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The following are the Questions and Answers included at the end of each DHHS/ICAP PowerPoint presentation to long-term care providers, beginning with the first webinar session on March 5, 2020 through July 23, 2020. Copies of these PowerPoint presentations and recordings of the webinars can be found here: https://icap.nebraskamed.com/covid-19-webinars/

Responses were provided based on information known on **3/5/2020** and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates. Q&A session – COVID19 Webinar 03.05.2020

1. Will you be sending out the power point slides following the webinar?
Yes, the slides with Q&A will be posted this afternoon or tomorrow morning. We will send a link posted online.

2. Do gowns need to be non-porous?
The way isolation gowns are labelled is not according to the type of isolation you are doing, they are actually labelled for the type of care you are providing. So, if you a have patient who requires contact and droplet isolation that is also being bathed, you would choose a gown that is non-porous, so that you don't get wet from bathing. If you had the same contact droplet resident and if you were going to do something that is actually fairly low contact and the person is wearing a mask, fairly contained and you need to do a transfer for something like that then a standard isolation gown is plenty. This resource may be useful:
https://www.infectioncontroltoday.com/personal-protectiveequipment/understanding-barrier-level-protection-medical-gowns

3. Are we to test for COVID19?
Your facility would not test for COVID19. As of this minute, the testing in the state of Nebraska is only done at the Nebraska Public Health Laboratory. So, in order to get a test for COVID-19 you have to call your local health department who has to discuss the case with a member of the state department of public health. We will help you work through that on a case by case basis. Now, when testing becomes widely available if other academic laboratories in the state followed by other commercial laboratories in the state start to have the test available, guidance and recommendations will change and will be on top of it as best as we can.

4. Any suggestions on how to monitor/screen visitors?
We mentioned before, we can get some more specifics and put additional links on that. The major questions that you would ask will be: We will place an example on the Nebraska ICAP website hopefully sometime today.

a. Have you travelled to the countries that are considered the highest risk i.e. China, South
Korea, Iran, Japan, and Italy? These are the countries as of now that have significant community transmission.
b. You could also ask about returning travel from these additional countries, Seattle

Washington area and certain counties in California (this is not a formal rec at this time.) Singapore, Thailand, Taiwan, Hong Kong to fill out questionnaire and self-monitor. Refer
folks to Nebraska DHHS Coronavirus.
c. Have you had any contact with someone who is a known or suspected case of COVID-19?
d. Do you have a cough or any other respiratory symptoms like sore throat or fever?
e. Eventually, there may be settings who are instituting checking temperatures on sign in. That's not something we are officially recommending at this time but if your facility wanted
to do that
f. CMS recommends that written policies need to be in place regarding visitation.

5. What percentage of alcohol does the hand sanitizer need to be?
As per the guidelines, at least 60% alcohol is recommended.

6. For eye protection-what is the best recommended?
The CDC is currently recommending a full face shield if you have them, but we understand that it is becoming difficult to obtain. A face shield is more of a moisture barrier to an N95 respirator. In absence of availability of face shield, we would recommend using safety glasses or goggles. Wear face shield correctly, make sure it goes below your chin. You still need to wear a mask for respiratory protection, when wearing a face shield.

7. Do they anticipate that COVID-19 will be seasonal similar to influenza?
Because this is a brand new virus we honestly do not know what would happen, what are the ambient conditions that will make this less viable. We do not have any information in this regard. Respiratory viruses can circulate all-round the year although usually at a lower rate, so signage should be in place all year round. Influenza precautions have to be taken seriously.

8. Can you comment on the importance of paid sick leave for LTCF workers?
Recent CMS guidance for LTCF specifically states that health care providers with symptoms of respiratory infections should not report to work. In addition to that, CDC has a guidance that facilities should have a program in place where healthcare workers who aren't coming to work for sick reasons should not be penalized. There should be a system in place where there is no penalty for a sick employee who does not report to work.

9. Since we already have community transmission in the United States why would we not begin screening all visitors to LTCs now rather than wait until we know it is here in Nebraska.
Go ahead and start screening. Make sure you ask the questions that we talked about. We could also put together a sample screening questionnaire. We can do that really quickly and have that up so you can access. See answer to #4 above.

10. We have a possible admission from out of state - a few hours from multiple recent cases. Do you have recommendations on how to accept them without isolating them out as different?

To be answered offline. Reach out to Dr. Maureen Tierney at Maureen.teirney@nebraska.gov

11. Would you recommend a trained team (Public Health, EMS, etc.) to mobilize and be able to collect COVID-19 Rule out specimens within the skilled nursing facility versus moving the patient(s) to the local acute care facility?

Brilliant suggestion! We are going to take the suggestion back to the state.

12. A staff member asked if they know of someone who is supposed to be self-containing and they are not-who do they call, or do they call? (There is a community member and they know they are not staying home. Not a staff person they are concerned about the community at large and our resident).

You need to call your local public health department and let them know.

13. Most local health department's (LHD)s don't provide fit testing, what other resources are out there for LTCs for fit testing, and should they plan for those contingencies.

At this point of time, there are few local departments that do it. I should not have suggested that –it is too much to ask. If this becomes available through additional surge capacity we will inform you.

14. How do you determine if someone is just experiencing cold symptoms verses being worried if they are experiencing COVID-19 symptoms? At what point do you become concerned?

As of this point, if somebody has not travelled and has not come in known contact of COVID-19 person, and they are experiencing symptoms of cold, the more likely chance is that they are having just common cold than COVID-19. It is important that you focus more on hand hygiene, PPE, and respiratory hygiene all time irrespective of the condition. We haven't been doing wide spread testing, we don't know inter community transmission rate, but there has been testing done, people who did fit in higher risk categories, all of those tests have been negative. We don't have a ton running around in Nebraska, that's a little bit of reassurance. Once we know it's in the community, we will continue to advise you that information will be made public.

15. If we run out of small hand sanitizer may we refill from a larger bottle for team members?

No.

16. What do we need to know about the CMS plan to heighten their focus on infection control practices during inspections of LTCF--are they increasing penalties etc.?

I don't think we can answer this question right now. There are some screening tools for LTC, ICAR questions, survey questions, asking facilities to dig deep into facility policies. There will be increased focus on infection prevention and control during surveys.

17. In a double occupancy room, why would both residents not be considered exposed in the event of a visitor in the room? Also, if moving one resident, why not move the one considered not exposed rather than moving an exposed resident through the facility?

If you had a double occupancy room and if you had a visitor with one of the residents exposed in the room, you would consider both of the residents exposed. Exposure questions are to be considered on a case by case basis.

18. I am being told that many PPE items are on allocation from medical supply vendors and limited supplies are available. Just thinking for the future - if these items do go fully out of stock what should be done for PPE?
This is ongoing and we are currently working on this. Efforts include trying and see if there are older, more available stockpiles, and if production there can be ramped up. We are not aware of particular sources as of yet. But it is an ongoing effort, we do think there will be some practical recommendations that will come out as we get closer. The whole idea of allocation process is to prevent stock outs. This is to prevent people from hoarding, stock piling etc., it is meant to help so that people maintain steady stream of equipment.

19. We have a stockpile of masks that are 12 years old for the preparation of SARS they are expired are we going to get approval to use this stock?
The first question is how old is that stock, is there any expiration date? People are working on determining how many years past expiration date, things are reasonably effective.
In addition, see this CDC guidance: Release of Stockpiled N95 Filtering Face piece Respirators Beyond the Manufacturer-Designated Shelf Life: Considerations for the COVID-19 Response https://www.cdc.gov/coronavirus/2019-ncov/release-stockpiled-N95.html

20. Honestly, as an LHD, we are so busy, we don't have time to fit test others at this point. If we had to fit test 20 or 30 or 60 people, that would take us out of the office for a full day. I agree see answer to # 13 above.
Will need to find out more if we could do more on the surge capacity.

21. Thoughts on using washable isolation gowns, as the disposable gowns are running low on inventory?
Reusable are something you can use in case you are running low on inventory. Please make sure that you are washing as per manufacturer instructions and they have some kind of permeability or warranty on them.

Responses were provided based on information known on **3/19/2020** 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 3/19/2020

1. I am getting a lot of questions about mail--does it need to be held for any period of time or can residents get their mail daily when delivered?
Although there is not really more data on it, New England Journal of Medicine published an article about Environmental hardiness of COVID-19 and what they said was they looked at its hardiness on different types of surfaces-copper, stainless steel, plastic, and cardboard. Plastic and stainless steel about 3 days, copper less than day, cardboard about 24 hours. There is not a particular recommendation, but if you think about it a letter because it has to be mailed, go to the post office and then come back, it is usually said to be in circulation for more than 24 hours since it left its site. https://www.nejm.org/doi/full/10.1056/NEJMc2004973

2. Can you clarify visitors? The regulation states for end of life and essential health care providers? Would this include (to enter the facility) ALL hospice staff or just to limit to hospice nurses and CNAs to enter in the facility?
In terms of health care workers that you are getting in, whatever you need to do to provide safe regular care the resident needs, you cannot go below that. For the visitor's part, end of life and to see their family member, the regulation allows to enter. It is important to identify essential health care personnel and who are you putting into the category of essential. If hospice nurses are the ones who see that patient and have that relationship with him, and they are coming out on a daily basis, you can actively monitor them as your staff are being monitored when they are coming in to see those patients, so you probably not treat them just like your staff. You don't want somebody coming into the facility as a volunteer who is just handing out things to read, because they aren't essential to the facility.

3. Will we be reimbursed from Medicare if therapy services refuses to come into our building for those residents on skilled stay?
We cannot answer this question right now, but we do know that there is lot of work being done at higher levels of leadership to try and get support for healthcare kinds of services and alternative services to keep facilities supported financially, that's kind of out of our normal lane. We will definitely push that question forward. ICAP has worked with couple facilities, for example, we found from local emergency department that there was a clinic refusing care. We interacted with that facility in a way providing education, helping them understand what staff needed to do to be safe. If your therapy services company, if there is an opportunity for education, we would love to try to interact with those people to help them understand the kind of things we are talking about on these webinars.

4. Please specify the requirements for masks. Are regular procedure masks ok or do we need to have N95?
That was presented on one of the previous slide sets for standard care, for nursing care, transmission based precautions for contact and droplet precautions are totally appropriate for LTC and for that an N-95 is not required. The things that we are really trying to prioritize for N95 respirators are if people are tested for nasopharyngeal specimens because that can generate aerosols as well as if a resident has a need for type of therapy that can generate aerosols such as c-path (CPAP) or nebulizer therapy. We can talk to facilities more 1:1 about specific therapies, but for most long term care and post-acute facilities contact droplet precaution should just include a regular surgical mask. Make sure that your staff are trained to know how to wear that mask appropriately and in this limited time, when people start may be running out and they are trying to reuse or continuous use of supplies, they shouldn't be touching their masks, they shouldn't be pulling it down under their chin, they shouldn't be doing those bad habits that we see a lot of times staff do with masks. If masks become contaminated, they should be changed. We also talked about the need for just in time training, if you are anticipating that you will admit a resident etc., hosting PPE guidance for how to put on and take off is really important, giving people the opportunity to talk through it in a slow manner, it is really important to build confidence and competency on this type of PPE and those PPE guidance are available on our website. Don't forget eye protection, you can use regular mask but make sure that you have goggles or face shield.

5. If we can't obtain a supply of PPE, what should we do?
We would recommend that all facilities keep a careful inventory of what PPE they do have and really look strongly at the recommendations we have in the slide set for extended use and reuse, so you can slow your burn rate is what people are calling your usage rate, so if you have no PPE at all that should be escalated to your corporate level, to see if you can share with another building, or consider calling your healthcare coalition to see if they can help you identify other vendors.

6. What is meant by extended use vs reuse of face masks and are we talking about surgical masks or N95 masks. Going from room to room is cross contamination a problem wearing the same mask as a care provider?
Extended use means wearing one face mask for several rooms and you should go to the CDC guidance of what that means. Extended use would be more appropriate when you know more than one resident has the same pathogen. Wearing it all day for multiple types of pathogens is not outlined in the guidance. N-95 masks and surgical masks are addressed separately in the FDA and the CDC guidance and so this is new information to people with experience in IP that you can reuse a surgical mask or do extended use. Reuse would be taking it off and trying to put it on at a later date which is generally meant to be less safe, but we really encourage people to go through the CDC guidance and call us if you have any questions. There are conditions that the CDC outlines when you cannot continue extended use for example, if the masks become moist with use, or if you were involved in aerosol procedures where mask is grossly contaminated or soiled, it should be taken off. Extended use is recommended over reuse.

7. Do you recommend that all of the HCP wear masks while working? Some states have gone to this already.
We do not believe that this is consistent with national guidelines at this time. That doesn't hit the prioritization level of PPE. Monitoring of staff every day is a good way to ensure that your staff are healthy and they don't need to be wearing a mask. Preservation of PPE is important at this time. We did have a situation where a spouse was sick and eventually turned out to have COVID-19 and when the spouse went to work (the spouse of the sick person), there was a questionnaire that needed to be filled out every day with screening questions. She answered yes to one of the questions that was when she was further assessed and sent home. Having a review of healthcare professionals when they show up at work is invaluable to the protection of other staff and residents.

8. Do you just assume they have COVID if symptoms seem like it and isolate? Or try to get them to the hospital for testing?
If outpatient, the question would be as long as they did not need hospitalization, you would assume it was COVID-19. For right now, since we are still in the situation of less than 30 cases, and we are trying to keep them as limited as possible, and when someone is in a setting like LTC or a hospital, and they are around vulnerable people, we would try to get testing. If the person was ill-enough that they needed to go to the hospital, they should be treated as if they were COVID-19 in terms of transport and communication to the facility and they could be tested when they arrive. If there is someone suspected of COVID-19 in LTC, the local health department will want to know.

9. Do you have any feedback or suggestion what should be done about healthcare staffing agency (traveling CNA's & nurses)? How should they be handled and what extra precautions should they be taking?
We think that agency personnel will fall into the facility screening procedures. They should be screened for temperature and symptoms every day like facility staff. They could be asked questions too, if it's a new traveler that you are getting into the facility, you would ask them where are they coming from or have they been to any of the hotspots. If that's the case, it is recommended that they self-quarantine for 14 days and not be working. If there is such an extreme healthcare worker shortage, they would have to contact the person who is in charge at that facility, as well as their agency personnel and a plan made in particular about how they should be monitored, should they be wearing a mask at work during that period of time. That's not a decision they could make on their own, it will need to be made in conjunction with the facility and their agency.

10. Can you clarify the information provided in the HAN that came out this morning, stating "to limit spread in Nebraska, all travelers should self-quarantine for 14 days upon returning home". Does this include even travelers that did not come from an area with widespread sustained transmission?
Yes, it does. Part of the issue, is that there are places that we know of where we have high transmission rate right now. But the places keep popping up all the time, last week when we had this call, we did not talk about Florida or Denver, and now we are talking about these states. Areas are popping up where there is transmission and part of the complication, one of the reasons we are doing this is in this frustrating scenario, where we do not have enough testing, we can get a sense of where the hotspots are, but we don't truly know how much is in the community because we are not able to really test for community surveillance. We only have 2 documented cases of community transmission that is cases we don't know where they came from. Every other case has been from travel elsewhere and the primary travel has been Italy, Florida, California, Washington, and New York. Everyone should be distancing, self-isolating, oblige to the governors recommendations to reduce the spread in Nebraska. If you have travelled, consider yourself at increased risk and do what you can to prevent your fellow citizens from getting sick.

11. What would be the best for serving food on in the rooms? Paper or regular plates
We addressed in our webinar last week, the guidance for how to handle linen, utensils, plates, and trash. None of that changes for COVID-19. Even though it can live on surfaces for a while, it is actually pretty easy to kill with our usual sanitation practices. The troubles comes when you try to transport dirty plates in the facility, so it is important that you use your basic infection control procedures that clean plates are all together and dirty plates are all together and never mixed. These general handling procedures for plates and utensils should be adequate for control of COVID-19.

12. I had two high school students on my staff go to Puerto Rico and they returned home on 3/15. Because they went to an area that was NOT of high, medium risk of exposure, are they ok to return to work?
All travelers have to be self-quarantined for 14 days. However, in case of essential workers, if there is no replacement for someone, you probably can monitor the symptoms and can have

them continue to work.

13. Can you review discharge cleaning of the room of a patient who was diagnosed or suspected of COVID-19 and would be discharged out.
The terminal cleaning of room should be like any terminal clean that you would usually do. The list of disinfectants is on multiple websites. The EPA has approved this list and agents that are really approved for COVID-19. Lot of bleach agents appear on this list. Ensuring that you have a healthcare appropriate disinfecting agent, you should use your general discharge cleaning procedures. In addition to that, the person who goes in to clean the room, should continue to wear a mask for several hours after the person is discharged from the room. Use the product as per manufacturer instructions, look at the wet time and kill time for the product. Just make sure you are auditing that process of your cleaning and appropriate amount of time as dictated by your manufacturer. Environmental staff can watch a video on terminal cleaning of room on NE ICAP website.

14. When the weather gets nice can families meet their residents outside as long as they keep the distance?
At this point of time, we recommend that you avoid it. As time passes by, we will keep you updated on this.

15. What about staff that has traveled to other states or countries still screen or just isolate them for 14 days?
Essential staff should be actively monitored on a daily basis. Non-essential staff can isolate themselves at home. They will not be tested unless they have symptoms.

16. Can we prevent Assisted Living Residents from leaving & returning to facility if it is nonmedical?
We will need to explore more on this.

17. Could you please give recommendations for the type of eyewear that is best?
As long as it covers your eyeball. Make sure it fits snugly. Face shields are top tier but are short on supplies.

18. How are we to handle an employee with a heart condition, who is self-quarantining because he/she is worried about contracting COVID-19? Are we to pay them the same as someone who is quarantined because of an exposure?
We are not sure of any guidance on this. We will further explore and post.

19. Does domestic mean in the US outside of Nebraska?
Any travel within the US, except for commuting to work (especially flights, and interactions with public while traveling)

20. How long do you have to keep the door closed on a room that you have done terminal cleaning on after a COVID19 resident has left?
That depends on the # of air exchanges that room has. See CDC Guidance at this link which is the basis for this table below. These values apply to an empty room with no aerosol-generating

source. With a person present and generating aerosol, this table would not apply. Removal times will be longer in rooms or areas with imperfect mixing or air stagnation. Caution should be exercised in using this table in such situations.
https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html

Air Exchanges per hour	Time (in minutes) required for removal 99% efficiency	Time (in minutes) required for removal 99.9% efficiency
2	138	207
4	69	104
6	46	69
8	35	52
10	28	41

21. Are residents able to go out and be pushed around the block? Or do they need to stay in the building?
We do not have clear guidance on this.

22. Mental Health. Isolation is not healthy for assisted living residents. How do you handle this for activities in the facilities?
Individuals can participate doing craft projects, exercise, etc., using generous social distancing - cancel group activities and communal dining. Consider how you might distance folks 6-10 feet from each other. We saw some interesting ideas on Facebook this weekend- "Hallway Bingo" https://www.facebook.com/watch/?v=644776636360039 We encourage you to think outside the box. Can your facility bring people together virtually?

23. What is your direction for families that would like to do the resident's laundry and leave it at the door?
There should be no reason that they can't continue this if it is something they have been already doing. The goal would be to allow the family to pick up and drop off laundry without coming into the facility. Is it possible for your staff to facilitate this by bringing the items to the door and retrieving them from the car or front door of facility? If so, then the practice could continue. If your staff are unable to accommodate helping with gathering and delivering, then the response will be no.

24. Can safety glasses be shared from well staff to well staff?
All items that go from person to person must be disinfected between uses. Use manufacturer's instructions for use for disinfecting. Store clean and disinfected items in a clean place, where staff will know this item has been disinfected. Consider also: where will staff place the

dirty/used glasses? How will they be kept separate from the clean isolation supplies? Ensure that cleaning and disinfection does not occur in a resident sink or a hand-washing sink. For example, the cleaning and disinfection could occur in the utility room, if glasses are transported in a covered, hard-sided tub.

25. Can you repeat most current report of hot spots?
The information is evolving so rapidly. HCWs should look to current sources for updates. The interactive map on the Johns Hopkins Coronavirus Resource Center is helpful at this link https://coronavirus.jhu.edu/map.html

26. For assisted livings, the home health companies (outside of hospice) are continuing to work in multiple communities. Should we limit them as non-essential healthcare dependent on each resident's needs?
See CMS Memo "Prioritization of Survey Activities" March 23, 2020
https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0

> "Access for Healthcare Staff CMS is aware that some providers (nursing homes, assisted living facilities, etc.) have significantly restricted entry for staff from other Medicare/Medicaid certified providers who are providing direct care to patients. In general, if the staff is appropriately wearing PPE, and do not meet criteria for restricted access, they should be allowed to enter and provide services to the patient (interdisciplinary hospice care, dialysis, organ procurement, home health, etc.)."

27. I read in the South Korea model that 20-29 year old without symptoms had the highest infection rate. That is the majority of our staff. Would it be acceptable to issue masks to our staff to wear throughout the day?
There should be no reason for staff to wear a mask unless they are caring for a resident with respiratory signs and symptoms, isolated individuals, and anytime they are performing cares in which droplets, splashes or sprays could occur. Mask supplies are becoming scarce and should be reserved for standard and transmission based precautions. (If you have staff that are self-monitoring after travel or due to a possible exposure, mask wearing would be in order.) IF guidance on this changes we will address in future webinars

28. Restricting hospice personnel except in "actively dying" situations (then only nurses) is occurring affecting patients and families causing stress.
Hospice regulations have not been lifted. Hospice nurses are still allowed in, and should be as long as they are being screened/monitored along with the facility staff.

29. Hospice clarification: should music therapy, social workers, holistic interventions be coming in?
See CMS Memo "Prioritization of Survey Activities" March 23, 2020
https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0

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general, if the staff is appropriately wearing PPE, and do not meet criteria for restricted access, they should be allowed to enter and provide services to the patient (interdisciplinary hospice care, dialysis, organ procurement, home health, etc.)."

30. What happens if come to a point where we are running out of gloves, I know we contact the health department, but what if we can't them?
Gloves will need to be reserved for blood and body fluid exposure risks, but there is not clear guidance on this yet…so continue to wear gloves for standard and contact precautions.

31. If a LTC resident tested for COVID 19 does any employee that may have cared for that residents or come in contact with that resident need to self-isolate at home? If so how can LTC facilities have the staff available to care for the residents?
For a smaller LTC facility it may mean that the majority of staff have come in contact with that resident. Prolonged contact with exposure can be assessed by using the exposure risk table we showed on the slide.

32. N95 masks - how long are they good to be used for by same person?
Until compromised or contaminated

33. With admissions is very difficult to find out if patient that is coming in has been in contact with someone infected. Would the recommendation be to "isolate" them for 14 days? Concern about shortage of PPE.
You should be monitoring all your residents currently, and you can address new admits by actively screening for 14 days. AMDA has a monitoring tool that you can consider for your own use.

AMDA screening tool for residents
https://icap.nebraskamed.com/wpcontent/uploads/sites/2/2020/03/AMDA-Resident-Screening-Form.pdf

34. If a resident has MRSA in their blood and there are recommended contact precautions, should we lift the precautions to just gloves only because we can't refill the supplies and will need them later for COVID cases?
Guidance regarding MDROs in Nursing homes can be found at this link https://www.cdc.gov/hai/containment/PPE-Nursing-Homes.html.

35. In the event of severe weather (tornado warnings), patients are held in areas of the building that are communal, exceeding the 6 foot and 10 person rules. Is this still acceptable in the event that these situations arise? What about patients that are in isolation or monitoring? Should they stay in place (room) during this time? Does staff stay with them?
I have not seen any guidance on this, but common sense would tell me that in this extreme instance, you may have to bring residents together. Masking all residents in this situation should be prioritized, if their condition allows. Follow normal tornado warning protocol, unless instructed otherwise (with the addition of masking residents)

36. We have assisted living communities refusing to let therapists (PT OT ST) in to treat their home health patients. They are saying only nurses are allowed in. Any advice on these situations?
See CMS Memo "Prioritization of Survey Activities" March 23, 2020
https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0

> "Access for Healthcare Staff CMS is aware that some providers (nursing homes, assisted living facilities, etc.) have significantly restricted entry for staff from other Medicare/Medicaid certified providers who are providing direct care to patients. In general, if the staff is appropriately wearing PPE, and do not meet criteria for restricted access, they should be allowed to enter and provide services to the patient (interdisciplinary hospice care, dialysis, organ procurement, home health, etc.)."

37. Just to clarify, if we have someone with a presumptive COVID-19, then their whole family will need to be home for 14 days.
Regarding a resident with presumptive COVID-19 - Regardless of exposure, all non-essential visitation is not allowed, according to the guidance offered 3/13 by CMS https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf.

> "Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation… Those with symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) should not be permitted to enter the facility at any time (even in end-of-life situations)."

Family should not visit, period.

Regarding a staff member with presumptive COVID-19, the staff member is restricted from work. See guidance at https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcpreturn-work.html for return to work guidance.

38. Have any new travel hot spots within the United States been added this week?
Nebraska is recognizing Colorado and Florida as new hotspots. The information is evolving so rapidly. HCWs should look to current sources for updates. The interactive map on the Johns Hopkins Coronavirus Resource Center is helpful at this link
https://coronavirus.jhu.edu/map.html

Responses were provided based on information known on **3/26/2020** 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 3/26/2020

1. When patient is in transition area on return from hospital, do they need to mask, and staff use full PPE (eye protection, mask, gown, gloves) for every encounter with the patient. If they are non-compliant with mask, what is recommended?
It depends on the circumstance. If the person is admitted for non-COVID-19 illness and has no

COVID-19 concerns, and if he/she is coming back, having a mask on would make sense. You will need to perform standard precautions and wear gowns for certain activities like washing. Wearing a mask should be fine otherwise. The main important thing is to segregate the affected unit from rest of the hospital units and have a dedicated staff for that and have limited movement into rest of the facility.

2. If a referral is exhibiting possible COVID symptoms, can the skilled facility request a COVID test before accepting? What if the hospital refuses?
At this point we are prioritizing hospitalized patients who have symptoms of COVID-19 to be tested. Although, I know that scenario has happened potentially, but we are really pushing for hospitalized patients who have COVID-19 symptoms to be tested. We also think that the scenario of waiting for test results is going to go down in these particular kinds of settings. We are going to try and push for those tests to go to either NPHL/Regional path because they can turn around the tests at least right now faster than some of the commercial labs. So, I think that in that scenario, we can try and work through those. If there is a problem, and if you want to email me (Dr. Maureen Tierney Maureen.Tierney@nebraska.gov), I am happy to try and facilitate in that situation.

3. If we have a resident that goes out to the hospital and is returning with a diagnosis of pneumonia but no documentation related to COVID-19 is it safe to assume that COVID-19 was ruled out?
You can definitely clarify from the facility, if someone went for a diagnosis of pneumonia and was diagnosed with strep pneumonia. Based on the culture result, they have probably a good reason to understand that this appears to be a pneumococcal pneumonia with a clinical/radiological picture that is very consistent with the diagnosis, then they may want to rule that person out for COVID-19 because they have a very clear diagnosis of that, so those are the type of things that you can ask the facility before you accept. We would not recommend to base your decisions based on assumptions.

4. So for rural LTC settings it is okay to keep a COVID-19 positive resident in their facility, just put in droplet precautions?
The question about keeping someone in your facility is going to be a decision sort of combination with local health department, state public health department and the facility. We want to keep people in the facility in the place where they feel most comfortable and if the facility feels very comfortable taking care of that person, and ICAP feels that there is a good understanding of the precautions that need to take place. Couple of issues is protecting other patients in the facility. There are many options made available but much of it would be case-by case basis.

5. Should public water fountains be shut off in an LTC?
We are not sure of the public health guidelines on this. But we will definitely explore and keep you posted. Maintaining and disinfecting the public water fountain would be another issue.

6. If we have a new admit that comes into the SNF with a fever above 100° and does not have a dx of COVID-19; do we have to place in isolation and use PPE or just use universal precautions?

Well, you have to first know why they have a fever of 100 degrees if they are coming into your facility. If the person just gets into the facility and have a fever as they come in, there has to be a very careful evaluation of why the person is having fever (for e.g., was it because of a surgery that the person is developing post-surgical infection). In the meantime, while you are figuring out, based on the symptoms the patient should be placed on contact and droplet precaution. Once you a have a clear idea, you can assess the situation.

7. If a healthcare working in LTC has a family member who is returning from a known hot spot (WA) can the family member isolate and the worker still come to work?
This has to be handled on a case-by-case basis. The family member needs to isolate and the healthcare worker needs to monitor. If the healthcare worker can isolate with them, that would be great. If they can't, he/she should talk to their supervisor about what plan can be put in place. If that person does come to work, it is important that they wear a mask and be actively monitored. There have been recent COVID-19 exposures among health care workers and residents in a nursing home. Any facility that is not actively monitoring their healthcare personnel every day when they come to work are recommended to institute that immediately. As part of this, the facility should take temperatures when the health care personnel arrive at work and ask screening questions. If the person at home who came from a high-risk area were to develop symptoms, then that health care worker should immediately self-isolate.

8. Are they still recommending that surgical mask are enough protection for staff in long term care facilities if we have a positive case?
The recommendations for care of patients and moving to droplet precautions is sort of a moving target and ongoing. If someone is not undergoing an aerosol generating procedure, the requirement for a negative pressure room and an N-95 mask is not necessary in that setting. When a health care worker is wearing a droplet mask for a suspected COVID-19 case or a positive case, the resident should also be wearing a mask when the health care worker is in the room. In addition, we recommend that facilities follow the line with eye protection as well either by using face shield or safety glasses.

9. On the slide it said a fever of 100.0 degrees. Is that the new recommendation for employees also?
The recommendation for a fever of 100.0 degrees to employees is actually based on the issue about healthcare workers that might have been exposed and the lower threshold is because of the potential for infecting other vulnerable people. So, that's where a temperature of 100.0 degrees comes in. As per the CDC, 100.4 degrees is often used as a standard in the case definition and the more restrictive testing definition. I don't think we really need to absolutely focus on 100.4 degrees. Always remember that when we are talking about residents of the long term care facility, there are different definitions of fever for them. The fever definitions can vary depending on the group you are checking.

10. Where are the state designated COVID treatment/recovery centers for nursing home patients?
The state is currently working with CHI. Right now, they will be at Midlands hospital in Bellevue, and St. Elizabeth hospital in Lincoln.

11. Our local health department is asking for skilled nursing facility team members to quarantine
for 14 days if they have any domestic travel, especially if out of state. Currently AHCA/NHCA guidelines do not recommend this as of yet. What do you recommend doing?
In terms of health care workers quarantining post travel, the recommendation is for health care workers who are coming from high risk areas of domestic travel. If they can self-isolate they should. If because they cannot be self-isolated at work, that is the discussion that needs to happen in consultation with an infection preventionist or an infectious disease physician at their institution to make a decision based on the health care worker shortage or expertise that's necessary and then a plan is to be created. That person is going to be actively monitored, temperature taken on their way to work; the person would check their temperature even at night and he/she will need to wear a surgical mask when at work. It has not been mandated that all health care workers with domestic travel have to stay home.

12. At what point would you place a LTC facility in complete lockdown where staff wouldn't be able to leave? What do you recommend for staff members with children?
We can see putting facilities under lock down (no new admissions if you have COVID-19 patients) in terms of people not being able to leave. If someone is positive whether healthcare worker or not, one wants to make sure that there is a capacity for them to isolate within their own home if possible. Sometimes we may be trying to create sites where people can isolate if they can isolate at home. We don't know if we can foresee a capacity where no one would be able to leave. Local health departments are trying to work hard to orchestrate the best recommendations they can.

13. What if we have a patient in our nursing home or assisted living patient who may have COVID-19 but they do not want treatment or hospitalization? Can we keep them here, use Isolation precautions, PPE's and bring in hospice?
As we talked about before, that would be on a case-by-case basis, so the answer is very possible yes. But, we think that the issue is also regarding obviously wanting to try and respect the wishes of that individual and support them in this situation. But we all also think that there is an issue of protecting other patients. The belief is that if a facility can manage what they need to do to prevent transmission in their facility, have a capacity to do that, then we think that's a possibility. It is not necessary that everybody who is COVID positive would have to come out of LTC. If a facility can't manage a particular patient, there would be an option where folks can go.

14. If we have a COVID positive resident that went to the hospital and then to a recovery center, how will we know where that resident is and how will the center know where to send them back to upon full recovery?
We think that information will be gathered in their record and will try and smooth out that process. But, those kind of operational details are really up to be determined.

15. We heard that the IA National Guard delivered PPE to Montgomery Co. in IA. Is something similar possible in Nebraska? Our facility is still having difficulty laying in PPE supplies.
PPE supplies when they come in are distributed to local health departments, so they probably have used the National Guard to do that process. We don't think that we have required using

the National Guard to do that yet. PPE supplies were delivered to local health departments, so we believe that at the end of last week, DHHS and the preparedness group working in conjunction with NEMA are constantly looking for sources and supplies for ways to get it and when new shipments come in, they are again distributed primarily to local health departments. If that's something the National Guard can help, they will do that. But, the National Guard was just basically the messenger here. Iowa is following the same procedure as we are.

16. Should assisted living facilities follow the same guidelines as recommended for Nursing Homes?

In Nebraska based on the risks that we identified; we are telling you yes. That did not come out in a CMS/CDC document, we are saying in Nebraska we will really like you to look at the nursing home guidelines versus assisted living facilities.

17. Are we required to limit nurse practitioners from the building?

If the Nurse Practitioner is essential in taking care of the patients in the facility, he/she should be allowed into the nursing home. If you think that the person is non-essential, and you don't need that person to be providing care, you can limit that person. Those Nurse Practitioners should be subject to employee screening and must be monitored. Even if they are essential employees, and come to work with fever and cough, they cannot work.

18. If employees have been diagnosed with sinus infection, the flu, or GI flu; when are they able to return to work?

If somebody has a confirmed respiratory panel and diagnosed with influenza, that person is required to follow the influenza protocol that facilities are aware of. If there is a healthcare worker who is suspected to have a respiratory illness that they have not been able to diagnose otherwise, then they can contact the local health department, or the health care worker can contact their primary care provider and get requested for a test to rule out COVID-19. We are prioritizing health care workers in testing and it will be easier to get those beginning next week.

19. What are their recommendations for nursing homes that are not able to clear a hall or area to be designated as a transition area because they do not have available rooms - and- what if that resident returning has a roommate and again, the facility does not have any empty rooms to make changes? In our instance, if the facility is full, there are no options for moving people around.

Dedication of a unit or wing is not a requirement to admit a resident back who does not have any reason to be suspected for COVID 19 or has already been ruled out for COVID 19. Those facilities without the capacity of creating such a unit can still admit the resident and actively monitor them daily for fever and respiratory symptoms. However, if the facility has the capacity to implement this additional steps and they want to be extra cautious they can consider it. The exact wording from the CMS guidance is as follows:

> "Note: Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present. Also, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor, or returning to long-stay original room)."

20. If there is a positive COVID19 resident that does not require hospitalization it was recommended that all staff entering the nursing home must wear a surgical mask at all time, however, someone went on to say that full PPE should be worn for direct care provided to all residents because some may be infected but still asymptomatic. Is that the recommendation? Part of the question is because most of our facilities are already encountering concerns with having adequate PPE.

First of all, if a resident is going to be tested positive for COVID-19 in a nursing home, the current plan is to have discussion with that nursing home and resident and may be transfer the resident out of the nursing home to a designated COVID-19 care center as discussed during the call.

Secondly, we did discuss that there can be a situation where while we are considering transfer of the COVID -19 positive resident, we may simultaneously be trying to rule out active transmission of COVID-19 within that facility. In that specific situation, temporarily, healthcare workers may have to use PPE while taking care of everyone in a particular unit, wing or facility. However, the key is that it will only happen if there is confirmed case of COVID -19 in a nursing home and an investigation is taking place to make sure there is no evidence of active transmission in the nursing home. In this particular scenario, nursing home will be working together with the local health department in making those decisions. In all other scenarios, PPE use should be in accordance with standard guidance that we are currently using in every day practice.

Here is the link to the CDC Assessment Tool which describes when the above mentioned process should take place:
https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/03/CDC-NH-COVID-19-Assessment-Tool-3.19.2020.pdf

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Responses were provided based on information known on **4/2/2020** 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 4/2/2020

1. As a SNF accepting a new admission from a hospital with a negative COVID-19 test, what precautions do you recommend we take? Keep them isolated from our at risk residents?

The recommendations are now that you do and keep them isolated. If it's possible to create a wing or even part of a hallway, it will be easy to distinguish folks who came back from the hospital, they have been ruled out as they had a negative COVID test and keep them separated from other individuals.

2. What are your recommendations for admissions to long term care facilities if the patient has been tested and test is negative, and no symptoms are present, do they need to be isolated at the long term care facility and if so, for how long?

The recommendation is 14 days. If you can, it would be better to have a sort of transition unit for people coming from the hospital who tested negative. Because, for people coming from sort of that environment, it is probably better to have them in the transitional area, not absolutely

necessary. It is prudent to take some extra precautions.

3. Did I hear correctly - if any staff person has any symptoms - a cough or runny nose or elevated temp - ANY symptom at all, they should not work?
Yes, if there is any kind of respiratory illness like fever, shortness of breath, sore throat, and cough. For healthcare workers there is prioritization of testing. They can call their PCP and get testing arranged and get the tests done. If the test results are negative, they can continue to work while wearing a mask.

4. Can you clarify all HCW that should wear masks are every department including dietary, maintenance, housekeeping, office staff or just clinical staff such as nursing staff and physicians?
Any time when there is clinical interaction. In other words, folks who have exposure to patients. In this kind of setting, it might be useful to have meals delivered outside of the patient's room and then the person who is carrying for the folks go in, try and pool tasks, so that why you don't have to have dietary wearing masks necessarily.

5. How can we plan for use when we cannot even obtain PPE?
Local health departments have been given the urging right now because of this directive to get more PPE to LTC. Utilizing the PPE request form that your local health department has and contacting them again will be helpful. There should be more PPE for sure coming to LTC.

6. What is your recommendation for cleaning a room of an ALF/LTC for a positive COVID especially with carpet and personal items?
You need to clean the room, high touch surfaces especially. We haven't seen any special directive on carpet. The positive patient is definitely going to have droplets that could be landing on surfaces in the room. You will need to use an appropriate disinfecting agent that the CDC has a link to the EPA list of appropriate disinfectants. You will need to clean it especially adhering to the wet time of the disinfectant and make sure you hit it on all the high touch surfaces. Please follow the guidance on using disinfectant properly. For daily cleaning, the recommendations for COVID positive patients is that the daily high touch surface cleaning actually be done by people who are going to be in the room already, so it's usually not the role of many other people who are doing that but to not have environmental cleaning coming into COVID positive rooms on a daily basis, but more on a terminal clean basis. There are recommendations for terminal clean and what environmental cleaning people should be wearing for those terminal clean on the slide set. Do not vacuum a carpet in a COVID positive room while there are people inside the room to prevent aerosolization. Link to cleaning and disinfecting your facility—CDC guidance https://www.cdc.gov/coronavirus/2019-ncov/prepare/disinfecting-building-facility.html

7. You are saying for all healthcare workers to wear surgical masks; however, in writing it only states when possible - can you come out with a stronger stance in writing?
NE-DHHS website says "When possible, employees should wear a mask when working with patients". If you have the capacity to wear masks that is if you have masks in your facility they need to be worn when seeing patients. If there is any director of any LTCF refusing to support this directive, please let Dr. Maureen Tierney know about it. Nebraska medicine has very good guidance on how to implement universal masking.

- Link to Nebraska DHHS Guidance for Novel Coronavirus: LTCF (including assisted living, nursing
  homes, and independent living, etc.)
  http://dhhs.ne.gov/Documents/COVID-19%20Long-Term%20Care%20Facilities.pdf
- Universal Mask Policy and FAQ, Nebraska Medicine
  https://www.nebraskamed.com/sites/default/files/documents/covid-19/surgical-mask-policyand-faq-nebraska-med.pdf

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Responses were provided based on information known on **4/9/2020** 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 4/9/2020

1. We can no longer get bleach germicidal wipes. What should we use?
Bleach germicidal wipes are great disinfectants. But, there are also disinfectants that are effective against coronavirus. EPA has a list called N, that we have on the ICAP website. In addition, facilities can use healthcare labeled bleach and mix bleach for bucket immersion where you would mix diluted solution of bleach into a bucket and use cleaning cloths to clean rooms. Many facilities continue to do this because, with that dip immersion process surfaces actually, stay wet more likely their general contact time. Between the list N of other disinfectants available and you can make yourself with bleach, we think that it should be OK.

- EPA List N: Disinfections for use against COVID-19
  https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
- Information on how to mix bleach solutions
  https://www.cdc.gov/coronavirus/2019-ncov/community/disinfecting-buildingfacility.html

2. Where can we get thermometers to take temperatures for several clients in a group home setting?
The question makes us presume that it is difficult to purchase thermometers through your usual avenues. It is important to help your local health department and state health department understand what supplies you are unable to get and so if you could perhaps email us that or consider reaching out to your health care coalition for support on those kind of questions. We don't actually have any information at ICAP on thermometers that are available to purchase.

3. In regard to mail should we be holding it for a certain amount of time before giving it to the residents and also family has been bringing this should we stop allowing them to do this?
On regular cardboards or delivery packages, virus does not survive that long (usually not more than 24 hours). If the virus is sitting in the mailbox for a day, it shouldn't be a problem. The other thing is that when you are going to handle packages, you still have to perform hand hygiene. Dr. Tierney had requested a facility wait a couple days before letting residents share newspapers. If you are going to pass it on to the next person to kind a leave couple days sitting, virus would die if there were anything on it before the next resident could handle that. Some

places are waiting an additional day just to be on a safer side but clearly you would not have to wait for more than a day. In terms of increased concerns on sharing of papers/magazines, we probably shouldn't be doing sharing of papers at this point of time.

4. We have staff that is willing to isolate in our facility for 2 weeks - we currently do not have confirmed cases nor symptomatic residents'. Any advice or suggestions on whether this is a good idea? (Staff that is willing to live in our building - to minimize exposure from other staff that may be exposed through spouse or other scenarios)

If you had no exposure, we are not sure why are you wanting to isolate the staff. If someone is exposed and they are asymptomatic after they get exposed, they are required to have a 14 day quarantine. The best thing to do for that healthcare worker is to stay home and self-quarantine, separate from rest of their family. However, Individuals who have been exposed but are asymptomatic can work as long as they are monitored with daily checking of temperatures and symptoms prior to their work. But if they tend to develop symptoms over time, it is required that they isolate at home and stop coming to work. Up until last week, for any outbreak in LTC where healthcare workers were exposed, there would be an investigation as to the level of that exposure and recommendations may be based on that level of exposure whether a healthcare worker should quarantine away from the facility for 14 days. We would try and triage based on whether that was low, medium, or high risk exposure.

In terms of the above question, there is a lot of movement right now, most healthcare workers are finding ways to separate themselves from their families so that they are not bringing potentially the exposures they may have at work home. So, if your facility is going to do that, it could protect individual's family and it also protects the residents and staff from that person going out to the world, getting exposed and bringing it back. As long as it is done in a careful way, it might provide a way to decrease exposure coming into and going out of the facility.

5. Has the governor changed his stance on SNF admitting positive patients?

The particular recommendation form the Governor or statement in the LTC guidance was that if there is a test pending on a patient who is an inpatient in an acute care facility, that the result of their test needs to be obtained before someone should be moved either into for the first time or back into a Skilled Nursing Facility. The recommendations are that a facility should admit the patients that they would normally admit even if they are coming from an acute care hospital that may have had COVID-19 patients. If the person has been in a hospital for a reason other than there has nothing to do with COVID, they had a stroke or some other issue there have been no other COVID symptoms during their admission, that a negative testing is not required and a negative test achieved prior to them going in. Again, if they have test done for any reason, the result needs to be back. But, if there is not a reason to test someone based on clinical history, there should not be a reason to test them to accept them back in. That is also why the recommendation is being made that facilities develop a sort of step-down or transition area for when people come back from the hospital or are newly admitted from the community. So that if indeed, there is a chance that there was any exposure, for the first 14 days they be in a separate area from other patients to prevent any transmission. Insisting on a test being done when it is not indicated clinically isn't really beneficial. Having a transition setting in you LTC facility would be beneficial.

6. Moving the patients out from the nursing home if they are positive. Criteria?

There is not so much criteria as there are factors that come into that decision. There is some capacity at certain facilities to take patients from LTC. If the facility is not capable of managing those patients or if there is particular imminent concern that keeping folks really places a risk on other individuals and so it will come into place in terms of what is the skill level of staff available, number of staff available, size of the staff tested positive, is there a capacity to create a cohorted COVID unit. The decisions are made on a case-by-case basis and often have to be made with the best information possible.

7. Can facilities get test kits to have on hand? (Rapid test kits)
Test kits and transport media are at a bit of premium. Nursing homes and LTCF are an extremely high priority and we would allocate nasopharyngeal swabs and transport media to LTC facilities. Will have to get that worked out with the public health lab, they are the source of that, they have those materials available. We have approximately 400 LTCF in the state, we are wondering what we could do to get those distributed. It is not trivial to get them all out. We would say anybody who is particularly interested in that, and feels like it is a concern, we can certainly accommodate that. We would have to work with the distribution people, the public health lab.
For Nebraska Public Health Lab to request N-P swabs and viral transport media:
Client services: 800-334-0459
Courier: 402-559-2440

8. Should the dietary department be wearing masks while in kitchen and when prepping room trays?
There is a CDC guidance on universal masking who are not healthcare/frontline workers/who doesn't come into contact with patients directly. Dietary may fall into this category if they are not going into patient rooms to deliver trays. It would be better, if they can avoid delivering to patient rooms. Instead, have the nursing staff deliver the food trays to patient rooms. What we know about the importance of personnel wearing the cloth masks in public, the guidance that we have from CDC is in situations where you can't have enough spatial separation that you would wear a cloth face mask to do that good source control, and so for people working shoulder-to-shoulder at points in a day, that's a great use of your face masks for source control. Cloth masks would be good for people who are not doing clinical work. If you do have your nonclinical staff wearing cloth masks, it is important to talk to them about the hygiene of those masks. Those masks have to be washed at least after one shift of use which is a good minimum frequency. Please do not put a damp cloth mask in your locker or purse, as it is not considered safe not necessarily specific to COVID but also for allergies, moisture, and infection issues. If people are going to remove their cloth masks during their day, it is important to know where are they going to put it and how are they going to lay it down so that it stays clean. What we used for universal masking for healthcare workers is putting the mask dirty side down on to a paper towel, doing hand hygiene before removing mask and before putting it back on. It is important that you don't forget the importance of these steps when your non-clinical workers are making use of cloth masks.

9. If you currently don't have any positive COVID-19 residents should staff be bringing in a clean uniform to put on AFTER arriving for their shift? Also, we have heard several facilities making staff bring a different pair of shoes to wear when working. Is this something we all should be doing?

There is no evidence that floor or shoes are part of COVID-19 spread right now in the facilities. We don't think changing shoes is needed at this point of time. There is no reason to have a separate uniform unless you have a scrub that you use at your facility for regular use. There is nothing special that you need to do but use the uniforms appropriately if you are suspecting the patient of COVID-19 or any other infection. You don't need to bring a new scrub just for the process of going in and out of the facility. You could leave work shoes outside the house and can wipe off the bottom of your feet with a disinfectant wipe before you leave the facility. None of this is required based on what we know of how COVID spreads. If these reasonable measures are making your staff comfortable such as bringing a different pair of shoes or wiping of shoes, please go ahead and do that.

10. In a memory care only community, if a resident tests positive it would be difficult isolating the resident because of memory issues. Is this a case where resident could be transferred to hospital?

I wouldn't say that was the case where someone would be able to be transferred to the hospital. I think that we are trying to look at - could we have other convalescent areas that's such a unique aspect of care which we are balancing risks and rights of the patient as well risk and rights of everybody else around them. But, there are some facilities which would have less capacity to be able to work with somebody in a memory care unit, so right now that would have to be done on a case-by-case basis. But, that's been looked at as a potential option for future. If someone has memory issues and they are being transferred to hospital, consider this question "what do you think is going to be the impact on that resident when they go to the hospital?"

11. What is the process for notifying facilities of positive COVID19 tests done by the NE Public Health Lab?

As of this point in time, when the results come back to the local health department (LHD), the LHD notifies the facility of the results. There is a link posted below on how to create an account at the NE public health lab and get your results electronically to look it up. Whoever ordered those tests need to be careful that the email or fax number you are putting on your account, will go back by secure email or fax to the party who ever ordered tests. You can always find that information out. It should comeback pretty quickly if you follow the protocols. We consider LTCF as our highest priority. If any facility has any positive case, please feel free to reach out to ICAP directly. You need to make sure that all infection prevention measures are in place at your facility.

> Facilities ordering COVID tests through NPHL should establish an account with NPHL. Go to this site for guidance on setting up an NPHL account and ordering a test at NPHL: http://dhhs.ne.gov/han%20Documents/ADVISORY04022020.pdf

12. We are having calls from larger health systems (Omaha) reaching out to rural Critical Access Hospitals to inquire about us taking suspected and/or positive COVID SNF/skilled patients to make beds available in metro area. What do you recommend? We are considering but want to be able to serve our population if need be as well

I don't think we can answer this question. I think every facility should have the expectation that they are likely to end up having to care for COVID-19 positive patients whether it is a CAH, AL, or LTC. I think understanding what the referral pattern for instance, in your LTCF if a positive COVID patient is ill-enough to require acute hospitalization, you would follow the normal

pattern of referring them to where they need to go. But the concept of working as partners is kind of a one whole Nebraskan community to try and support as best as possible. Think about it and work with your colleagues, the acute care hospitals and DHHS are also working together to look at all potential options.

13. What should facilities expect to happen if they have a resident or a staff member test positive who has had contact with other residents and staff members- should we expect that the National Guard will come in and test all of our staff and residents such as was done at the YRTC- Kearney?
This is what happened-there were exposures from health care workers to the residents or from a resident to other or residents to healthcare workers. So far, facilities have worked with their LHDs and ICAP to make sure they have right cohorting in place of the residents in addition to infection control measures and the testing is decided based on the symptoms. If there is a symptomatic resident or healthcare worker, the facilities have tested themselves, done the tests and sent it to NE public health lab. So, the facilities are doing it by themselves, their local health department is helping them get the test kits that they use and send the tests. That is what is going right now. Because facilities are very different in whole variety of issues in terms of what the living situation is, are people in multi-bedded rooms' vs single bedded rooms, what are the levels of staff and training that's been provided, number of cases involved, and extent of outbreak, there is not a particular answer. DHHS in combination with ICAP and LHD looks at situation and makes best recommendation on what can be done.

14. Pt. admitted to hospital with underlying respiratory issues, is having symptoms, but hospital refuses to test, can we request they test before we accept them into our SNF?
If the patients are having respiratory symptoms consistent with possible COVID-19 infection, you potentially have the right to ask for test to be done.

Responses were provided based on information known on **4/16/2020** 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 4/16/2020

1. I feel that there are conflicting statements being made re: dismissal of positive COVID patients back to their nursing home/assisted living. I have heard it said that a positive patient would be required to have a negative test before they are discharged to their nursing home and then next time hear them say that we will have them go back to NH while they are still positive. Is the return to the NH only being considered if it is felt by the health dept., that the nursing home is able to care for?
If your facility does not have the ability to take care of the patients who need continued transmission based precautions because they have not had 2 negative tests, then you will want them to get tested before they come to your facility. However, if your facility has the capability and you have established a zone in your facility to take care of COVID positive patient, then you may be able to take that transfer. Both options are not conflicting, both may be true based on what your facility can handle. You are assessing from individual point of view is to whether you believe you can provide the necessary staffing, equipment, and your plan to set up the way you

believe you can handle that.

2. Re: the transfer flow sheet. It is wonderful but I have a couple questions. Says must have 2 negatives but we were told only 1 negative needed. With fever for 72 hours?
The statement on the form is directly taken from the CDC guidance. The CDC guidance is that you need to have 2 negative tests in order to discontinue their transmission based precautions, if you are going by the test based criteria. If it is based on symptom criteria, people need to have at least 7 days from the time of disease onset and at least 3 days when the fever goes away. It is not the right way to mix both test based criteria and symptom based criteria, it is advisable to choose either one of those. The symptom based criteria is really used in different scenarios, discontinuation from home isolation, for people to be able to go back to work because of the highly vulnerable population in LTC, we are relying on the test-based strategy to determine if it's safe for somebody to go back. So that is why we focus on the test based strategy to make sure that someone who is going to go back to the facility does not feel that they can manage the transmission based precautions. 2 negative tests as opposed to 1 negative test is primarily because there have been a number of situations where someone said negative, positive, and then a negative. So, we want to make sure that the negative is truly negative at the end of when somebody has been positive. So, in this scenario for a situation of someone who had tested positive, returning to LTC with the facility doesn't feel they can't handle the positive patient, it is 2 negative tests that are required at least 24 hours apart.

3. There was guidance given yesterday by DHHS that if an employee was COVID positive, they may continue to work as long as they wear a mask. Could you clarify?
If there is a situation where a healthcare professional has been exposed and they are asymptomatic, only if all other staffing options have been exhausted, they can work as long as they are masked and as long as daily monitoring of fever and symptoms occur before they begin work. Ideally, if someone has been exposed and is asymptomatic they can work, but cannot work if positive. If someone is positive, then you can either use the test-based strategy that we talked about above or you can use the symptom-based strategy as to when that healthcare professional can go back to work. COVID positive worker if not cleared of the infection either by test-based or symptom-based strategy shouldn't be coming to work.

4. If a nursing facility utilizes staffing agencies and there is an agency worker coming from out of state such as Iowa, do they need to quarantine for 14 days?
Ideally, yes. But again, if there is a staffing issue that you bought travelling nurses in as you don't have enough staff, I would consider that person exposed potentially and then handle that as if they are an exposed healthcare worker. That means if all other staffing options have been exhausted, then they would work masked, but actively monitored for development of fever or other symptoms prior to working.

5. What is the recommendation for facilities that are smaller and at full or near full capacity (one open room) so they are unable to establish any of the zones discussed?
As mentioned earlier, these are recommendations but not mandates. This staffing plan is just an attempt to stop spreading the infection from one place to another. If the facility is smaller, you can still establish a red and yellow zone easily. The least you can do when a person comes back positive is to designate that room as a red zone so that everyone is aware of it and follow the

needed precautions. Dedicate staff to the red zone and you can contain the spread to that specific room. The rest of the unit will be yellow zone.

6. If there is a room with two beds available for isolation, do you put one resident in there or two? What if one arrives today and COVID status is unknown and tomorrow another patient arrives and COVID status is unknown, can they go together? We were told yes.
In this scenario, if both are asymptomatic coming from the hospital, both belong to same transitional zone, and they have no known exposure that we are worried about, it would be OK for them to stay in the same room. For the people with unknown COVID status, you would also want to consider the presence of serious MDROs such as C. Difficile, it is not advisable to place the person with C. Difficile infection with another person.

7. We isolate new admissions d/t coming from hospital and do not know if exposed. We are low on isolation gowns. Are gowns still needed if they are not symptomatic? The Gowns are now very hard to get now.
It is hard to answer. Ideally, yes. You are trying to avoid in case that person becomes positive for COVID which we don't know. But there are chances that it can happen. We are trying to avoid transmission here, wearing the mask by itself decreases the chance of transmission. You could also wear eye wear with masks for increased protection. If you are running out of gowns, choose an alternate option of reusable cloth gowns. It is not 100% needed, but highly recommended. If you have shortage of gowns you definitely want to reserve those for the activities where you would have very close contact with the residents or you would have soilage that you wanted to protect your uniform from any kind of fluids. It is important that you try to cautiously use gowns and try to preserve their supply.

8. If we have a resident who has tested positive and we have to move that resident to a "red" zone how do we move all their belongings i.e. lift chair, pictures on their walls etc.? When moving residents to other units depending on their level of exposure, what is your recommendation regarding how to handle their possessions and items in their rooms, moving it all safely through the facility and avoiding contamination?
As far as we know, some facilities have been moving the patient and packing up their belongings into different packages and then leaving it up until they are cleared off and set the room back later on. Everyone's approach might be different based on facility decision. We have worked with once facility in the past that they were able to use reusable totes and they cleaned items before they put them into the totes and those items were pushed towards the hall as clean items and then staff in the hallway could move a clean tote through the hallway and then at the point that the resident would come out of isolation, you could use a similar process. With that same facility, they also bagged curtains, linens etc., considering they were dirty, cleaned them right away, transferred them like they were dirty and then only took them back when they were clean. The totes are a nice option because they can be cleaned before and after use with a disinfectant.

9. If a facility is requiring all staff to wear N95 masks when in close contact with residents, are these recommendations any different?
The recommendation is to wear a surgical mask if there is no COVID-19 resident in the facility. If you are trying to figure out the difference between COVID-level precautions versus this

recommendation, that they are already taking, the difference is that it is not only the N-95 mask, it is also the gloves, gowns, eye protection that goes along with that. We are working with some facilities who are given N-95 masks when they are working with their local health department because there are positive residents in the facility and so we think that the N-95 masks would be worked in to the red and yellow strategy and they would be really important for the isolation of red and yellow residents. Perhaps, the surgical mask would be more appropriate for green zone. In lot of facilities there is no green zone, and so N-95s would be one for all, because the residents in the facility are only yellow or red. In other words, if a resident is COVID positive, it is necessary for the staff to wear gloves, gowns, and eyewear in addition to N95s.

10. What type of PPE do you suggest in the Gray zone? What is recommended PPE for staff providing care to a YELLOW Zone resident?
Ideally, you need to have gloves, gowns, and eye wear. If no gowns, at least masks, and eye wear are recommended. Ask the resident to wear masks if possible. When in close contact, consider using gowns in the gray zone. The PPE for yellow zone is also the same—masks, gowns, and eye protection. If you run out of PPE, you may want to reserve it for close contact activity like changing clothes or briefs.

11. Can we get a link to this leading age document?
Below is the link to the NE leading age website. Please look for the form on the right side of the webpage labelled "Transfer Assessment Flow Chart" under COVID-19 resources.
www.leadingagene.org

12. If a GRAY Zone resident ends up COVID Positive, does that change the GRAY Zone to a RED Zone, or does the GRAY Zone resident physically move to an identified RED Zone established in another area?
It depends. If you have already identified a red zone in your facility, then you can move that patient to the red zone. If you have not already established a designated red zone, then you can actually turn that transition zone to red zone right away. I there are patients in the transition zone already and they are not exposed because of extreme precautions, because there is no transmission happening, they may not need to be considered additionally exposed. They might continue to be there as a yellow zone but if the patient comes back as positive, that room should be changed to red zone. Red and yellow can be in the same transitional zones. But if you think that there might me transmission happening, you can designate them as yellow zone.

13. Will there be copies of the slides that can be printed off?
The slides can be accessed at this link
https://icap.nebraskamed.com/covid-19-webinars/

Responses were provided based on information known on **4/23/2020** 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 4/23/2020

1. Is Ambu bagging enough protection for staff/resident during CPR?

Patients with COVID-19 or suspected of having COVID-19, staff should be wearing full PPE and
that includes gloves gowns, mask, and face protection. There will be lot of aerosol generation with the use of ambu bagging. There are some guidance out there that talks about rapidly incubating and not doing prolonged bagging. In addition to residents who are suspected of COVID-19 or confirmed COVID-19, if a person rapidly declines and arrests, we should be suspected that something else is going on and that would be a time to don full PPE as if a person is having new symptoms.

2. We have a provider who will not order COVID testing despite symptoms. Can we get an order from our medical director to test? Can we be penalized if we do not test a symptomatic resident?

Yes, if a PCP is not ordering test for a resident who has COVID-19 symptoms, the medical director has the right to order that. We are in a mode right now, where we are encouraging wide use of COVID testing when there is even a mild degree of symptoms and we have broadly defined COVID symptoms. So, in a LTC environment it's troubling to me when someone would hesitate because of the consequences for the broader patient population, so you have to follow your chain of command but the clinician should order it, the PCP or the medical director of LTCF. If you feel like, you are still not making headway call Dr. Tom Safranek, he can arrange to get a test ordered. The number one thing is to be on a look out for patients with respiratory symptoms or COVID like symptoms and to isolate those people immediately. There was a LTC facility in Papillion who had a rehab patient transfer from an acute care hospital in Omaha and the day after arriving that person developed symptoms, they probably instituted isolation precautions. They had 8 providers, medication aides and nurses who delivered nebulized respiratory therapy over an 8 day period, but they all wore proper PPE. We followed those individuals and tested them, none of those individuals developed COVID illness and since the patient was isolated, and no other patients in that facility developed COVID illness. It is very important to respect the isolation and PPE guidelines.

3. Do all residents need to wear face masks when out of their rooms or just dialysis residents?

As of this point, it is better that everyone who should wear a face mask, should do. Staff that are in clinical areas or are going to come in contact with a patient, should wear a surgical mask, residents can wear cloth mask whenever possible. Residents with suffocation or trouble breathing or who cannot get their mask off on their own, shouldn't be wearing a mask.

4. Do dialysis resident's need to be in isolation d/t leaving facilities routinely to go to dialysis?

This is the time where you can make use of transitional zones. It is possible that on way to dialysis center or back, resident can contract the virus and end up transmitting in the facility. That's why it is important to have a transitional zone and staff should make full use of COVID level PPE.

5. So if you have no residents with symptoms do you still have to use surgical masks or can you use fabric?

Yes, you still have to make use of surgical masks even if your facility has not seen any COVID-19 patient.

6. Can we use patient gowns as isolation gowns as they are short sleeves? Gowns are very difficult to get.
We have talked about in previous webinars about using the short sleeved gowns to supplement the good isolation gowns with long sleeves. You could prioritize the long sleeved gowns for those high contact activities such as bathing, changing briefs, or repositioning s resident. You can save the long sleeve gowns for those things but for really low contact activity, we think that as a crisis intervention, kind of one of the last resort items, you could try to use the short sleeved patient gowns. In communities where there is good volunteer support, you could also request volunteers to help you sow sleeves onto gowns, we heard that one facility had done this with good success. So, may be for facilities who have not yet started having cases that would be an avenue to try. But, we think the cloth gowns certainly don't replace the healthcare grade personal protective equipment but, you could use them to supplement lower contact activity. Strategies for optimizing supply of isolation gowns:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/isolation-gowns.html

7. I'm seeing a few facilities in Grand Island still doing non room activities. Are residents okay to be out in a dining room for activities if under 10 people and 6ft apart?
We strongly discourage any out of the room activities or group activities as of this point. We understand that there may be some situations and scenarios where it is really hard to implement. 6ft is just a number, there may be chances of spread beyond this depending on various factors such as air flow.

8. I understand the Governor has authorized a site to sign up for testing? Up to 3000 a day? Does this include Antibody testing, as well? Would you expand on this please?
We are working on having an additional vendor provide lab testing. We believe lab testing would be what you might say open to the public where an individual can self-refer and doesn't really need a doctor's order. We are working on the logistics of that and where those specimen collection stations will be located. The promises allegedly that they can do 3000 lab tests a day, the details are not finalized. It is probably going to be another 10 days, sometime around May before the testing becomes available. Anybody who wants testing right at this point in time, we have excellent turnaround time. Anyone involved with a LTC facility gets a test paid for at public health expense at the Nebraska Public Health Laboratory, there should no inhibitions on getting lab testing at this point in time.

9. What is the number that we should call to notify ICAP? Also we have been instructed on the Governors call not to notify Licensure--do we or do we not?
ICAP can be reached at 402-552-2881. We are about to post a document on our website that talks about the afterhours. It would include contact information of our IPs. It is required that facilities particularly rehab and SNF must report positive COVID cases to regulatory. That was also reinforced by CMS early this week that those results are meant to be going through CDC. We may be able to put a link on slides with information on that. There was an instruction early on in the Governor's calls, where he was trying to get people to focus on reporting to the LHD and then the LHDs would provide necessary information on to licensure. I think since that time,

because of some direction that has come out specifically from licensure area and also with the CDC reporting that has changed. So, if you do have a presumptive or positive case, they are asking you to report to both the LHD and to Connie Vogt through that form that her team has made available and to contact them and let them know that. So, that has changed over the last month as to that reporting guidance.

10. What is the recommended PPE in the gray zone for these new admissions? Yellow zone staff just wear masks, correct?
Ideal recommended PPE for the gray zone includes gloves, gowns, face mask, and eye protection. If you have PPE shortage, at least when you are doing high contact activity or performing aerosol generating procedures, make use of full COVID level PPE. For low contact activity, you should still have your mask and gloves on. The PPE for yellow zone is also the same—masks, gowns, and eye protection. If you run out of PPE, you may want to reserve it for close contact activity like changing clothes or briefs.

11. Do you have the checklist format available for use for identified resident and staff along with testing recommendations to send out?
https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/04/Actions-needed-to-betaken-upon-identification-of-a-COVID-19-case.pdf

12. Does ICAP understand that in nursing facilities and assisted livings, that creating zones is very difficult as people LIVE in their rooms/apartments for years and have all their belongings? Also, to relocate these people to create zones could lead to increased fall risks, etc. due to dementia and other factors?
We understand that completely. Please reach out to ICAP if you need help on this. You can create a signage where the room itself can become a zone. You can have multiple red, yellow, or gray zones. It may not be concentrated in one place, but if you are doing something like that, you need to be very careful on how you staff these rooms. One big advantage of having those together is that you can have a dedicated staff for that particular zone without possible chance of contamination through the facility.

13. Could you provide the website for application of PPE?
https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/03/COVID-19-PPE-PrintablePosters.pdf

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Responses were provided based on information known on **5/14/2020** 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 5/14/2020

1. I oversee four assisted living facilities. The struggle we are having are residents returning to the gray zone. Any resident who goes out for dialysis, a doctor's appointment, an ER visit, rehab stay for issues not related to COVID are going in to a gray zone, which is the resident's own apartment, where we are assigning staff to care for only residents who are in the gray zone. Since this is assisted living these residents may only need help with

bathing or dressing or even less than that. We are running out of staff to take care of residents in the gray zone. We encourage telehealth but sometimes this isn't appropriate based on the reason for the visit. I would like guidance on the necessity of admitting residents to the gray zone solely for going to a doctor's appointment. For residents coming back from inpatient stay at the hospital or rehab, we can request a COVID test before discharge, but that only shows they are not positive on that day and isn't a guarantee. How are we to keep up with this?
You don't have to dedicate staff to each patient in a gray zone (see discussion and slides earlier in the presentation). You just need to be sure they don and doff PPE and do proper hand hygiene before leaving that area. One staff member could take care of all the gray zone patients, even if they are in different places in the facility. There could be a different risk in each of these circumstances, but there is some amount of risk each time a resident leaves the facility and comes back. Risk of community transmission can depend on whether there is COVID-19 in the county. Those things can also determine the risk of getting COVID 19 in your facility. The gray zone in your facility is not a mandate by CMS or CDC, but it is a strong recommendation. We recommend that you use the gray zone for anyone who has left the facility. If your choice is between not having a gray zone because of lack of staffing or having one person staff all the different gray zone rooms, then we recommend having the one staff member take care of all the gray zone rooms, using appropriate hand hygiene, proper PPE, donning and doffing, etc.

2. What is the zone suggestion for a positive resident who was transferred to the hospital is tested at the hospital and results negative? What zone do we bring them back in?
Once someone is positive, you need to know when they can come out of the red zone in long term care. The CDC prefers test basis strategy, although they now allow symptom-based strategy. But you still get the sense in the documents that for highly vulnerable individuals, they do prefer either extended duration for symptom-based strategy or a test-basis strategy. A resident who has tested positive, and then are asymptomatic for 3-5 days, then they can be tested to see if they are negative or not (usually it is recommended to retest 10 days after the positive test, if they have been asymptomatic for 3-5 days). If they get a negative test then, you can retest in 24 hours apart, and get another negative, then they can come out of red zone isolation. However, if you don't get a negative at that point, you will have to retest until you get the 2 negatives before bringing them out of the red zone. This person, who was positive, went to the hospital, they might be still be having symptoms and that is what caused the hospitalization, so they shouldn't be tested until 3-5 days after symptoms are over. If the person who had a positive first had symptoms resolved, actually was hospitalized for something different like a fall, then one test by itself still doesn't get them out of isolation. It still takes 2 tests to do that.

3. What is the best method to transfer a symptomatic resident into the red and light red zone areas to protect the yellow and green zones?
Transmission based precautions are needed. The resident should wear a mask. The resident should be clean and contained. Wipe down a wheelchair (including wheels), put a clean blanket on the resident. The person moving the resident should remove their dirty PPE before leaving the resident room. They should doff their gear, put on clean materials for transport or they could hand off to a clean person new PPE to move the patients. This is the same as you would have done before for C Diff, etc.

4. Are you recommending N95s for all encounters in Red and Yellow zones, or just for aerosol generating procedures?
If you have N95s, we prefer using them. The CDC guidance does not require them, but it does prefer N95s. If you don't have enough N95 masks, then surgical masks are fine. But for aerosol generating procedures, you should use N95s. These are preferred in the red and yellow zones all the time if you have enough of them. Nebraska DHHS has improved its supply line in the last 2 months and it is worth long-term care facilities trying again to use the online form and request them. There are also now reprocessing facilities available across the state for N95 masks (here is the ICAP website link: https://icap.nebraskamed.com/wpcontent/uploads/sites/2/2020/04/UV-Light-box-locations-in-Nebraska.pdf

5. Is it acceptable to isolate a hospital return in private room with private bathroom versus a dedicated gray zone? If you only have a couple grey zone residents and can't dedicate 2-3 staff members to care for only two residents, do you have any recommendations outside of good handwashing and PPE practices?
If there is a transition zone set up without private bathrooms in their rooms, but if there is an alternative of a private room with a private bathroom, you need to remember that the transition has to be a single person room (single bathroom preferred). Even if you have a two bed room, you consider just using the one bed in the transition zone. If you can't do this in the transition zone, then the next best option is to go ahead and use the patient's own private room with private bath and make that a transition zone room for 14 days with dedicated staff for that patient (ones who work with other transition zone patients only).
We just recommend the good hand hygiene and PPE practices that you mentioned. The only other suggestion is to plan to do as many different tasks in the room (batching them) as you can

6. Do you recommend closing resident room door when administering an aerosol treatment in a COVID free facility? Do you have any thoughts on how to handle a roommate that resides in same room?
In a COVID-free facility, you will follow the same guidance you do under normal circumstances. You don the PPE, wear facemasks and eye protection and be sure to pull the curtain between that patient and the other patient in the room. The best practice, because nebulizers do generate some aerosolization, you want to keep the door closed if possible. Even in the absence of COVID, it is good to close the doors because there is always the chance of spreading influenza, etc. This isn't an urgent issue right now, but when things improve (a year from now?) you might want to put something like this in policy then. But remember the best practice is always to close the doors during these procedures when you can.

7. We are a skilled facility attached to a critical access hospital. If we have a resident who is hospitalized for a non-COVID reason and the hospital does not have any COVID patients and the resident is in the hospital for 14 days and the resident does not have any signs and symptoms of COVID-19, do we have to put him in the gray zone when he is readmitted to our facility?
If the patient was in the hospital for 14 days and there has been no exposures, then that counts as the quarantine time. These kind of situations need to be considered case-by-case basis.

8. What are your recommendations for a resident with dementia who wanders who is going for
outpatient surgery tomorrow? Results will come back to us and guided to the gray zone. We will do our best to keep this resident isolated, but this lady literally paces the halls all day long, and is not competent enough to understand isolation. We have no positive cases or suspected cases in our facility, and we have no confirmed cases in our county. She will be going right next door for the surgery. Can you share any guidance in this circumstance?
We understand this will be a difficult patient to isolation. Try to minimize as much exposure to others as you can. This situation is not unusual for memory care units, whether or not there is COVID present in the county. Do your best.

9. So you have developed these zones for our residents who go out to appointments, so how is this any different for our staff who go to Walmart and out and about outside of facility, and come to work and go into and out of resident rooms?
When a resident goes out to a healthcare appointment, into hospitals and clinics, that resident will be entering a higher-risk area, with more chances of exposure, because there are higher chances of encountering sick people there. Healthcare workers have the responsibility to be extra careful to avoid exposure for the safety of our patients, especially for this very vulnerable population in the nursing homes. If we come into contact with COVID-19, it might also be the residents of our nursing homes who pay the consequences. Remember that and be extra careful in going out, maintaining social distancing, doing hand hygiene, using masks and PPE, etc. Our healthcare professionals have more knowledge about the risks, and do even better than our residents might do when they leave the facility.

10. How should therapy services be handled for a Medicare Part A resident (no COVID diagnosis previously) who has been admitted from the hospital and in a transitional gray zone room?
If it possible that the person can get therapy in their own room, it is best. If that is not possible, maybe they can get therapy last on the day's schedule to clean well afterwards and not risk infecting other residents. DHHS says to remain on Medicare Part A, they have to meet their therapy goals to continue to be qualified. She agreed that in-room therapy is the best option, with the second option of placing them at the schedule for therapy the end of the day if they have to go out to a therapy room; surfaces would be thoroughly cleaned afterwards.

11. Question from Chat Box: What is CMS saying about current rules for residents leaving rooms for activities?
Connie Vogt of DHHS clarified that if there is no COVID-19 in a facility (staff or residents) and no people with respiratory infections; residents can do communal dining staying 6 feet apart (maintaining good infection control processes and social distancing) in the dining rooms.
Restrictions have not been lifted for activities because these are usually high-touch things like bingo, cards, etc. To be creative, you could try listening to music or have a sing along while they are out for dining, things that are not high touch activities. There is no word from CMS when regulations on residents leaving room will be relaxed. It may be hard for some dining rooms to accommodate this because of close quarters.

12. Where are the slides posted after the call?

https://icap.nebraskamed.com/covid-19-webinars/

Responses were provided based on information known on **5/21/2020** 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 5/21/2020

1. Our facility has had no COVID-19 cases and our county has very few cases. I know that CMS is now allowing facilities to restart communal dining with 6 foot distancing. This is very difficult to accomplish, as most tables are only 4-5 foot square tables so that means one resident/table. Like everyone else, we are seeing weight loss and increased depression among residents. We are considering starting communal dining again but are struggling with how to accomplish this without having four separate dining times, which is not feasible. My question is can we have residents that are roommates sit together at the same table since they share the same bedroom and bathroom?
No. Even in a shared room, there are curtains that provide some kind of source control between residents, but that isn't possible at a small dining table unless you have a Plexiglas barrier installed on the table. We understand the issue; one possible solution might be to some of the residents out for dinner and some out for lunch, so everyone gets out once a day but the 6-foot distance between people would be maintained. With current restrictions, that is the best option. Response from webinar viewer via email: In our teams discussion we have thought about adding a bedside table at each table (when moving in that direction), this makes the 6-foot distance between residents.

2. Do you feel it is safe for dietary aides to enter into a room in a green zone to hand sanitize before entering, present/set up the residents food in the room and then sanitize hands and serve a resident in the next room? Or do you feel it should be the dietary aide staying outside the room and then the nurse or nurse aide presenting/ setting up the food for the resident in the room?
When possible, have as few staff members enter the room as you can. In a red or yellow time, the dietary aide entering the room would need PPE and that is in short supply. You might be able to use the dietary aid to remove the trays from the clean cart and hand them to the staff member in PPE to give to the residents. We have seen cases where dietary aides have been positive and residents positive, so we don't know who has transmitted the COVID. If you could eliminate the need to expose residents to that one additional worker, that's the best choice. This is true in the "yellow" zone, but in the "green" zone you could have the dietary worker take food into the room, so long as that worker is aware of using hand hygiene, etc.

3. If a resident that tested positive and was in quarantine for 14 days and a repeat test on day 14 is still positive, what type of isolation does the patient need to in at this time? What PPE is necessary?
That person still needs to be in full COVID-level precautions. He needs to be in the red zone, using red zone PPE. You need to get two negative tests, or go the full 28 days with the patient asymptomatic for more than a week before you can take them out of isolation.

4. With potential needs for testing for Nursing Facility residents and staff, what are ICAP's

recommendations? I am hearing of some facilities where there are being teams deployed to do testing of the entire facility. Is that testing something that is being done through DHHS?
We have heard of some facilities choosing themselves to do a point prevalence study inside their facility, hiring a contractor and getting testing everyone. That was not the recommendation of the state DHHS. In other places where the National Guard has done testing in the whole community and a high number of COVID positive cases are found with a high rate of transmission, we have heard that the National Guard has gone into a few facilities and done that testing. There may be some situations in high-risk communities where that has happened, but at this point, there has not been wide-spread, large-scale testing across the state and there has not been a recommendation on that.

5. I am hearing COVID positive staff in other facilities say they experienced fatigue and some gastrointestinal disturbances. Is this a symptom we should be focusing on, in addition to respiratory illness, as a strong indicator of suspicion of COVID?
We are continually seeing updated listings of symptoms to watch for with COVID. Here is a link to the latest guidance we have on our ICAP website:
https://paltc.org/sites/default/files/Active%20Screening%20apr%2028_revised.pdf.
This screening tool was written for residents but would also apply to staff. Fatigue, body ache, loss of taste and smell and even headache are all symptoms that have been added to the screening guidance since it was first written. If you see those symptoms in a staff member, you should stop them from working and test them.

6. If half of the hallway of dementia residents tests positive would you consider the whole hall a red zone? The residents all have dementia and would not be compliant with isolation.
There are different ways to handle this. Some facilities were able to build some type of partition within that memory zone so the red zone patients are one side of the partition and yellow zone patients are on the other side of the partition. Making the whole unit as a red zone can make sense, but you need to be careful. In the red zone, we have suggested that someone working in the zone could wear the same gown going from room to room (i.e., dispensing medications). But if you have patients who have not tested positive for COVID living in that same red zone, you can't employ the same red zone strategy of using the same gown throughout the unit. If you call it a red zone, you might not be able to follow that same reuse of gowns strategy. You still want to try to establish the most separation as possible between the positive and negative residents in the unit. You are still trying your best not to have transmission of COVID between positive and negative residents. There is a guidance for memory care unit
https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/caregiversdementia.html
but remember that this red zone is not the same one we typically discuss on calls. It will require a modified strategy. You have to be careful in the hallway and wear your eye protection and N95 masks in the hallways at all time. For residents, still try to differentiate between the yellow and red zones.

7. Is it acceptable to store a designated employee's cleaned/sanitized face shield(s) in a grey zone resident isolation room if it is near the entrance and more than 10 feet away from the resident care area? Do the face shields need to be brown bagged individually after they are cleaned?
If the question is if you can store clean patient care equipment in a resident room when the

patient is there, you should not do that. If you are using a resident room with no patients in it as a clean storage room, you could do that. You still need to follow basic infection control principles of not storing clean and dirty items together. Even in a brown paper, the face shields should be stored in a break area away from patient care. Before you start your shift you put on your clean shield for the day.

8. Why do you think that more facilities are not taking advantage of the UV light disinfection?
The UV light disinfection is a very new process and not all facilities know it is available. Facilities also have to come up with a transport system, but that could still be a barrier. We want to know from facilities if there are other barriers to using the UV disinfection. Please email or call during office hours to give ICAP this information. (Chat box input was invited here).

9. When are you considering to letting up on the lockdowns of facilities? What do you want to change to start considering this? Residents and families are asking this every day.
CMS has announced a guidance that is currently being reviewed by Nebraska DHHS licensure staff. Part of the CMS guidance allows state authorities to make some of these decisions based on COVID cases in the state. Don't expect visitation to start tomorrow; it is listed in CMS guidance as coming in Phase 2. The state will be announcing that after consideration. There may be some phased in loosening based on testing strategies, etc., but that information is not available yet. We hope to add this information to the transcript after we contact the DHHS if they are ready for us to announce it.

10. Leading Age developed the Post-Acute Transfer COVID 19 Assessment for residents transferring from hospitals to nursing homes. Are there guidelines for how often to test those patients who are in/out of hospitals frequently? If they are tested in hospital and are negative, come to the nursing home, then go back to hospital for a few days, then come back to the nursing home, should they be tested with every hospitalization even if it is in the same week as their first negative test?
Testing depends on what symptoms are causing them to be hospitalized. Are they going in to be treated for a fall, or for symptoms that might come from COVID-19? If they are going in for COVID-19 like symptoms, then they need to be tested. If they are going in for a continuation of an earlier hospitalization or other issues, then they probably would not need to be tested. Even the Leading Age algorithm doesn't ask for testing all the time, just for certain symptoms.

11. If we have someone from our staff doing the COVID-19 swabbing to obtain the baseline testing– what happens if someone they swab comes back positive? Will the staff member who did the testing be required to self-isolate because they have a known exposure? The employee would be in full, appropriate PPE when doing the swabs.
If the person is using the appropriate N95 facemask, gown and gloves, there is no exposure you are considered fully protected and you should not be required to stay away from work. CMS guidance recommends that if you are in a two-patient room, only one of those patients should be in the room during the testing procedure. The healthcare worker would be protected by PPE, but the other resident would not be predicted.

12. In our independent and assisted living environments, we are experiencing challenges with a couple of things. People are being discharged from one health system while still testing positive and not notifying anyone in the community of the discharge or the situation. In other health systems, they are not discharging patients until two negative tests. What is the best practice that we can ask for to keep our residents and staff safe? In a recent situation, it involved two county health departments as well.
The best way to deal with that is to educate the patient who is being discharged home. Give them very clear guidelines about when they can come out of isolation. The local health department should always be informed. If the patients are being discharged to another local health care jurisdiction (while the discharging hospital is in a different local health department jurisdiction) that communication is essential to protecting everyone. There is no need to keep a patient in the hospital until there are two negative tests for COVID. The patient can be discharged safely and self-isolate so they don't need to stay in the hospital.

13. I am not seeing the printouts on the website for this webinar
Sorry for the delay in posting; here is the link: https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/05/COVID19-and-LTC5.21.2020-FINAL.pdf

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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. 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 Health Care 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/UVLight-box-locations-in-Nebraska.pdf
- Nebraska Medicine COVID-19 PPE Guidance Extended Use 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-UseReuse-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 masks). 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 Health Care Association/Nebraska Hospital Association resource/algorithm for testing and admissions: https://icap.nebraskamed.com/wpcontent/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.

Responses were provided based on information known on **6/4/2020** and may become out of date. Guidance is being updated rapidly, so users should look to CDC and NE DHHS guidance for updates. Nebraska DHHS HAI-AR and Nebraska ICAP Long-term Care Facility Webinar on COVID-19 6/4/2020

1. Regarding the COVID planning tool, which is due June 22. There are a few items I hope you can clarify.

a. Access to adequate testing: Can you tell us what our steps are in identifying this answer?

You have to write a plan on what access you want to use. If you have a private lab, that is your access. If you will be working with the local health department, you need to check with them on what will be their process. If you have to set up an account with NPHL (Nebraska Public Health Lab) for testing, you will want to do that. Then, in the COVID planning tool, you will identify which process you plan to use. Also, you will want to identify who will do the test. You need a plan, listing who will do the testing, It can be a nurse from your own facility trained to do the test. For assisted living facilities that might not have a nurse on staff, you need to have a plan to use a contracted person or perhaps someone from the community or local hospital who could do the testing for you.

b. Other than the facility having a plan in place to do the testing themselves, is there a way to ensure that testing will be available through other vendors? We have had Bryan Mobile lab do testing at one of our communities a couple weeks ago but I don't feel this is a guaranteed service if we would have an outbreak.

If there an outbreak (or a case in your facility), you will have to notify the local health department and state licensure. When you notify the local health department, they usually do provide you some guidance on testing, whether by themselves or in cooperation with the ICAP team, they will usually supply you the test materials you need for outbreak containment. That will be the process in those cases (usually).

c. Local hospital capacity: Ability for the local hospital to accept transfers from nursing homes. How are we to ensure this?

Many health departments have developed some dashboards and are keeping tabs on

the bed capacity in their local hospitals. Your local coalition or local health department should have this information. If you are seeing a an increase of cases that is overflowing your hospital capacity, your plan should be rolled back the restrictions. Even an increase in numbers should be enough to make you consider putting back some restrictions, because your staff could be exposed, too. You need to keep monitoring the situation.

d. PPE requests: Is there a way to know if county health department can keep up with our PPE requests?

We have heard from the state health department that they have enough PPE to fulfill the requirements right now. Since the state health department has it, the local health departments can reach out to them for PPE. We still have to know our burn rates, to keep the local health departments informed. We still have to fill out our PPE requests and ask for the current two-week's PPE. A facility should be prepared with enough PPE on hand at least have enough PPE (obtained through your normal channels) if there is a positive case in your facility and you need to place everyone there in PPE (at least 2 days supply needed for that). Calculate the amount of PPE you would need to put everyone in the facility in an isolation gown for two days and make a request so you have that on hand. It might take that much time for the local health department fill your immediate needs in that case.

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

2. We are wondering about the facility testing that needs to take place. What happens when asymptomatic staff and residents refuse to be tested? Will the facility be penalized if staff refuse to be tested? How should the facility deal with or cope with staff who will not be tested?

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

3. We completed mass testing and all residents were negative. One employee tested positive.

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

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

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

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

restrictions.
Our recommendations are based on best recommendations and our desire to help facilities keep COVID out of their buildings, where it can be so difficult to control once it is inside a building/facility. In short, as of now, we still recommend anyone who goes out should come back into the quarantine (grey) zone. Later you will want to look at the different factors of the type of appointment, community rate/spread of COVID and then come up with your plan on which patient goes into grey zones.

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

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

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

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

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

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

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

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

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

2. Is nasopharyngeal testing and or antibody testing specific to COVID-19 or just coronavirus in general?
This was discussed in a different webinar presented by Dr. Trevor Van Schooneveld last week:

(slides: https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/06/COVID-19-CAHSlides-w-QA-6.2.2020.pdf) Testing for the common cold is not the same as COVID-19 testing, which is specific. The antibody test is also specific to COVID-19, but is not recommended at this time, it is not helpful right now.

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

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

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

6. Is it acceptable to allow staff to self-screen prior to reporting to work area versus staffing a "screener" IF they have demonstrated competency of taking temperature and

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

7. Can we cover the N95 masks with a surgical mask in the gray zone to save the N95 masks?
You could use a face shield over the N95 masks to keep them from being soiled. Face shields can be disinfected and used again. However, a surgical mask being used over an N95 mask would be a waste of PPE. The surgical mask would make it more difficult to breathe through the N95. A face shield is better. As part of a phasing document, you will want to get to a point where we are no longer at crisis level measures of PPE. We want to get to the point either where staff are wearing the PPE for fewer shifts, because there is more available or because it is working to do the UV light disinfection of N95s. If we are that short of N95s, it needs to be elevated and talked about at a state level, because it should be a consideration for phased reopening.

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

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

10. Can I alternate between two N-95s--using one for one shift and then storing it in a proper paper bag and using my second N-95 and then going back to my first N-95 for my next shift? We are essentially alternating between the two N-95s to preserve PPE.

That is a good strategy in crisis-level PPE availability. It is a stopgap. We think facilities should be looking ahead to the next phase, because it shouldn't be the practice forever. We encourage facilities to be thinking about reprocessing those if that is available in your region (send off for reprocessing between uses; maybe have 3 of them for each staff member to cycle through). As we move forward we hope to get to a point where the N95 masks can be used for one shift and then discard them if reprocessing is not available to you. One effective strategy to mitigate the contact transfer of pathogens from the respirator to the wearer could be to issue each HCP who may be exposed to COVID-19 patients a minimum of five respirators. Each respirator will be used on a particular day and stored in a breathable paper bag until the next week. This will result in each worker requiring a minimum of five N95 respirators if they put on, take off, care for them, and store them properly each day. This amount of time in between uses should exceed the 72 hour expected survival time for SARS-CoV2 (the virus that caused COVID-19).3 HCP should still treat the respirator as though it is still contaminated and follow the precautions outlined in CDC's re-use recommendations.
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

11. Will all future new hires need base line testing?
If the new hires are coming in before reopening, they will need baseline testing. If they are coming in after reopening, they would be subject to the same daily screening and self-reporting asked of other workers, who are coming in and out of the facility and going out into the community and facing the same risks as the new hire.

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

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

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

of the reasoning for testing that the staff members will change their minds and allow testing.

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

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

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

Responses were provided based on information known on **6/18/2020** 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 6/18/2020

1. For KN95 respirator use, do you have to be able to get a face seal? We have seen problems with these and sealing.
Anytime you are wearing a filtering face piece respirator, you do have to do a seal check. Here is the N95 mask seal check video link: https://www.youtube.com/watch?v=pGXiUyAoEd8 The seal check consists of holding the mask tight to your face and making sure you don't have air billow out around your face or suck in around the respirator. If you can't get a seal check, then you don't have respiratory protection. If you can't get a seal check, then the respirator is only acting like a procedure mask. Some healthcare workers have difficulty getting a seal, but if you can't get that seal, then you should not wear the mask for airborne precautions.

2. Can the K95 respirator be re-used utilizing the CDC recommendations of placing them in a paper bag?

Yes, they can be reused. CDC states that when you put it into the brown bag for reuse, the CDC wants that respirator to sit by itself for 72 hours. That is the length of time the CDC has found it needs to be alone and then any virus on the mask is dead. You need to have enough masks to cycle them through and have them sitting alone for 72 hours.
Here is the CDC Language:

> "…One effective strategy to mitigate the contact transfer of pathogens from the respirator to the wearer could be to issue each HCP who may be exposed to COVID-19 patients a minimum of five respirators. Each respirator will be used on a particular day and stored in a breathable paper bag until the next week. This will result in each worker requiring a minimum of five N95 respirators if they put on, take off, care for them, and store them properly each day. This amount of time in between uses should exceed the 72 hour expected survival time for SARSCoV2 (the virus that caused COVID-19).3 HCP should still treat the respirator as though it is still contaminated and follow the precautions outlined in CDC's re-use recommendations."

https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

3. If all newly admitted residents or readmitted residents in the grey zone are required to test negative before we admit them to our facility, do staff have to use N95's in grey zone or just use surgical masks with face shields instead?
They do have to use N95s. The [COVID-19] test [residents] have before they are admitted is just a single date in time. It means they were negative that day, but it doesn't mean they might not have been exposed, possibly by an asymptomatic healthcare worker at another facility. That is why for the 14-day period in the grey zone in your facility, healthcare workers should wear eye protection and an N95 mask. If you cannot get N95 masks, you first want to contact the state of Nebraska, because we have been told they have a good supply of PPE (including N95 masks) right now.
Use this form: https://form.jotform.com/NebraskaDHHS/PPERequestForm
If you were at a crisis point in your facility where you could not get N95 masks, you could use a surgical mask and a face shield, but ICAP prefers the N95 masks for protecting your staff. That test is not a guarantee that the patient is negative, just that they were negative at that single point in time. If you have worked with the state and local health department and still cannot get the N95 masks you need, please let ICAP know so that we can escalate this concern.

4. If we have our driver transporting a resident with symptoms, the resident is sitting in the back. Should just the air conditioning be on or windows down? Which is safer?
You need to consider your resident's safety and run the air conditioning on low fan speed in the heat. Anyone transporting a symptomatic resident needs to take precautions, so the driver needs to be wearing a mask. Vehicles might not provide for 6 feet of separation between the front and back, so you need the driver in full COVID PPE, including N95 respirator, gown and gloves. Make sure you are also alerting the staff at the destination you are going to, so they can protect themselves and be prepared for the situation. Remember to make that communication by a phone call, not an email or fax that could be overlooked.

5. Do you have guidance on how to help memory residents in ALF facilities to comply with masking to participate in the group activities? We are trying to remind them, but it is a constant struggle with some of the more advanced dementia residents.

ICAP understands what a difficult challenge this is, as you may not realistically be able to get everyone to comply with masking. You might find some of the residents who might think it is fun if you present them with a fancy printed mask and ask them to wear it. You could try giving them their favorite mask pattern. It will be difficult, and if that is a requirement for getting people together in a group, we're going to have some issues in that area. We don't have anything to offer right now. The CDC does have guidelines for memory support residents and facilities https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html so we recommend you really look through these guidelines for assisted living https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html regulatory guidance affecting assisted living, or the guidance given out by other regulatory groups. You could try a group list to find information and ideas from other facilities facing the same challenges. Try to use all those avenues to gain some insight on how we can better help memory residents with the task of how to keep a mask on. Even with phasing and reopening, if you are in a community where there is a fair amount of COVID, it might not be time yet to do group activities. That might be a point where you have to pull back to having residents stay in their room. You aren't required to go along with everyone else in reopening if it doesn't make sense in your own community and facility to do that yet. There is a lot of accountability on facilities to be aware of what is going on and how you can keep these residents safe.

6. We have a staff member who tested positive and was symptomatic. She was quarantined for 14 days. She was tested again per facility policy. Again, she tested positive, but this time was asymptomatic. Her baseline is a cough (is a long time smoker) and is taking antibiotics. With viral shedding impacting test results, at what point can we bring her back if she tests positive again?

If her symptoms are gone, it could be okay to let her come back to work. Your facility is not required to follow the test-based strategy (for your staff) and can choose instead to follow symptom-based strategy. We recommend at 14 days, even if they test positive if they have been asymptomatic for 5 days. If they show resolution of their symptoms, return to baseline, resolution of fever. They do have to wear their masks at all facilities.

7. The baseline testing guidelines are different depending on who is giving guidance. DHHS said test 100% of staff, it looks like you recommend not testing previously positive staff.

Testing 100% of the staff is right, but you can include those past positive staff tests in your total testing. You can guarantee what you will find that previously positive staff will be immune; a test on them might come back negative or positive, but that doesn't make anything. Recovered staff could test positive for a long time. You already know what the results are that you wouldn't quarantine someone who is recovered because they have recovered. You do need to retest all the staff who previously tested negative or unknown.

8. Do we have to change reusable gowns in the grey zones, or can the staff use the same gown?

In the grey zone, you will change the gowns after each use. If it is a washable gown, after each use, when you take it off it goes to the laundry.

9. The facility has a new admission in the grey zones - low contact - can the staff go with just facemask and hand hygiene and gloves?

The preferred PPE in the grey zone is glove, gowns, N95 masks and eye protection. If the gown supply is limited, we have allowed that facilities can reserve using gowns for high contact activities (like yellow zones).

10. How long do staff have to wear N95 after completing an aerosolized treatment?
In the grey zone, yellow zone and red zone, staff should already be wearing an N95 respirator, so, this question can only apply to aerosolized treatment of residents in the green zone. In the green zone and you don't usually wear an N95 masks for treatment, you need to remain in your respiratory protection until the particles are effectively circulated out of the room, which depends on the number of air exchanges in the room. Because you don't suspect anyone in the green zone is exposed or has symptoms, you don't need to worry about these procedures. But when you go into a yellow, grey or red zone, if you are wearing an N95 mask, just keep wearing it as you always do, for the whole shift. But if you do want to take it off, it depends on the air exchanges in a room. It is estimated that in many cases that is about an hour after the procedure is done. Here is the link and table for Airborne Contaminant Removal from the CDC Environmental Infection Control in Healthcare Facilities (2003) Guideline. Values apply to an empty room with no aerosol-generating source. With a person present and generating aerosol, this table would not apply. Removal times will be longer in rooms or areas with imperfect mixing or air stagnation. Caution should be exercised in using this table in such situations. https://www.cdc.gov/infectioncontrol/guidelines/environmental/appendix/air.html#tableb1

11. If I have multiple units in my facility, do you recommend that each unit has its own zone?
If you have one unit, you are unlikely to have all three – red, yellow and green. Most likely you will have red zones and yellow zones. It is always best to plan to have a dedicated red zone with dedicated staff and little traffic in the area. The yellow zone is where the exposure was and where you are moving the symptomatic people out. If space constraints make you have to have the red and yellow zones in the same unit, you can do it, but it is not the best strategy if you have alternatives available.

12. How many times can a N95 mask be worn individually before UV light sanitizer needs to be used. Then how many times can it be UV sanitized before you disposal of it?
We are aware of the problems of shortages, but we really want people to just wear an N95 mask for one shift; at the end of that shift it can either be brown-bagged or go in for UV light disinfection. One shift is our goal, and if we drive that usage down farther that is even better. Pre-COVID the general practice was use [an N95] one time and dispose of it, but if you don't have enough PPE for that now, we want to you to inventory your supply and request enough PPE for that to happen. In Nebraska the UV disinfection stations mark the masks as they are disinfected and throw them away after 5 disinfections. Even if you haven't cycled them 5 times through UV disinfection, if you get a mask back and you can no longer seal check it and get a seal, you need to throw that mask away.

13. How do you handle staff who won't test for COVID, especially if you have up to 50% of staff who refuse?
This is an issue of following the state guidance. In the state guidance document, it is outlined about how you handle declination of the staff. This is a licensure issue. They have clear procedures to how to handle this situation. Dr. Ashraf would try to educate the staff about how

important it is to test for reopening. If there is COVID in the community, there will be more chances of exposure and the staff needs to know about the importance of providing safe care to their residents. Education may help the staff to understand the need for testing.

14. In phase 3 of nursing home reopening, are the grey zones eliminated for new admission and readmissions?

Grey zones are not mandated, but if your community is seeing high number of cases of COVID; if your hospital and outpatient clinics are still seeing cases; based on your risk assessment, you may decide to continue to have a grey zone as a precautionary measure. You would want to document your reasons for continuing to have a grey zone. If you are not seeing COVID-19 in other healthcare settings or the community in general, you may opt not to have a grey zone.

15. Can a previously-positive person be re-infected with COVID-19 again? Are they assumed to be immune?

If someone was previously positive and is recovered (14 days have passed; the person is asymptomatic for at least 5 days) that person is considered to be immune for now, but we don't know right now how long they are immune. Dr. Ashraf has not heard of any reliable data that shows that a person can get COVID-19 again, but we don't have an "expiration date" on that. No one knows.

16. Do you have to use a different N95 mask to go into different grey zone rooms?

No, you do not. Extended use of eye protection and respirators are encouraged. There is no data that shows that viral particles can fall off the mask and infect someone else. You should be careful to always clean your hands after putting a mask or off or adjusting your mask because you can contaminate yourself or the environment with touch contamination. For residents in all different color zones, you can extend the use of respirator between rooms and leave it on until it is time for you to take a break. National guidance says this is safer to the healthcare worker because you still often touch your face, so cleaning hands often is very important.
See Extended use of N95 respirators at https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html

17. Do staff need to be wearing face shields and goggles when performing aerosol generating procedures if you have no COVID-19 in the facility and residents have no signs and symptoms?

No, that is not a requirement in the green zone because people in that zone are assumed to not be exposed.

18. Please give guidance again as to what PPE needs to be worn when in contact with dialysis patients in the grey zone. Does staff need to wear an N95 mask or a procedure mask, gown (only for close personal contact), eye wear and gloves?

This is an often-asked question. In the grey zone, you want to assume the resident could become positive, so you want to wear full COVID-19 PPE (N95 masks, gowns, eye protection and gloves) for all resident contact in the grey zone. We understand the difficulties of obtaining enough PPE, and if you are a crisis level, you can prioritize your use of a gown and gloves in working with those residents, and only use the full PPE for high-contact care. But if you have enough PPE, you should use it for all care of residents in the grey zone. The only thing you

might relax on is the gown use in low-contact care; otherwise, you have to wear all the PPE all the time. This is the simple rule to follow for care of residents in all these zones: red, yellow and grey. This is the preferred way. In the red zone, even for low-contact procedures you must wear full PPE, including gowns.

19. How are facilities doing the fit testing for the N95 respirators if they don't have a staff member authorized to do the official fitting?
Because of the pandemic, there have been waivers issued for use of N95 masks without fit testing (OSHA News Release https://www.osha.gov/news/newsreleases/national/03142020)
Most facilities are not requiring true fit testing for use of N95s. Normal fit testing can take about an hour in normal times and can include either qualitative or quantitative measuring the number of particles that escape around an N95 respirator when it is in use. It can also include a medical evaluation if it is safe for the person being tested to wear the mask. In the absence of having a respiratory protection program and having someone certified to do the fit testing, you can do a seal check. There are educational videos available through OSHA and NETEC to train staff on how to do a seal check. Following the video, you take a respirator and cup it to your face, checking so air does not billow out around the mask.
Respirator seal check video: https://www.youtube.com/watch?v=pGXiUyAoEd8

20. In Assisted Living facilities with apartments for each resident, how you are suggesting we set up a red zone, a grey zone and a yellow zone? Any advice would be helpful.
Assisted living can make it difficult to set up zones because you cannot move whole apartments. In those situations, we have recommended you make that whole room a red zone. You cannot cohort residents, so instead you want to cohort staff to a zone. One staff member would only take care of the red zone patients, other staff members only care for yellow zone patients and others only to green zone patients. Dedicated staff is used to set up these zones and we have seen this implemented successfully.

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1. Appendix A Testing guidance for a staff member who refuses testing but does NOT have symptoms and was NOT exposed says that this staff member should wear PPE in accordance with the following CDC guidelines but it does not say how long this person is to be wearing. Is it for fourteen days? Fourteen days from when?
Based on Dr. Ashraf's understanding, if there has been no exposure and the staff member is asymptomatic, for PPE the staff member needs to do universal masking (surgical masks), based on facility policy. Wearing PPE will depend on the situation. For example, a staff member taking care of a patient with C Difficile infection will need to follow contact precautions. Always follow Standard precautions and transmission-based precautions, and you should consider wearing some eye protection. That is why the CDC guidelines didn't set a number of days, because you never stop using the right PPE based on these precautions all the time.

2. Can we have confirmation that we use a new mask each shift and not reuse the mask (previously using it for 5 shifts)? Also, we do not need a new mask for a grey zone resident (please clarify)?
Remember that a surgical style mask is not the same as a respirator. Surgical (procedure-style) masks should not be worn more than one day. You can wear a surgical mask for one day if you are working in the green zone (unless it is soiled; then you get a new one). The N95 masks (work in the red, grey and yellow zones) don't need to change while working in those zones unless they are soiled, contaminated or damaged. But if you are moving between the zones (i.e. from grey or yellow to green zones, (if not wearing goggles or face shield) as an extra precaution, you could consider changing your N95 mask. But if you were wearing a face shield, that should have protected the N95 mask from splashes, so in that situation, you can continue to wear the same N95 mask that day, even if you are going from a grey zone to a green zone. But we recommend, that at least the face shield should be cleaned between the grey and green zones, just to ensure that you didn't accidently touch the face shield.

3. If KN95s can be reused after 72 hours, why don't the same rules apply to the N95s? Why do they have to be UV disinfected.
The CDC suggested the method of bagging the KN95 or regular N95 for 72 hours, which should provide enough time that the COVID virus dies off. Kate's opinion on this is that it is preferable to disinfect the N95 mask when you can because there could be other pathogens carried on the respirators from the environment or wearer, such as staph and strep. It is more hygienic to send them away for disinfection, which might also combat some of the other things we have hear of such as rashes from wearing the respirators for a long time. It is not a requirement to disinfect the respirators after every use, but it is preferable. Staff may prefer to wear a disinfected mask rather than one that sat in a bag for several days.

4. The 4th of July is soon. Our assisted living will be in Phase 2 on that date. Can our resident go outside, line the sidewalk wearing masks and social distance and watch fireworks? There would be more than 10 residents.
We need to review the Phase 2 guidance; this is a regulatory issue and you need regulatory guidance on this. However, here is some infection control guidance on this issue: In terms of infection control, if you are going to have a resident come out and watch fireworks (assuming you are taking them out somewhere close to the facility (backyard, etc.), you need to plan ahead. The 6 foot distance is a good guidance on paper, but you will need to be very careful on how you manage keeping residents at a good distance from each other during the fireworks. If you have too many people, it may be hard to control that size of crowd. Fewer people might be manageable, possibly by setting out chairs at a distance for the viewing. There may be ways to do it safely, but you need to plan ahead for how much space you have available, how you are moving residents to that space, and if you have staff to make sure the residents are compliant with keeping social distancing. Having a resident in quarantine in your facility would be a barrier to planning an event like this. Again, this is still a regulatory issue and would need to be reviewed by the DHHS; if they approve (Connie Vogt at DHHS) then you can take steps to plan to do it safely.

5. We are using cloth masks for residents when they are out of their room. What is the guidance for storing those cloth masks in resident rooms when not is use? Can they be

worn for one day and then laundered, or do they need a new mask every time they exit and reenter their room?
ICAP has seen an article written by Dr. Allison Freifeld of UNMC on this issue; she talks about a limit of about 4 hours for wearing a cloth mask.
https://www.nebraskamed.com/COVID/fabricmasks-useful-but-not-a-cure-all before it needs to be laundered and dried at hot temperatures. Consider that cloth masks left hanging for a long time in a room could be contaminated there. If residents are out and about they would want to wear them out for an hour or two and when they return to their room it is laundered.

6. In the terminal doffing poster, it says "after outer glove removal". When are we wearing two gloves?
None of the ICAP team has advocated for two glove use. It requires a lot of practice to work in two pairs of gloves. That is a PPE strategy more suited to a containment unit. If you are wearing an outer glove there is a glove inside. If you have a one glove method, you remove the gloves off and then sanitize your hands. There are a lot of good techniques shown in the terminal doffing poster, which gives us good methods to clean the face coverings, but it is something that you need to apply some of your own culture and PPE teachings on.

7. If our facility is all yellow right now, can we take residents from the same unit to the bathhouse? For example, Station 1 bath on Monday, Station 2 on Tuesday? Are your bathing recommendations to be followed at all times (even if there are no COVID cases in facility)?
One of our slides today was on this topic. Remember that different people in the yellow zone have different levels of exposure risk. You might only have one or two of the residents become positive, but you have to protect all the residents in the yellow zone from each other, two. You still need to clean the bathhouse air between residents so you don't unintentionally expose one yellow zone resident to another yellow zone resident. Dr. Ashraf noted that people in the yellow zone will only be there for 14 days, unless you have another exposure going forward, then the yellow zone can be extended longer than the 14-28 days planned. During that 14-28 daytime if they can tolerate it, you should do bed baths in the room. But if there are some residents who really need the bath during their time in the yellow zone, you may consider a strategy so you can provide baths. Avoiding baths is preferred, but if they really need it, you could plan to bathe one of those residents in the bath house at the end of a bathing day. If you want all the yellow zone people bathed, then you need to use the formula where the bath area has at least 10 air exchanges (41 minutes) before the next resident can safely come in the room without the mask to be bathed. The healthcare worker, wearing the proper mask, can come into the room during those 41 minutes and clean it, but to be safe for the second resident, you need to have the air exchanges. Confirm with your facilities department (maintenance supervisors) to know how many air exchanges are happening in the bath house per hour. (Fewer air exchanges require longer rest periods between baths). Maintenance supervisors will be aware of the workings of the facility's heating and air conditioning systems and help with the number of air exchanges per hour. This is an item on regulatory surveys. At Nebraska Medicine the facilities staff could verify the air exchanges, especially for negative pressure rooms. You can contract with services to come in and measure this for you.

8. A new admission from a low or no incidence hospital coming into our facility, which is also a no-incidence facility. We place resident in a grey zone, can staff wear only an N-95 mask and no other PPE for routine cares? We are observing and monitoring the resident.
An important clarification to remember: If you are not planning to use all the recommended PPE for a grey zone, DO NOT call it a grey zone. Call it an observation area, a monitoring area, but not a transitional zone. If you call it a grey zone but are not following all the PPE recommended, your facility could be cited for this by surveyors. If you are taking in a new admission from a high risk area and want to do a 14-day quarantine, follow the exact PPE requirement that is there for the grey zone. You have the right to NOT have a grey zone (transitional zone) and observe and monitor residents, but do that with your own policy in place about how you are going to do this observation, and what PPE you will use in your facility for this observation. You can make those kind of informed decisions on your own but then it cannot be called a transitional zone. For Phase 3, though, Dr. Ashraf recommends looking at your community incidence of COVID (in hospitals, etc.), you probably still want to have a grey zone and used full PPE as recommended. You could get an exposed resident from another county or hospital with COVID transferred into your facility, even though you are not seeing COVID 19 patients in your own county or local hospital. If you call that unit a grey zone, though, you must use full PPE.

9. For 41 minutes of resting air for baths: how do we give 40 residents a bath twice a week if we need to do 41 minutes of rest between each resident? That is essentially 55 hours of rest each week. Can you please clarify?
The idea if you have people who require COVID precautions (yellow, red, grey zones) those are the people you need to do the air exchanges for in the bath house. If your facility houses mostly yellow zone people right now, you will need to plan for bed baths. You could do a combination of bed baths and using the bathhouse with rest in-between residents. This doesn't mean you have to do this on every single resident, but rather just for those residents in yellow, red or grey zone precautions. If you don't have a yellow and red zone in your facility, the only restriction you have in your facility should be for grey zone residents, and that should only be for a 14-day period. The green zone residents can use the bathhouse as usual, as long as the bath house is not located inside your gray zone. There is an issue only when you have residents in yellow, red or grey zones. In those cases, the first option is bed baths. Sometimes that won't work for those residents in those zones and for those people you need to apply the formula for letting the bathhouse rest between baths for the required air exchange periods.

10. Is there written guidance anywhere that we could refer to that specifically states what PPE you should be wearing in each zone? Here is the link:
https://icap.nebraskamed.com/wp-content/uploads/sites/2/2020/06/Review-of-IsolationZones-and-PPE-2020.pdf

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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-assesmenthcp.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 longterm 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.

Responses were provided based on information known on **7/9/2020** 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 7/9/2020

1. **On the 6/19 webinar Dr Anthone said that work was in progress in getting contracts signed by hospitals to assist with testing and over 50% of these contracts are already signed. Can you tell me where we are at with this because I cannot find anyone to assist with baseline testing?**
   As far as Dr. Ashraf, knows, those contracts were in the process of being signed, but we don't know if they are functional yet. Dr. Ashraf needs to check with the state, but also thinks there may be a DHHS call scheduled as early as Friday, July 10 to address testing issues. This issue may come up on this call. The call's focus will be to go over testing issues one more time, since the baseline testing has started. Dr. Ashraf does not know the time for that call, but ICAP will try to send out an email via its distribution list if we receive a copy of the call invitation.

2. **Is there anyone considering a move to full PPE for ALL LTC/congregate living health care workers going forward until a vaccine is developed? It seems LTC will be moving in and out of quarantine repeatedly as COVID is more prevalent in the community and staff/families bring risk and/or reintroduce COVID repeatedly. Donning full PPE for the high-risk population in long-term care, much like is worn in ICUs and COVID units would minimize risk with highest PPE use across the board. What are your thoughts?**
   If we have an unlimited supply of PPE, maybe that could be considered for high-risk counties. But since we don't have that large PPE supply, I don't think this can be the standard. There are communities where there are low numbers of COVID and low rates of transmission, so the full PPE might not be practical there. It is a good thought, but it can't be quickly implemented. Also staff can get into PPE fatigue from wearing it all the time, so getting breaks are important. So even if you have to go back and forth into quarantine, having a break from PPE can still be helpful to comply more when isolation and PPE are actually needed. We don't know of a standard answer, but since there are still PPE shortages, it isn't an option right now.

3. **In our facility we do not have an anteroom and not able to maintain 6 feet from resident to door. Where do you recommend we Doff our PPE?**
   Inside or out Without an anteroom, you should doff while still inside the room, but as close to the door as possible. The 6 foot space is for respiratory source control, but you would still have your mask and eye protection on while doffing the other PPE. The 6 feet refers to social distancing and the need to wear a mask while out in public. While doffing PPE, if you are

moving close to the door, you should be at least 6 feet away from the resident by that point. The doffing you do will be of your gown and gloves, and those would be disposed of inside the room before going out the door. The rule to remember is that you never don your gowns and glove inside the room and you never doff your gown and gloves outside the room. And then you do hand hygiene, always. The only exception is would be for staff working inside a red (COVID-positive) unit, where you are going from patient to patient with the gowns on because all are COVID positive. In that case you would then just doff the gown before exiting the red zone.

4. **Could you please clarify how you would address staff who refuse COVID testing, both direct patient care staff and non-direct patient care staff. Do they all need to wear full PPE?**
   You will need to look to state guidance http://dhhs.ne.gov/Pages/COVID-19-Testing.aspx "Staff and residents declining testing should be treated as having a positive COVID-19 test result," on this question. It also matters if the staff member was known to be exposed to COVID 19 or not, or symptomatic. If a staff member is completely asymptomatic, not known to be exposed and then is refusing to test for COVID 19, they will be wearing PPE based on the activity they are doing with the residents and the situation with the patient they are helping at the time. If they are working with a patient who has a known MDRO, for example, or patients in an isolation zone, the regular rules for wearing PPE apply. At a minimum that staff member should be wearing a mask at all times, and probably eye protection as well. The need for the gowns and gloves depend on the type of activity being performed. Follow the standard, transmission-based precautions. But ICAP stresses that the state document says that if staff or residents refuse to test, they should be treated as positive and the staff will have to be off work for 14 days. That is especially true if they are symptomatic. The confusing point is where someone is asymptomatic and not exposed.
   A comment provided later by a webinar viewer:
   The phasing guidelines state that Asymptomatic and no exposure staff who refuse baseline testing are not treated as if they are positive. They have to wear "appropriate" PPE for the situation.
   Dr. Ashraf said he completely agrees with that information. Appropriate PPE should be used as it is always done – no additional PPE requirement beyond the new COVID guidance that universal masking is required in facilities.

5. **In the ICAP guidance, it identifies recommendations for yellow zone PPE for people who are 'taking care of residents'. Would these individuals be identified as our clinical team C.N.A./LPN/RN?**
   Yes, anyone who is going to interact with the residents are going to wear PPE. Housekeeping staff, however, is also included as providing care because they also enter the patient's environment to take care of their needs. If they happen to meet and interact in the hallways, which shouldn't happen often (transfer, etc.), then that staff also needs to be in PPE.

6. **Will the cool water be warm enough to kill bacteria and viruses?**
   Most facilities are using detergent to disinfect laundry; so if that is what the facility is doing, they need to verify with the detergent vendor that this is the load type (laundry cycle) that should be used with that detergent to make it effective for disinfecting laundry. If using a hot

water method to disinfect (only a few Nebraska facilities still use this method, which requires daily temperature testing and verification), then this process would not be okay to disinfect the gowns.

7. **We were advised on our CDC national call approximately a month ago to fold our mask in half prior to putting into bag so clean is to clean, is this no longer the recommendation? If we are labeling front and back, do we need a clean bag each time?**
That is not how the biocontainment staff does it, but it may not be wrong, so long as you are folding it clean into clean, which is another technique the CDC is recommending. ICAP thinks it will be difficult to fold and N95 mask and Margaret Drake fears that handling the mask in this way by folding adds more risk of contaminating it. The biocontainment unit staff agrees that the CDC is not wrong in its direction to fold your mask in half. But Nebraska Medicine does not use that process so the biocontainment unit staff did not demonstrate that today. Also, if you label your mask and always put it in the paper bag the same way each time, you don't have to use a clean bag every time. The biocontainment unit staff does not know of any specific recommendation on how long a bag can be used. Staff should inspect the bag and can use it as long as it looks good. You just want to be sure you are putting the mask into the bag exactly the same way every time.

8. **Why would she not put gown on first?**
They were demonstrating extended use of the N95 during that part of their presentation, which is why they did not put the gown on first that time. In most places, staff will be already wearing their N95 masks, but in the demonstration, they were also showing the use of face shields, which is not currently being done by every facility.

9. **In recent guidance it is noted for each instance of resident care, a new/clean gown and new/clean gloves should be donned. What do you consider 'resident care'? Personal cares? What about entering a room to support with a remote control or TV, blanket, water, etc.?**
It depends on what zone the person is working in. If you are caring for a resident in the COVID unit or "red" zone, then anytime you enter the room, you have to be wearing a clean gown. However, if it is a COVID unit where all the residents are COVID positive and the staff is dedicated to that unit and only working there, then those staff can go to room to room in the same gown. But except for that, anytime you go in a room where a gown is needed, each person entering the room needs a clean gown to enter. Even in the "red" zone, you always change the gloves. It is only the gown that could be kept on from room to room, and that is ONLY if you have a unit where all the residents are positive, cared for by staff members working only in that unit. In the yellow zone, where you are quarantining people, if you don't have enough gowns, we have said you can prioritize using the gowns only for high-contact activities. You may not need to don a gown to go into yellow zone (exposed residents) rooms – if you are not doing high contact activities. The low contact activities described in the question could be done by staff not wearing a gown if you don't have a supply of enough gowns. You should not reuse a disposable or reusable gown (unless it has been laundered in-between). To clarify, when the NETEC team has visited long-term care facilities on site, they really advocate for using gowns in the yellow zone. If there are enough gowns, the rule should be that a fresh gown should be used for any room entry in a yellow

zone room. Only as a crisis-type strategy are you allowed to not enter a yellow zone room without a gown. NETEC has noted some confusion in sites they visited between recommendations. The safest thing is always to wear a gown. The only situation allowable for conserving gown use only for high-contact activities is when there is limited supply of gowns. It would be even higher risk for facilities to be reusing gowns. The biocontainment unit staff offered the idea that in the case of a shortage of gowns, facilities need to look into every available option. For example, if there are not enough disposable gowns, a facility could contact a supplier of reusable patient cloth gowns and see if those could be obtained for use as isolation gowns for staff. NETEC is concerned that if the decision is left up to staff to make on what are high-contact activities, etc., the staff might not make the right choice, or try to conserve the gowns in the interest of saving costs for their facility. That is what NETEC has seen on site; when there is confusion on when to wear a gown in patient care in the yellow zone, staff will choose not to wear a gown. Dr. Ashraf agreed, that this option offered is only when there is true crisis-level shortages of gowns, and not as a loophole to avoid using gowns for cost savings or other reasons.

10. **Is it necessary for facilities complete fit testing for N95's or is it acceptable to just do seal checks because we are still having trouble finding someone to help with fit testing?**
    The biocontainment unit staff advises that as long as you are doing the seal check properly, that is a good control measure. Recent OSHA guidance is that facilities should be making a good faith effort to get fit testing done. In the absence of a true fit test, a good seal check is a workable alternative, but facilities need to continue to explore the option of getting true fit testing for N95. The end of COVID is not on the horizon, so facilities need to continue to pursue getting staff fit-tested. Here is the OSHA link on the subject: https://www.osha.gov/memos/2020-04-08/expanded-temporary-enforcement-guidancerespiratory-protection-fit-testing-n95

11. **When a caregiver is caring for green zone residents and gray zone residents, can they continue to wear the same N95 mask with all residents?**
    ICAP and the biocontainment staff agree that you can use the same N95 mask. The face shield should be protected with a face shield. Hand hygiene needs to be done anytime touching the N95 mask because it is always considered dirty. If staff can't be dedicated to one zone, they need to remember to clean the face shield one more time moving to another zone, but that is not mandated.

12. **Wearing one gown from room to room with positive COVID residents is ok, correct? Of course changing of gloves would be done after every room.**
    If you have set up a COVID unit (red zone) set up, this would be fine. The biocontainment staff agreed.

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1. **Once a facility enters Phase 3 and is able to allow limited visitation, are therapy dogs allowed?**
   The most recent guidance Kate has seen on therapy dogs is from the CDC where the guidance says to treat your dogs the way you treat your family. You don't want to take them around and expose them to more people than needed. We would advise dog owners not to do that. We have to remember that this virus has only been known about for seven months and we don't have a ton of data on how animals carry or are affected by COVID. Because of that gap in information, it isn't time to roll the dice because we don't know what that could do. Dr. Ashraf added that in general, Kate is right, the guidance is to avoid pets in the facility. If there is a medical or psychological need for therapy, then in those scenarios you will be extra careful and just limit the exposure to the person in need. Avoid the common areas and go only into the resident room who has a therapy need. It is not completely, absolute a "no", but any animal/pet there has to be a real psychological/mental/therapy need. For those purposes, it would be okay but limit the exposure to that resident who is in need as much as possible.

2. **I saw a news story last night that said when someone has a diagnosis of COVID and retests and still shows they are positive, that it is being counted as another case of COVID. Is this true?**
   If it is after two months (eight weeks) it can be true. Within the eight weeks, it is very hard to say that people have a new case. Even after eight weeks people can continue to have a positive PCR from their previous infection, but as of right now CDC guidance says you can retest, looking for the infection, after eight weeks. So if they are tested after eight weeks, then there can be a question. I am not 100 percent sure that anyone has a really good grasp if this is really a new infection, a reinfection, or just a continuation of the first positive infection. But if there is a really clear reasons to believe this a new infection and they are tested again after eight weeks, and there is a positive test result, then it is possible that it can be a reinfection. Kate Tyner said she thinks that some people seem to think that the data is not accurate because of factors like this. However, there are not a lot people who are lining up to be retesting after they had a positive test. She does not think even if that were happening that it would inflate the numbers very much. In long-term care, ICAP has advised that we don't retest people who are known positives unless they meet certain criteria and we have waiting periods for that discontinuation period. This is not a large amount of cases that would make us have any uncertainty about the data you would find on the DHHS website, for example.

3. **In non-transition units, do you feel it is okay to allow dietary personnel to enter into resident rooms to set up room trays? Do you know if there is a regulation stating that dietary**
   Dr. Ashraf said if we are talking about a green zone where no one is exposed, symptomatic or positive for COVID-19. In those units there is no restriction on a dietary person going in the room and delivering a tray. However, Dr. Ashraf recommends that these staff always perform good hand hygiene before entering a room and always wears a mask. Anyone with resident interaction should be wearing a surgical mask and should be doing good hand hygiene going in and out of the room. Dr. Ashraf has seen situations where the dietary teams are going in and out of the rooms on a unit and not washing hands between the rooms. That should not be happening. You can have dietary staff going in and out of a room in the green

zone, but be sure you instruct them about good hand hygiene between the rooms and always wearing their masks 100 percent of the time.

4. **The CDC guidance for universal eye protection for those facilities in areas of sustained transmission makes sense. The exposure guide mentioned for the employee would selfmonitor though if they were not wearing the eye protection but wearing a mask when exposed to a COVID-19 positive resident without a mask. This seems confusing or contradicting; can you please clarify?**
   Kate asked the group to remember that the exposure guidance was written before the universal eyewear recommendation came out on July 9. People have been working towards this for some time. The need to have it on a table is important because many facilities did not have that in place. If the people are self-monitoring and are they in the building, they could work so long as they are screening for symptoms, etc. They would not be automatically excluded for not wearing a face shield. That is different from someone not wearing a mask. Not wearing a mask is an automatic exposure. The slide with the exposure guidance was reviewed again and Dr. Ashraf tried to clarify on the discussion point from that table. The first point on the table was that if the healthcare worker was not wearing a mask, then it is always an exposure. The other part discussed was about healthcare personnel not wearing eye protection. In the scenario shown, the person with COVID not wearing a cloth mask. If you are encountering a person who is COVID positive, you are wearing a mask and you are not wearing an eye protection and the person who is COVID positive is not wearing a mask, you can get exposed through the eyes. That is because this person's secretions are not contained. If the COVID positive person is talking droplets are probably going into the air. Even if you are wearing a mask, there is a good chance that your eyes can get exposed. In that situation, it is recommended that if you were not wearing eye protection, you might have been exposed and you might have to take 14 days off. The point is that even if you are wearing a mask you ask the other person to wear a mask to avoid exposure.

5. **Do you have any clarification as to what is meant when stating a resident has "diarrhea"? If a resident has one stool without any other symptoms and receives medication to prevent constipation do you recommend testing?**
   That is a different scenario. In that case, you have a reason to give the medication Is that one stool. This refers to someone who is given medication because they are constipated, and the medication triggers a bowel movement. This is an expected response of a medication and that is a totally different scenario. Dr. Ashraf would not count it as a symptom of COVID-19.

6. **We were told that our dialysis patients who were positive and are recovered did not need to remain in gray zone and could go back to their normal rooms. Has this thought changed?**
   A grey zone is for transitional people who are coming into a facility and doing their quarantine. Once quarantine is over, they can go into a green zone if they are okay at that point in time. Kate asked Dr. Ashraf about the potential for reinfection among dialysis patients and if that would affect whether or not they would be moved into the green zone. Dr. Ashraf noted that his earlier advice was directed to the general population of long-term care facilities. Decisions about dialysis populations depends on which county you are in. If a facility is still in Phase 1 or Phase 2 of reopening, and there are still cases of COVID in your

community, dialysis patients are still at high risk for exposure as they go in and out of the facility three times a week for treatment. In that scenario, you probably will still want to keep them in the grey zone, as long as the risk of community transition remains. Even if you go into Phase 3, you are not mandated to keep them (or anyone else) in a grey zone, but if you have specific If you are in Phase 3, and still seeing cases of COVID 19, your dialysis patient is still at high risk of exposure when they come in and go out. Want to keep them in the grey zone. Even in Phase 3, you are not mandated to keep anyone in the grey zone. But if you have specific risk factors in your community or in the dialysis facility, you may want to keep that person in a grey zone even after you have you have gone into Phase 3 and even after the 14 days are over. That is still in place if your community transmission warrants that. If the hospital cases, community cases, and/or dialysis facility is seeing cases you may want to continue the grey zone for those dialysis patients. But if your community is not seeing cases, your hospital is not admitting COVID-19 positive patients, nor is the dialysis facility is not seeing COVID-10 cases, especially if you are in Phase 3, then you don't have to keep that person in the gray zone, not even for the first 14 days.

7. **With the guidance for a face mask at all times, how should facilities handle break rooms for meals?**
   Obviously staff cannot wear a mask to eat. Kate said some facilities have handled this by opening up additional spaces for break to keep people socially distanced. That might allow for only having one or two people in a fairly large break room. Sometimes people can eat outside at picnic tables, distancing people wherever you can. We know people need a break to eat, etc., so facilities need to plan for that. You can also consider Plexiglas dividers or other things to put more precautions in place.

8. **What are the height guidelines for the Plexiglas?**
   The height guidance depends on what you are doing near the Plexiglas. If people are seated like in a place like a dining room table and they only take off their masks once people are seated, it would need to be a different height than if people are standing up. The height has to be above your head to be safe. If not, the droplets coming out of your mouth (if you are talking, sneeze or cough) could go above that Plexiglas barrier. A barrier your head is controlling the source. If it comes up to your chin, it is not going to give you the amount of source control you are looking for. Dr. Ashraf doesn't know if there is a written height somewhere we can share, but that is the general principal.

9. **An employee tested positive in April. She was retested in July and is now presumptive positive. Will this be an issue for all past positive residents and staff during baseline testing? What is the timeline to shed COVID from the body for elderly residents and middle-aged staff?**
   Retested to July. That is about three months into the disease process, which is highly unusual, but If we know the specific dates we can look into it further. Dr. Ashraf invited the questioner to contact ICAP after this webinar to go over the details further. Usually the CDC says that after eight weeks you can retest. You should not be retesting someone who previously tested positive within e weeks of that first test. If a facility is doing a baseline testing, don't test anyone who was positive in the last three months. If it beyond the three months, Dr. Ashraf would be anxious to know whether the patient has a reinfection. Kate

said that if a facility has that situation, ICAP would want to work with them one to one to sort out the details. So far, ICAP has not identified a reinfection case in any of our long-term care facilities.

10. **What should the temperature "number" on the resident and staff screening tools say? Do we go by the CDC/McGeer definition of a fever or is the temperature number lower when doing the COVID assessment? Just clarifying. Right now we are using 99.6.**
    The temperature definition in the McGeer is pretty good to use. The problem with resident testing is using a set number like 100 is not a sure thing (100 or above is a fever in an older person, or a repeated 99, also considered a significant issue.). If the temperature is two degrees F above the resident's baseline then that is also definitely a fever. For staff members you can use the CDC definition for a fever.

11. **If residents and family members are visiting outdoors, and there is 10 feet between them, would it be appropriate for the family member to wear a Faceshield instead of a mask so the resident can actually see their face?**
    The resident would be wearing a mask. Dr. Ashraf thinks the masks are more protective than the face shields. We don't have good scientific data on the protective nature of using a faith shield alone. Kate said that would be a risk she wouldn't want to take. Until we get more guidance, it is better if a mask is worn. Dr. Ashraf added that If you prolong the distance that is probably okay, but we don't have much concrete data on that right now. ICAP will continue to discuss this with its partners and pass along the information later.

12. **We purchased a Plexiglas drum shield that works great. Is also somewhat portable and looks better than something we can make. Drum Shield link:**
    https://www.amazon.com/ShieldScreen-Panels-DS6LLiving/dp/B01DJJJ78E/ref=sr_1_1?dchild=1&keywords=drum+shield+6+foot&qid=1594922102%20&sr=8-1

Responses were provided based on information known on 7/23/2020 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 7/23/2020

1. **If your community is in Phase 3, but your facility is in Phase 2, would that mean you don't have to wear N95s in transitional zone?**
   You need the N95 mask anytime we are in transitional (grey) zone, which is a place of quarantine. We are quarantining people because we think they are coming from a place that has a high COVID transmission rate and that there was a high risk that while they were out (into a hospital, or out to a doctor's visit or dialysis facility), where they might have been around someone with COVID-19. For those people we have decided that we will have them in quarantine for 14 days in a transition (grey) zone. Whenever you are quarantining someone, you are using full COVID PPE, which means using gowns, gloves, eye protection and masks (N95 is the go-to mask). We want staff working those grey areas who can get a good seal check on their N95 mask. Your last resort is to use a surgical mask ONLY if you

cannot find people to work in the grey zone who can get a good seal check on N95 masks. The point is that anytime we use the term grey or transition zone, we are using it for quarantine. Anytime we are quarantining people, we are using full COVID PPE for staff. You are not allowed to just observe and monitor someone in the grey or transition zone because you are in Phase III. You can observe and monitor someone in any unit, even green zones, but observing and monitoring is not part of the grey or transition zone. But if you have someone who is at high risk of exposure, that person has to be in the grey zone with staff in full COVID level PPE protection. Observation and monitoring can be done for someone who did not have high risk of exposure, who might have gone outside the facility but went to a clinic appointment in a place where there is not high rates of COVID transmission or no COVID cases. In that case, you may still want to monitor, even if the resident is returning to a room in the green zone, because there was no risk of exposure when they were out. Your surgical mask would be fine for PPE in that case. In Phase 3, you have to determine whether the risk to the resident requires quarantine when they return to you. If it requires quarantine, use the full PPE and keep them in the grey zone. You can monitor in green zone and you can use surgical masks, but whether you use a grey zone depends on what kind of community you are in and the place you are coming from.

2. **How does this new guidance affect the following scenario? Baseline testing for staff reveals a positive worker who is asymptomatic. Does the facility still have to go into a yellow zone for residents if all residents are asymptomatic as well?**
   We are exhausting exorbitant amounts of PPE for these situations. The new guidance is saying is that if there is an asymptotic positive person, they are probably not going to be transmitting infection after 10 days. But for the first 10 days, there is still risk for transmission. Because there is still risk for transmission, there can still be exposures associated with those asymptomatic residents. The new guidance does not say not to isolate asymptomatic people at all. They are saying to isolate for less duration because they might recover quickly, but it doesn't mean they can't transmit during those 10 days. If you identify an asymptomatic person in your facility, who has exposed other people, you will still need to go to the yellow zone. The only difference is that instead of that person needing to isolate for 28 days, that person may come out of isolation in 10 days. That is the difference. Kate Tyner added that 14-day quarantine period is different than a 10-day convalescent period. Quarantine is because if you were exposed, you could get symptoms anytime in the 14 days since the exposure. You could end up with a positive test, not end up with any symptoms, or get very, very sick in 14 days after the exposure. Fourteen days is the quarantine (incubation) period. What the CDC has changed is the period of time it takes someone who tests positive to convalesce and get better. These are two different types of isolation. Person exposed still need to be isolated for 14 days -- that has not changed. We know those PPE needs for caring for people in the quarantine zones feels like a lot. But we believe in that quarantine area, having a yellow zone. We know that it works. That is why there is a state program to help with obtaining PPE, to get you through that 14-day quarantine period when you know there has been a positive case in the building, and ICAP is glad to help you with that. In the situation where there are large exposures, ICAP is working with facilities one to one to try to connect them to the state and local health departments to get them the PPE they need.

3. **I have heard of communities admitting new residents and not having them isolate for 14 days or have decreased the number of days in order to move them into the locations. Has the recommendations changed or is this recommended?**
   Dr. Ashraf does not like the idea of reducing the duration of quarantine because it goes against the science of this. As Kate just mentioned, you can become positive anytime within those 14 days; you can still get symptoms anytime in that period. Reducing the duration of isolation is not helping anyone because if they have a real exposure, that is where you have to figure out if someone has a real exposure. If there is a real chance for exposure there is no way out but a 14- day quarantine. The difference is whether you think there is a chance of exposure or not. In those communities that are in Phase 3 now, if their residents going out to a place in their community where the community is not even seeing a case and they are coming back, then that person is not at high risk for exposure, so that person does not require quarantine. That person can just come back to their room in a green zone and live there. There is no reason to do a seven-day quarantine or a three-day quarantine. A quarantine should either be 14 days or zero days. You either need quarantine or you don't need quarantine. If you are in a situation where you send out a resident to a doctor's appointment in a community where there aren't many cases and they come back, then you don't need a grey zone when you are in Phase 3 for that person. They can come back to the green zone and live there. There is no need for a three-day or a seven-day quarantine. That does not make sense.

4. **If a facility is in Phase 3, how should we handle families who want to take their loved one out of the facility for an outing - go to their house, go out to a family event, etc? Do they need to quarantine when they get back or do we just observe them for any change in condition?**
   This is the type of thing we have to assess now. If you send out a resident with the family member, when they come back you need to talk to the resident and risk assess. You might even want to talk to them before they go out of the facility and give them some guidance on how to avoid exposures. Assess what they did. Were they meeting people from other parts of country (hot spots) or were they just going to be with people who live in that community that haven't seen any cases. There are two different levels of exposures. If they were really out meeting people while they were gone who came from all across the country and having a party, that is a person who you would worry about having an exposure. You don't know that an exposure really happened and you don't know if there was anyone they met who was positive, but you know they may have come from high risk places and there is a chance one of them may be positive. Now you have to weigh the factors. When you weigh those factors, you will need to decide if that resident was in a high-risk activity. For that person, we will put them in our grey zone or transitional zone for 14 days quarantine and we will use full COVID-19 PPE to care for them. If the resident was just with family who live in that community and there are no COVID cases in that community, then we risk assess that. If we don't believe that there is any reason that this person was exposed to COVID while they were out, in that case they can come back into the green zone and stay there. They can be observed and monitored in the green zone. That means you just screen them a little more than usual but that can be done in their green zone. That is perfectly fine because they have no need for quarantine. That is what the facilities have to start deciding when they are in Phase 3. Do they think the person coming back or a new admission who has come in had a chance for a

high-risk exposure, then the facility can put them in the grey zone and follow the 14-day rule using full PPE. If not, observe them in the green zone.

5. **Are facilities able to self-screen staff prior to entering the facility for their shift and then someone just review the screening log in a timely manner? Or does another staff member need to come check their temperatures for them?**
   The term "timely manner" has to mean immediately. The timeliness is if someone is selfreporting a symptom, there shouldn't be a time lapse for them to start working with that symptom. If you mean "timely manner" means that you will catch that before they hit the floor, then self-screening is fine. But, if you cannot catch that within that time frame between when they report the symptom and enter the facility, that is not timely and that is not right. All it takes is one staff member entering the building with even a mild symptom to spread infection. Even someone working one hour with symptoms has exposed people. Kate Tyner said it is better to hardwire that facilities are watching staff who are coming in for their shifts.

6. **If a resident goes out to a clinic appointment with staff present the entire appointment, can they just come back to monitor and observe if we are in Phase 2?**
   It depends which community the facilities are in. If they are in a community that is seeing transmission and they have gone to a clinic where other people come, including people who may have COVID could in to be checked out, then that is going to be a person you may consider putting into a grey or transitional zone when they return. But, if you are living in a community that has not been seeing many cases of COVID-19 and you have observed and monitored this person all along on the clinic visit, where there wasn't any chance they were exposed to anyone, when they come back it is fine to put them into the green zone.

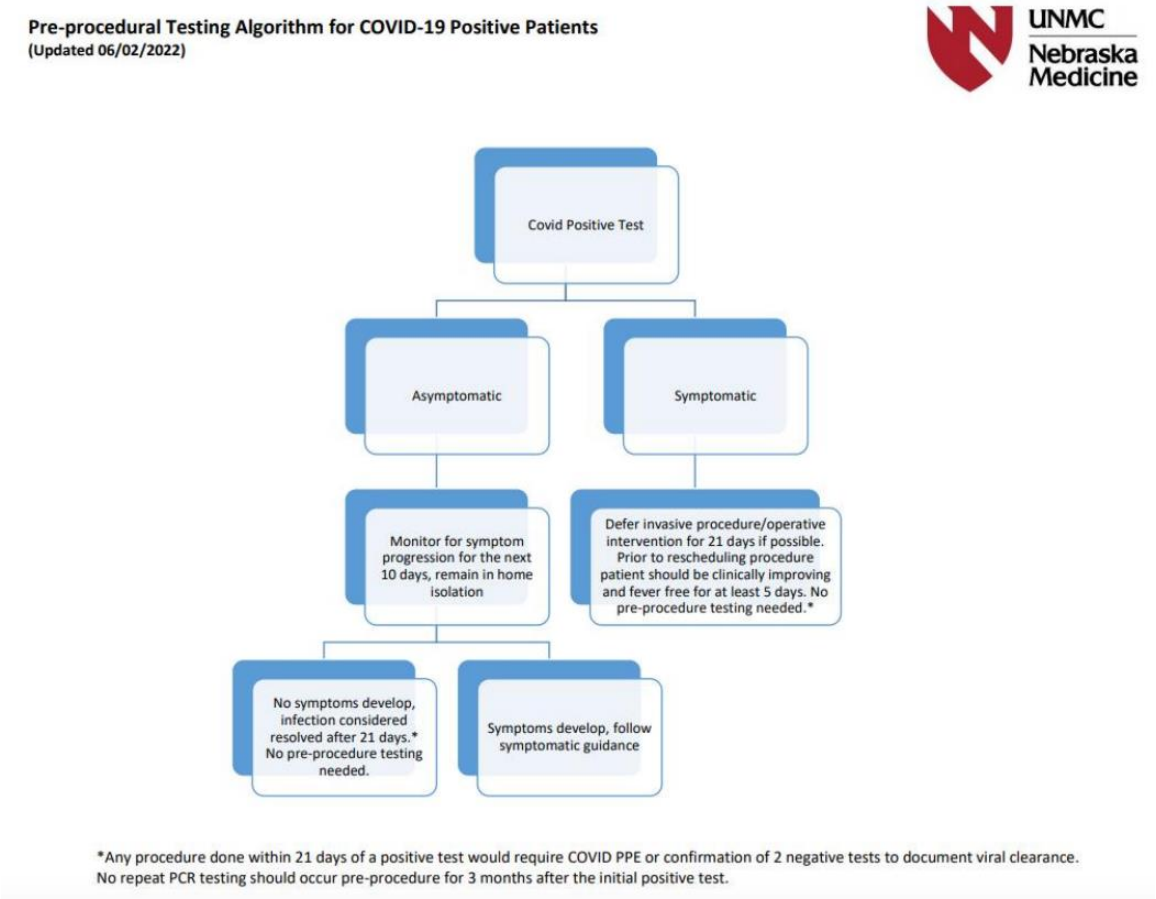
7. **Because we also do rehab, we will have always have units that are transitional units. What advice do you have on visitation plans for these units?**
   Visitation plans for that rehab unit will be based on the need. If you go into the guidance, it also depends on the Phase you are in. If you are in Phase 3 you may have a grey zone. But having rehab patients doesn't mean you always will have a grey zone. It will only happen if you are in a community that is seeing a high number of cases. Then you will have a continuous risk for exposure if they are coming in and out of a facility. If you are in that kind of situation where you are in a community where you are seeing a high number of cases and you are quarantining them for the purpose of chances of exposure for the first 14 days, the best guidance is that you do not allow visitation for those 14 days. Even in these situations, there can be psychosocial exemptions for that. The general rule is, for those kind of situations, we don't allow visitation in the 14-day quarantine period. If they are in quarantine, there can't be visitation unless you are risking someone's mental health or behavioral health or some other situation like compassionate care issues. In those situations, you may be able to arrange a very well-thought out plan where there is limited visitation, so long as you are limiting exposure coming into the facility. There are ways to do that and we have discussed those in past webinars talking about safe visitation. Those slides are uploaded on the ICAP website (https://icap.nebraskamed.com/). You can always call us and we can work with you on a caseby-case basis to make those visits safe. Visitation in those situations is allowed on a compassionate care basis, but not a general rule.

8. **What would your guidance be for staff who travel on vacation to the southern states (Texas, Tennessee, etc) upon their return? Do you make them stay off for 14 days or could they have a test in order to return back to work?**
   Test is going to be good for that day only. The next day they can be positive, and if you are not testing again the next day, you are not sure what is happening that next day. Once they have come back, they still have 14 days where they can develop symptoms or become asymptomatically positive. The test is good on that day but it doesn't tell you what is happening for the next 14 days. The guidance is (as of this point) is that you talk to that person, find out what kind of exposures they may have had and then decide whether you want them to quarantine for 14 days before they come to work or you allow them to come to work. The state has not mandated quarantine if you are traveling within the United States, but have mandated quarantine for anyone who for traveled overseas. However, the facility has the ability to risk assess the person who has come back and then decide if that person should quarantine or not. We have seen in last few weeks at least a few cases where someone went for vacation, came back, worked and was then was tested positive. Dr. Ashraf has also seen situations where they were tested, and because the test results can take days to come back they were allowed to work and a few days later the test came back positive. That meant the entire facility had to go into a yellow zone and that could have been easily avoided if the person hadn't come back to work. You have to make a case-by-case decision, based on the type of exposure the staff may have had. Wherever you can exclude these travelers, if staffing allows it, it might be helpful for you in the long run. You have to make your own policy, but this is some rationale based on what ICAP has been seeing. You want to have the background to make your own policy. Kate Tyner added that ICAP has Have seen great success stories when where someone traveled in an area where they knew they were exposed to someone who as COVID positive, reported that to their employee then the staff member was held out for 14 days. The staff member eventually became COVID positive, but no exposures happened because the staff members weren't in the building. ICAP has seen four cases in the last week where facilities took this strong stance and didn't allow the staff who were possibly exposed into their building and it worked out in their favor. It is a policy that is difficult to employ, but it does save in the long run. You need a careful risk assessment when staff returns, to have a culture where staff feels good about telling you what is going on, and especially if they know they were exposed to someone who was COVID positive, then those people have to stay out of service.

9. **If someone goes to hospital for four days, is it recommended to isolate them upon return, caring for them with staff wearing full PPE?**
   Yes, If they went to a hospital in a community that is seeing a high rate of transmission of COVID-19 in Phase 3. In Phase 1 or Phase 2 it is mandatory to isolate them regardless of which county you are in; they have to be quarantined. That is part of the phasing guidance that came out, that new admissions should be quarantined. For those places in Phase 1 or Phase 2, it is a must. For Phase 3, it will depend on circumstances. There is no mandate of quarantine or grey zone in Phase 3 but our recommendation is to look at the community and look at the place where you went and then decide.

10. **How long are you recommending we wait to do a surgery on a patient who has been COVID positive?**

Nebraska Medicine has an algorithm we will post (below; here is the link https://www.nebraskamed.com/sites/default/files/documents/covid-19/pre-proceduraltesting-algorithm-for-covid-positive-patients.pdf?date=06022020) If someone needs surgery, you have to decide the urgency of the surgery. If someone needs surgery today, you don't want to delay. If they need it today and are COVID positive, there are ways to do it with appropriate PPE. It all depends on the urgent level need of the surgery. If they needs a surgery today and they are COVID positive, you do it, use appropriate PPE, and get it done.



11. What are your feelings about the safety of the plastic barriers with the plastic hugging arms? Are these safe? How would you sanitize?

Dr. Ashraf said you have to see it to figure out how to sanitize it. Kate mentioned that she, Teri Fitzgerald and Dr. Ashraf have seen a hug wall that has been developed for another grant. ICAP's experience in testing one is that it is easy to trip on the plastic. For the person going into the sleeve, there is a lot of baggy plastic on some models and that can be a hard thing to manage in some models. You don't want people falling down and knocking down the barrier. Kate suggested you have to see a picture of it and find out how the manufacturer advises to disinfect it. Manufacturer has to tell you what sanitizing produce is compatible with the plastic so you don't degrade it. Some plastic can be easily broken down by alcohol, phenyl and some disinfectant products.

12. **We would like your recommendations regarding isolation of patient residing on a memory care unit. Are we ahead to keep them on the memory care unit due to higher risk of exposure to increased number of patients due to wandering potential? Concerns remain for other residing on the unit who may wander into an isolated room or the isolated patient potentially wanders out. What are your thoughts?**
    Kate said these decisions are addressed by ICAP on a case-by-case basis when infection preventionists are working with a facility. A lot of time if there is capacity on a convalescent unit, these are good candidates to be transferred out because they are a high risk to people around them. That space availability is driven by capacity, so being able to move them out can't be guaranteed. When ICAP is working one-to-one with a facility, this is something being assessed. We know that is available in state of Nebraska. If a new facility with an outbreak, call the outline. We are having capacity issue with calls we can take; it is best to call 402-552-2881. Facilities that have already been working with one of the infection preventionists, they can continue to call them directly, but for new facilities, they will receive help the soonest by contacting the main ICAP phone number.

13. **What is the contact information for Doug Carlson?**
    402-471-6500 (office); Doug.Carlson@nebraska.gov