gowns for all care the Yellow Zone, and that includes meal tray delivery. And the reason there is when you go into a resident room, you have the potential of having contact not just with the resident but their environment, whether that's brushing up against your pants or your shirt or whatever. If you go and transfer another resident, help another resident, you know your uniforms may have contact with another resident, and that's why when we have enough PPE, we should use it. So in a Yellow Zone, if you have sufficient gowns, you should wear a gown for all resident care and entry into the rooms. Only in the situation where you're really strapped, you don't have enough gowns, and we have been in those situations at different times in the pandemic so far should you prioritize high contact care for gowns, so the highest risk cares, things like toileting, transferring brief changes, repositioning a resident, things where you'll have a lot of bodily contact with a resident you can prioritize those things for gown use. But in most instances, a Yellow Zone would require that you wear a gown for all entry into the room. Anybody want to add?

**Dr. Ashraf:**

I completely agree. I think the rationale is that you may go in to deliver a tray, and then you see that that the resident is trying to get out of the bed and you're worried that they might fall, and then as a reflex go and try to help them. That can happen. It may not be a common scenario that that can happen and you cannot predict right away. So it is better to be prepared in all time that you are going to come into contact with something. Now, if you have to prioritize because you're running out of the gown, that is definitely an area of low priority. So, yes, at that point of time, you can cut back to just high contact activity use of gowns. But it's not forever. It's only while you are low on the gown. You probably should put the request for more gowns at that point of time, documented that you are putting in a request for the gown so that if you get a survey or something, you can show them that the only reason we went back on the gown is because we were running low and we have asked for more gown, and as soon as the gown will come, we will go back to our normal full PPE use. And you can also always try to do the tray

delivery with some other care. Combine it with some other care so you don't just have to go in to the tray delivery, especially in the Yellow Zone. So that's another thing to consider.

- 2. Is full PPE required for Gray Zone (transitional) if patient is a readmission from a hospital to an AL and low risk? Patient had negative Covid test at hospital, was not on Covid wing of hospital, is asymptomatic, has history of having Covid in April 2020, county is phase 4, AL is phase 3 of reopening with no active Covid.**

**Dr. Ashraf:**

If you are going to have a Gray Zone, if you're going to call it a Gray Zone, a transition zone, and your reason for doing that is to quarantine the individual, if you're planning to quarantine someone, then you're going to use the full PPE. So if you have a gray zone because you are intending to quarantine someone, then you're going to use full PPE. Now, remember that in phase three there is no requirement for you to have a Gray Zone. And if you think that your community is not seeing a high number of cases, if you check and the community is not saying a high number of cases and you think that the exposure risk is very low based on what kind of visit has happened, then you may end up deciding that yeah, I don't think this person needs quarantine. Therefore, this person can be just observed and monitored and not be in the "Gray Zone". You can always have a resident in observation without having them in a Gray Zone. You can have an observation in Green Zone. So, the point I'm trying to make is that if you are going to say that I am going to put this person in Gray Zone because this person needs to be quarantined because he may have an exposure that we just don't know of, then you will need all of the PPE because you just made a decision to quarantine that person because you were afraid that they may have had some kind of exposure. If you're not afraid that this person had some kind of exposure, if your community is not seeing a high number of cases, if you're already in phase three, then you are not required to quarantine. So if you if you feel like we don't need to wear a gown and glove because this person is low risk and they have never had any exposure, and our community is not seeing cases. So why should we be wearing gown and gloves, and I will argue, why should we keep this person in the Gray Zone? So, if you're going to call this a Gray Zone because you need to quarantine this person because they may have an exposure, then you do the full PPE. Otherwise, you just don't put them in a Gray Zone. Just observe and monitor, meaning that you may just increase their vital signs monitoring times and symptom screening frequency. I hope that answered the question.

- 3. Would a resident that has recently had Covid be able to interact with the family for the next 60 days on a one on one basis? Would he be able to hug, hold hands with that family member? It has been indicated that a post positive individual has an immunity for 90 days. So for a 60 day time frame, would he have this opportunity that non infected individuals would not have?**

**Dr. Ashraf:**

So, if somebody had Covid and they have recovered, then they are basically the 10, 20 days, whatever the time they were in the isolation for, after that isolation, they're not considered

contagious, so at that point of time I can foresee a normal interaction. However, just be aware where that interaction is happening. If you're allowing somebody from outside to come into your facility, your resident may not be able to transmit any infection at that point of time, but you don't know the person who is coming in. They may have, if they are an asymptomatic carrier and still positive right now and actively transmitting, they can expose certain people in your facility if you are not careful with having them mask when they entered the building and during the symptoms screening. So we look out for that, definitely. But in theory, what you are saying is making sense that that person is definitely at that point of time just outside the 10 day window, and is probably noninfectious. The only caveat that I will say is that there is a lot more than we don't know about Covid 19 yet. The CDC is saying right now that if someone had that infection for 90 days, don't recheck them because they are probably immune. However, remember, they also say that if there is any symptoms right now, after they even have Covid, go ahead and still test them. So they don't want you to test for your routine screening and things like that, but if somebody became symptomatic, you go ahead and still test them, meaning that they are cognizant of the fact that the reinfection can happen even within that 90 day timeframe too. And we really 100% don't know. I think it has been even shown, some documentation has been out there that it might even happen at day 45. Now it's not 100% confirmed, but it might even happen at day 45. So our knowledge it's still limited in this area, when somebody can start becoming reinfected and that is the caveat that limits us, you know, probably on day 20 - 21 when they're coming out of the isolation, that's probably the less likely chance on that day that they will have an infection, just one day after they have recovered from the previous infection. But really, when it will start happening, we just don't know 100%. That's why people are asking to still be more careful, because we just don't know how it behaves. I am pretty much aware of scenarios where people have said that they have seen the infection in 45 days, but those are not 100% confirmed and that's why I say this is not going by that. But we're still learning.

**4. I have found a private lab that can to antigen test with a throat swab for our twice weekly routine staff testing. Is a throat swab antigen test acceptable by CMS for routine testing?**

**Dr. Ashraf:**

I think what is acceptable by CMS, we might have to check with our licensure division on that, however, I think if people are going to follow the manufacturer's recommendation of the device, I think that should be good enough in my mind. If you're following the manufacturers recommendation, we can always ask the licensure to weigh in. But in my mind, if you are following manufacturers' recommendation, you're probably fine. Margaret, do you have any insight or any additional thought right now.

**Margaret Drake:**

No, I really don't. I really hadn't even heard of the throat swab.

Dr Ashraf:

We may have to look at the manufacturer's instruction and see, correct?

**Margaret Drake:**

Yeah, I'd be interested in who it is and what the platform is for testing.

**Kate Tyner:**

I think the information that this audience member needs to ascertain is if the lab is doing an FDA approved Covid screening. That's the thing, they need to provide you that in writing, they need to show you what the testing is, they need to show you that it's FDA approved. It doesn't necessarily have to be your homework project. If you're going to pay them money and work with them, they can give you this information. So that's what you're looking for, an FDA approved antigen testing.

**Margaret Drake:**

Yeah, I agree, Kate.

**Kate Tyner:**

But I think in this group, none of us have heard of a throat swab at this time.

**Dr. Ashraf:**

Definitely. It has to be reliable, and you need to know the sensitivity and specificity of that antigen testing also. The two test machines that were sent out, there were some studies done on the sensitivity and specificity. If the sensitivity and specificity is very low on those tests, then those test are not good enough to do the kind of thing that we're trying to do. So all of that is also going to come into play.

- 5. If you are in a Yellow, Grey or Red Zone, do you have to wear full PPE in the hallway or just in the rooms? Surveyors are saying if it is a Zone, you should be in full required PPE the whole time in the Zone.**

**Kate Tyner:**

Remember that hallways are common areas. In your hallways, you can have staff members who do not have on PPE. That would be in your Gray, Yellow and Green Zones for sure. You have to think about the logistics of this, what's reasonable. In most instances, we consider the hallway a clean area, and we work really hard to keep it clean. We doff our gowns and our gloves in the room. We do only clean things outside the room. I would have concerns if people were saying that in the Yellow Zone, for example, people would wear gowns throughout the hallway because we definitely shouldn't have dirty PPE on in the hall. If we have dirty PPE in on the hall, then we're going to be transmitting Covid. So from an operational perspective, it's very hard to tell who's doing what if people can have PPE in the hallway. When we've talked professionally with our NETEC colleagues, and other people who are doing this, we would really like the hallways to remain clean areas. That's what we have found in the past. I can't comment as to what people are surveying against. If we would need to see some things in writing so that we can engage Connie Vogt to say, "This citation occurred. Can you tell us more about it?"

**Dr. Ashraf:**

Another point is that, sometimes in the Red Zones, if the residents are coming out in the hallway, or even a Yellow Zone, like in a Dementia Unit, the residents are coming out in the hallway, which makes the hallway dirty at that point of time. There may be some rationale of wearing PPE in the hallway in those areas where you cannot keep the residents, for whatever reason, in their rooms and they're coming out in the hallway, then then I can see the need for the hallway to become, dirty, and you need the PPE in the hallway. Otherwise, as long as you are maintaining your hallway as a clean area, then what you need is basically your mask on in that hallway. That's basically what it comes down to.

**Kate Tyner:**

I think with that, if you have a zone like a Memory Care Unit or Red Zone, where people have been in the hallway with dirty PPE, another thing that has to be considered is when you eventually decommission that unit, how do you thoroughly clean all those spaces where that PPE has been worn? I've worked with some facilities one on one decommissioning those type of units. That's a lot of work to clean sequentially throughout that unit. To decommission it as a dirty zone, you don't just get to flip on and off the switch and say, today it's Covid, tomorrow, it's not. It would really have to be thoroughly decommissioned to release it if you had people all over in the hallways because they would be contaminated.

**Dr. Ashraf:**

Yes, we will be happy to take a look if you reach out to us individually. We'll be happy to review the situation with you. And if we need to talk to the licensure, we will definitely do it if we find that there is unreasonable expectation. I think that kind of brings up the point that there's so much that everybody is learning as of this point that that, we just have to keep up to date with what is out there, what other recommendations are out there, and then have to keep everyone else up to date in the system and we are doing that. We are definitely trying to do our best to meet that. I'm hoping that with our Project ECHO, we will be able to have more robust discussion on these types of issues and have more awareness about these with every nursing home in the state and I'm hoping that one day you all will be experts on these situations yourself and can have a very good discussion with the surveyors yourself. I think that's also why it's important that you get into the right training program to get involved in those kind of discussions. So that's an important point to kind of always think about.

- 6. If we are reporting weekly, on day one we test a staff member and on day 3 we get those results back negative, does that get reported as suspected? If on day 3 they are positive does it go in as a suspected for day 1 and positive for day 3?**

**Margaret Drake:**

Is this NHSN they're asking about? If you're testing someone and they're suspected and you put it down as suspected, and then the next time you're reporting, even if it's within the same week, if you get the results back and they're positive, you're going to put a one for positive.

**Dr. Ashraf:**

So, Margaret, what I'm understanding is, if today's Monday and I'm reporting on Monday afternoon, on Monday morning, I got a person that is starting to show symptoms, they're in a light red zone because I'm suspecting Covid. I sent a test, so now I'm submitting my report to NHSN, I put down "suspected one". Two days later on Wednesday, I get the results back and it was positive. Then I will go in the next Monday, and I'll report we have one positive confirmed case, but not necessarily go in and change the suspected.

**Margaret Drake:**

No, you do not ever change the suspected.

**Dr. Ashraf:**

So the previous week's suspected, we will not change that, because in the previous week, we had one suspected. In the current week, we have no suspected, but one confirmed, right?

**Margaret Drake:**

Right. Correct.

**Dr. Ashraf:**

So you're basically telling them what was happening in that week. When you tell them that you have one suspected, and zero confirmed, and then next week, you tell them we have zero suspected and one confirmed, they will know that suspected person probably got confirmed.

**Margaret Drake:**

Right. Correct.

**Dr. Ashraf:**

You don't have to go and make it zero.

**Margaret Drake:**

No, you don't want to go back. One of the slides said they're not to change your suspected, so you don't want to go back and be changing, "oh, now they're negative, no they're not suspected". They will always stay suspected because you did suspect them and you tested them for that week. Don't carry it forward to the next week.