Q&A from 4/29/2020 KDHE & CDC COVID-19 Long-Term Care webinar

Questions	Answers
Do you have a link to a study showing that asymptomatic persons can spread COVID-19? I hear talk of it but have seen no data to support it.	https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html References provided in the section “Asymptomatic and Pre- Symptomatic Infection”
How about Hospice workers, nurses, Chaplains, social workers - are they essential in the care of dying patients?	Yes, they are allowed, but they do need to do symptom assessment, and should not be there if they are symptomatic; they should wear a mask while in the facility.
According to the preparation guide, a suspected COVID case refers to having a fever and two or more symptoms. Is this the requirement for healthcare providers on when to send them home? For example: if a team member reports a sore throat only, should they stay home for seven days? Does this mean someone who reports a sore throat only needs to stay home for seven days? We've also had GI symptoms on our symptom checker, but this symptom is not listed as high risk on CDC or the PUI form. Should GI symptoms be included, and team members sent home for them?	Anybody with any type of symptoms suggesting an infectious illness should stay home at least until symptoms resolve. If a person meets the PUI criteria, that would increase your suspicion for COVID-19. Guidance for healthcare personnel has been updated and can be found here: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
Do Elders show fever as an early symptom?	It varies, but fatigue is the most common first symptom.
How do you define suspicion of COVID 19 for reporting to KDHE purposes?	If a person meets the PUI criteria and/or if a provider orders a person tested for COVID-19.
Can we get some suggestions on how to keep residents safe in a secured dementia unit? At times trying to keep a person with dementia in the room can increase agitation and aggression.	We have experienced this with several dementia locations in KS and have sent those needs to CDC. Guidance for dementia units is forthcoming from CDC. Please be on the lookout for this. We will share it with this group as soon as it is on the web.

What types of PPE would you wear for residents not showing signs of COVID if you have one infected resident? If there is a positive case and you're recommending wearing PPE for all resident care, should staff don and doff PPE for each individual resident or wear the same PPE for all residents? If you get one confirmed case, all staff wear the PPE, since there is a shortage of the gowns, do they wear the same gown between rooms to conserve?	The CDC recommendation is to use full PPE (gown, gloves, mask, eye protection) for all residents in your facility, even if you have one resident who is infected. This is because residents can be asymptomatic but infected, and because we don't know who has it and who doesn't. We need to treat everyone as if they were infected. However, you can use the same mask and same eye protection (goggles or face shield) for the whole shift, and more if stored/cleaned properly. Gloves need to be changed between every resident and hand hygiene should be performed. Gowns should be discarded between each resident, and when gowns are in short supply, prioritize gowns for high contact activities. You **should not** go from room to room with the same gown. See for more on gown and other PPE conservation https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/.
Do you recommend oxygen saturation screening at the beginning of the shift for all employees as well? We were thinking about starting this.	This is not currently recommended. If a facility chooses to do this they can but should consider availability of supplies for performing and cleaning the equipment for this check.
What is the best practice for dining services if there is an outbreak? Should all residents even those needing assistance with eating be required to eat in their room?	CMS has put out guidelines to discontinue communal dining at this time (not only for outbreak situations); facilities should try to follow this as closely as able. Those who need assistance with eating could eat in their rooms if there is enough staff to provide one-on-one supervision. If this is not possible, bringing only those residents out to the common area to be supervised while eating is acceptable as long as there is adequate spacing maintained between each resident to adhere to social distancing.
We are supposed to get vitals at least 3 times a day, but what times are you suggesting? We do it when the resident awakens, when second shift comes on (around 2-2:30pm) and currently at around 7pm so as not to wake residents in the night. Some are saying we should do it during the night shift, not twice during 2nd shift. What are your thoughts?	This schedule is good. There is not a need to wake a resident up to take vitals unless clinically indicated.

If there is no known COVID infection in the SNF, can we take the residents go outside for better psycho/social well-being? Do they need to wear face mask when being escorted to dining room or out of their rooms?	Yes, the residents should be allowed to go outside. Nothing in the stay at home orders or social-distancing or even home isolation/quarantine says the people cannot go outside; the key point is limiting exposures between people. It is good to go outside. They should be allowed to move around and be active. You can take residents outside one at a time or in small groups and maintain social distance while they are out. If the resident is able to tolerate a cloth face cover, they should wear one while out of their room for any reason, this is the preferred method. Facemasks should ideally be reserved for use by staff giving direct resident care.
Are there any guidelines on COVID positive employees returning to work? Do you consider the return to work as 7 days from initial s/s plus 72 hours fever free, 10 days total? Or is the 72 hours fever free within those 7 days?	**Note**: this guidance was recently updated from 7 to 10 days. The 72 hours fever free (without use of fever reducing medications) can be within the minimum number of days (now 10) or an extension of the minimum number of days, depending on the person's symptoms. See links below for more guidance. KDHE Release from Isolation/Quarantine CDC HCP Return to Work Guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
We are an LTC attached to a CAH. Our physician is wanting to know if we should even admit a patient to our CAH due to the relationship with the LTC. We share the dietary and laundry department.	There is no restriction on admitting persons to any of your facilities. You should still be able to admit patients/residents as you normally would, but follow the precautions outlined in the CDC LTCF guidance. **Note**: isolate/quarantine admitted residents for 14 days after admission and look for signs and symptoms of COVID-19.
Are the cases listed earlier in LTC and group settings a positive of residents only or staff and residents? How are positive cases counted?	Both residents and staff. A positive COVID-19 test (PCR) result is considered a positive case.

Are there any plans for protocols to reopen for family visits? Is the CDC and CMS having discussions on how nursing homes will open back up so that a DPOA/Guardian, or Emergency First Contact can visit there loved one again? Will this be looked at, as a State to State plan for timeline of allowing visitors in a nursing homes, or a one size fits all for all nursing homes?	The guidance to shut down visitations originally came from CMS, though CDC and KDHE do recommend they be followed. We are unaware of what CMS has planned for when/if they might put out guidelines to reopen for family visits. KDHE does not have a plan to create protocols for reopening to visitors at this time. However, we realize how important mental and emotional health. As such, we are in support of facilities finding creative solutions (outside of the obvious virtual/electronic visits) to allow for families/friends to visit their loved ones while keeping needed social distancing in mind for safety of your residents (during this time of shutting down facilities to normal visitations). Examples we have heard of/suggested so far: • Family stay outside the facility but visit through a window. • Resident sits just inside porch door, family visits from porch. • Resident and family sit outside for visit The key to any visit like this is to limit exposures as much as possible. If an active outbreak is occurring or if individual residents are in isolation/quarantine the facility should halt non-virtual/electronic visits until illness has resolved.
Are nursing homes expected to go out and find/purchase COVID-19 test kits for their residents and staff in case of the need for testing?	Having supplies on-hand for collecting as quickly as possible for suspected cases would be ideal but it not a requirement. Preparedness and early detection and response seems to be very important when trying to contain COVID-19; having the ability to test as quickly as possible is a big part of this. Testing supplies can be found through normal medical supply vendors, partnering with the local acute care facilities or other long-term care in your area, or you can work with your local health departments to explore the capacity that they have for providing them. Once KDHE is made aware of the presence or suspicion of COVID-19 in a facility we can also work with our state laboratory to provide supplies if they have some available.

Will LTC facilities be required to report to 3 entities KDHE, local health dept and CDC? How could this be streamlined so we aren't overwhelmed? Do these 3 entities share information with each other?	Reporting of COVID-19 is required within 4-hours of suspicion and confirmed disease due to the need for immediate public health response. Due to the importance of early detection and response there is unfortunately not a way to do away with the need to report to KDHE. However, we now have an online reporting portal for COVID-19. This covers reporting of the suspicion of COVID-19 (preferred) or a confirmed case of COVID-19; only one report person ill person should be made via the portal. Use of the portal will alert both KDHE and your local health department of the reports you make. KDADS does not have access to this system, however, the HAI/AR Program is trying to partner with partners in order to streamline reports required of our healthcare facilities as much as possible. Any ideas on how to best streamline reporting for LTC, please send to Bryna.Stacey@ks.gov and include any contacts you have for KDADS.
If COVID-19 is brought into a facility that has been on lockdown from visitors, from an asymptomatic employee, is the data showing that this virus can be contained once a resident has contracted the virus by isolating the resident, or is the data showing wide spread, cluster infections throughout the facility once a case has been presented?	Preventing the virus from entering the facility is the first step and best strategy for controlling spread. Once it gets in, it can be hard to control. Proper social distancing, monitoring for symptoms, and universal masking in addition to use of other recommended PPE need to be followed as these tools give us the best chance to try to contain spread once it enters a facility.

Should testing be done prior to a LTCF accepting a resident even if the individual is asymptomatic? Hospitals are wanting to discharge patients to us. What is appropriate to ask them to do before we accept them? For example, no fever, covid-19 test, isolated for a period of time? If a facility has an admission or readmission that tests negative before returning to the facility, does the facility still need to isolate the individual for 14 days? So, are you suggesting that the hospital test if the LTCF is requiring it? Who pays for this testing? Will KDHE preform the test if asymptomatic? If hospital patients/prospect nursing home residents don't need 2 negative tests, then why do employees need 2 negative tests? So isolate and not quarantine when returning from the hospital? looking at CDC fact sheet on Quarantine and isolation	A resident being discharged to a nursing home after a hospitalization for non-COVID-19 related reasons, does not need to be tested for COVID-19 in order to be admitted to a nursing home. Residents with confirmed COVID-19 being discharged from the hospital do not need to be tested for clearance of COVID-19 in order to be admitted to a nursing home. KDHE recommends that any residents newly admitted or readmitted be in isolation/quarantine for 14 days from admission. **This includes residents who were tested and had a negative result.** The idea is to keep these residents who have been out of the facility separate from the rest of the residents to the extent possible, in case they had been exposed to coronavirus during the hospitalization and are still in the asymptomatic phase. Testing for these admissions would be recommended only if they develop signs and symptoms compatible with COVID-19. 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). Other considerations for facilities: • Review CDC guidance for Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019: https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html • Increase the availability and accessibility of alcohol-based hand rubs (ABHRs), **reinforce strong hand-hygiene practices**, tissues, no touch receptacles for disposal, and facemasks at healthcare facility entrances, waiting rooms, resident check-ins, etc. • Ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms. • Increase signage for vigilant infection prevention,

	such as hand hygiene and cough etiquette. • Properly clean, disinfect and limit sharing of medical equipment between residents and areas of the facility. • Provide additional work supplies to avoid sharing (e.g., pens, pads) and disinfect workplace areas (nurse's stations, phones, internal radios, etc.). IF the test-based strategy is being used: • Residents would ideally get two negative tests before being discharged from the hospital to the nursing home, though this is not always possible or timely • Employees who have been diagnosed with COVID-19 would get two negative tests before coming back to work KDHE I/Q: https://www.coronavirus.kdheks.gov/DocumentCenter/View/134/Isolation--Quarantine-Guidance-and-FAQs-PDF---5-4-20 CDC I/Q: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/social-distancing.html