Reopening Guidance for Nursing Homes Frequently Asked Questions

August 4, 2020

General Questions

Q1. Does the definition of staff include phlebotomist, IT, etc. when services are shared with the hospital?

A1: The term Healthcare Personnel (HCP) includes, but is not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel). This means that anyone who has the potential to expose residents to COVID-19 should be testing despite the amount of time spent on the unit or near residents. The Centers for Disease Control and Prevention (CDC) provides additional information on this topic.

Q2. Will the state provide case status in community (will they perform the calculation)? Where do I find the regions?

A2: A map of regions is available on the DHSS Coronavirus dashboard. Scroll down on the left side and you will see a map with 7 day case rates; there is a tab under that image where you can select Alert Levels. Hover over a region to see the region's alert level, which corresponds to the average number of new cases per day for the last 14 days. Keep in mind that while alert levels can provide useful information for guiding when risk is decreasing, there may be other factors that increase risk more suddenly than is reflected in the alert levels, for instance an outbreak in a facility or in the community. Because the regions had to be quite large to allow for data accuracy, smaller communities may have outbreaks that make transmission in the community more likely but do not change the region's alert level. Be sure to follow the guidance for when to change phases, which is partly based on alert levels and partly based on facility factors. Additional information is available in Table 2c: Geographic Distribution of Case Rates.

Q3. How should facilities address residents who desire to leave the facility for a home visit?

A3. Residents have the right to leave, but the facility must create and implement policy and procedures that frame the facilities plan about this issues, including the protocols regarding the return to the facility once a resident has left for any period of time. The reasons for leaving and how long a resident is gone may impact the policy. For example, the policy for leaving for a medical procedure will likely be different from a policy for leaving to spend time with a family member for a weekend. You would need to consider the safety of the other residents. The plan should include how the facility will ensure the returning resident will be screened, tested and/or quarantined. A facility must do all they can to protect all residents; be sure to inform residents of the risk of leaving and educate them on proper methods to social distance, wearing masks and hand hygiene. The facility would need to also inform the residents of their policy related to a resident leaving for a home visit, including what the resident may expect when he/she returns.

Staff Testing

Q1. Who will pay for testing staff every two weeks?

A1. The facility is responsible for covering the cost of testing employees.

Q2. Does the State have the supplies and capacity to test all of our residents and staff every two weeks?

A2. Yes

Q3. Can the staff/resident testing be done half one week and half another week? The logistics around testing 200 people at one time is very challenging.

A3. Yes, you can develop a process in your facility to do this. If an outbreak occurs, a facility may have to pull all staff back on the same schedule.

Q4. We have over 350 caregivers; logistically this is too much for us. We want to go with 25% every week which is about 85 people a week. We feel like this would give us good surveillance. Do we have the flexibility to make that change?

A4. No, staff testing needs to be conducted on a two-week interval. Please see additional guidance under Q3 of this section.

Q5. Are we required to confirm through the State PH Lab or can we use polymerase chain reaction (PCR) in house?

A5. You can use PCR in house (molecular test only; no antibody or serology test). At this time, we are also not accepting antigen tests for this purpose since the antigen tests so far have been less accurate than the molecular tests. Please see the FDA website above if you have questions on which type your test is prior to implementing.
The Alaska Division of Public Health's Section of Epidemiology and the U.S. Food and Drug Administration provide additional testing guidance

Visitation/Visitor Testing

Q1. What frequency should visitors be tested? What if they visit every X# days/ weeks? Do they have to show a negative test at every visit? If not, what are the parameters?

A1. Visitors must have a negative test performed within the last 72 hours to visit. Tests are valid for 72 hours from when they are performed (not when the results return). Visitors that tested within 72 hours should also have their symptoms checked on arrival and asked about any potential exposure (i.e. contact to a positive COVID cases in past 14 days, travel and no fever or other symptoms). Visitors and residents should wear a facemask if able. Visitors are monitored and should have few options in what they can do in the facility.

Q2. Test results may take longer than 72-hours. Are there any other options for faster results or can the 72-hour timeframe be extended?

A2. There are several options available which may be able to provide more rapid test results. Some facilities have Abbot ID NOW machines, which are PCR tests that can be run in 15 minutes and are acceptable to test visitors. Other options include at-home tests which you mail, some of which have rapid turn-around times. Because test result times can change rapidly, visitors should be encouraged to research all of their options and inquire about current turnaround times. Because contagious illness can develop in 3 days, 72-hours is the longest possible time it is safe to wait after a negative test result, so this time frame cannot be extended.

Q3. Is there an age restriction for visitors?

A3. Any visitors must comply with physical distancing, mask wearing, hygiene, symptom screening and other practices necessary to protect elders. We suggest facilities approach having visitors under age 18 with caution and consider having a staff member supervise. Children under age 12 may not have the maturity necessary to understand and follow infection precautions. Children too young to have a COVID-19 test should not visit.

Q4. Can more than 1-2 persons visit elders at a time?

A4. Prioritize visits and limit amount of people visiting and be diligent about number of visitors. Because each visitor multiplies the risk to all elders in the facility, we suggest that facilities limit visitors to 1-2 at a time. Social distancing must be maintained at all times.

Q5. Is it recommended that families do not touch the residents to further decrease the transmission of SARS-CoV-2?

A5. Facilities should remind families that being within 6 feet significantly increases risk of viral transmission, as does touch. It is recommended that families do not touch the residents as this would significantly decrease the transmission possibility of SARS-CoV-2.

Q6. Who will pay for visitor testing? There could be disparity among families. Low income families v. moderate/high income families related to cost in covering the test. There is concern that visitors will expect the facility to pay for testing since they will be enforcing the requirement.

A6. Visitors have to cover the costs of their own test unless otherwise indicated by other state departments through grants. Providers may pay for the test as well. We suggest facilities make their policies clear. Visitors can contact their insurance and research their options to find the best test for their insurance and budget.

Q7. Can Long Term Care Civil Money Penalty funds be used to pay for visitor testing?

A7. No, not right now. However, this may change in the future with federal initiatives for testing in nursing homes.

Q8. Are facilities supposed to limit the number of visitors for each resident per week and per occurrence?

A8. Yes, the facility will need to provide the safety and security for their residents. Each facility will need to determine the safest and most practical way to allow limited visits and ensure they can reduce the risk of transmission in the facility. Oversight of the visitation numbers, length and interaction will

Q9. Should facilities have *"visitation by appointment only"?*

A9. It is advisable to do visitation by appointment to prevent large amounts of visitors near or in the facility at one time. It will be up to the facility to decide on the process to ensure this guideline is met.

Q10. Can staff bring pets in? One staff has a hypo-allergenic dog that used to come in to be a therapy dog to residents, but that was stopped when the lock downs happened. Can they resume that?

A10. It is recommended to refrain from all pets, including dogs, from being brought into the facility due to the unknown nature of SARS-CoV-2 infection in animals.

Admissions

Q1. If new admit tests negative within 48-hours, do they still have to quarantine for 14-days as referenced under Phase III PPE?

A1. Yes, if the test is negative, continue to limit contact between a newly admitted resident and other residents as much as possible for 14 days following admission. Refer to Admission Testing Guidance for more information.

Q2. If the new admission received a COVID-19 test during their hospitalization, can that start the clock on the 14-day quarantine? Completing a 14-day quarantine of all new admissions will increase the length of stay in acute care due to decreasing bed availability and inability to co-hort.

A2. No, the test should be performed within 48 hours of admission to the facility. A test performed earlier than that would not detect an infection acquired during the hospitalization.

Q3. What about the person who has been isolated in a swing bed status in a critical access hospital (CAH) and has a negative test >48h prior to admission?

A3. The test should be performed within 48 hours of admission to the LTC regardless of the co-location of CAH and LTC services.

Q4. Do new admissions have to quarantine for 14-days? We have been using 7-days if the admission came from a private swing bed room (again co-located…) and is COVID-negative

A4. Yes, if the test is negative, continue to limit contact between a newly admitted resident and other residents as much as possible for 14 days following admission.

- If possible, assign resident to a private room.
- Use staff who have limited contact with other residents and staff to care for newly admitted residents.
- Consider re-testing newly admitted residents at the end of the 14-day period, especially residents in whom COVID-19 symptoms are difficult to ascertain.

Refer to Admission Testing Guidance for more information.

Communal Dining & Activities

Q1. Can facilities resume limited congregate dining if the residents are spaced out (one per table, a minimum of six feet apart) and eat in shifts so that there are fewer people in the room during the meal?

A1. Yes, for additional information please see page 6 of the Nursing Home Guidance under Phase II and Phase III.

Q2. If limited congregate dining is allowed, can facilities resume limited activities with residents in the same room, at a minimum six feet of spacing between residents? Limitation could be number of residents, or time limit together?

A2. Yes, for additional information please see page 6 of the Nursing Home Guidance under Phase II. This is to include social distancing of at least 6 feet. It would be in the best interest not to conduct activities and dining at the same time. Additional guidance can be found under Phase III.

Q3. Can several residents go out to the deck area if they stay six feet apart out there? For example, smokers have been allowed to go outside together at other facilities, so why can't non-smokers go out together if they are distanced?

A3. Yes, residents can go out on the deck with appropriate protection (face coverings/masks) and social distancing. Please limit the number of residents based on the areas ability to social distance. Smokers should follow the same criteria and should not be huddled together when smoking. Since smoking encourages more rapid and harsh exhales it would be advisable to limit the number of smokers at a time and follow a routine schedule with specific times for residents to take turns utilizing smoking areas. These areas should be barricaded from general public and monitored for compliance. Facilities may want to designate specific smoking spots within a smoking area at least 6 feet apart to encourage physical distancing

Essential Workers/Non-Essential Workers

Q1. If you are in Phase 2 and you start a CNA class and then have an exposure or case counts go up and have to go back to phase one do you have to cancel the class?"

A1. If a facility regresses back to Phase 1 due to a failure to meet all criteria, then the facility administration should contact state epidemiology for guidance based on their specific scenario. This response comes from the concern with low staffing of CNAs and the state is willing to address this specific scenario on a case by case basis.

This document will be updated as more information becomes available.