# COVID-19 Frequently Asked Questions

Last updated: March 19, 2020. Changes from the previous version are underlined and in red.

## Screening & Access to Nursing Homes

**Q1. Where can I find guidance that has been issued on nursing home access?**

**A1.** The latest guidance on nursing home access was released on March 13 from the Centers for Medicare & Medicaid Services (CMS).

On March 11, the DeWine Administration first released a Joint Directors' Order which outlines limitations and precautions that should be taken by Ohio nursing homes and similar facilities, including assisted living, regarding visitation. This order has been updated several times since it was initially issued. Additionally the Department of Health sent a letter to Ohio nursing home administrators further clarifying the order.
https://leadingageohio.org/aws/LAO/asset_manager/get_file/433391?ver=61

**Q2. What personnel and contracted staff should be permitted access to a nursing facility?**

**A2.** The Directors' Order states that access should be limited to those personnel who are "absolutely necessary to the operations of the homes." Those individuals may include staff, contracted and emergency health care providers, contractors conducting critical on-site maintenance and governmental representatives and regulators and their contractors.

**Q3. What are the requirements for screening individuals (visitors, suppliers, personnel, etc.) entering a nursing home or assisted living facility?**

**A3.** On March 7, the Centers for Disease Control & Prevention (CDC) issued updated guidance for screening healthcare personnel.

This same guidance should be applied for visitors during compassionate care/end-of-life situations.

**Q4. Are hospice staff considered "absolutely necessary," in light of the Governor's order? What does CMS guidance say about end-of-life visits?**

**A4**. In the March 16 letter sent to nursing home administrators, Ohio Department of Health (ODH) clarified that nursing homes must "make sure the health care needs of … residents are being met, and that contracted health care providers are being given access to the facility if eligible after screening, particularly hospice providers." LeadingAge Ohio encourages hospices to use discretion in determining which members of the interdisciplinary team should visit in-person and evaluate whether any services can be suspended and/or provided via telehealth or other assistive technology.

In the March 14 guidance to nursing homes, CMS defines healthcare workers as applying to other healthcare workers, such as hospice workers, EMS personnel or dialysis technician which provide care to residents. They should be permitted to enter the facility provided they meet the CDC guidelines for healthcare workers.

**Q5. How should assisted living treat home care companion services that are paid privately by a resident?**
**A5.** See Q14c.

## Visitation to Nursing Homes

**Q6. Should a nursing home restrict all resident visitation?**
**A6.** According to the March 13 CMS Guidance, "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. "

**Q8. How should we counsel residents and families who are accustomed to leaving the facility on a regular basis, for example, to go out to eat?**
**A8.** The Joint Directors' order does not restrict individuals' rights to move freely in and out of nursing facilities or assisted living. It is advised and considered best practice to discourage residents from leaving, and/or to encourage them to choose times and venues that would present a lower risk. For example, visiting with one friend versus attending a family gathering.

A facility is permitted to have a policy which outlines screening residents who leave and come back. ODH has not provided guidance on whether a nursing facility would be able to subsequently place an individual in isolation or discharge an individual who has left a facility and returned for non-medical reasons.

## Gatherings & Congregate Dining

**Q8a: Has anything been released in regards to cancelling Resident Council Meetings till further notice?**

**A8a.** On March 16, President Trump that nationwide, there would be a ban on gatherings of 10 or more individuals. LeadingAge Ohio encourages members to consider facilitating Resident Council meetings via technology or limiting the size of Resident Council meetings and set up meetings in such a way that individuals are seated at a safe social distance (6ft) from one another. Another option is holding more than one resident council meeting, for example, by neighborhood, which would allow for smaller gatherings.

**Q8b. If communal dining is no longer permitted, should nursing facilities/assisted living close their dining rooms?**

**A8b**. The elimination of communal dining does not mean dining rooms need to be closed, of course, but it is important to maintain six feet social distance.

Here are ideas for nursing facility/assisted living:

- Moving tables in the nursing area so they are six feet apart and placing one person per table (i.e. social distancing). Meal hours likely extended, as a result of the limitation on the number of residents that could be served at one time with this method. Prompting for those residents that need it and assisting by staff would have to be maintained.
- Meal delivery to rooms for all. Seems very challenging for those that need the prompting/assisting.
- Giving residents a choice: asking residents if they want the social distancing option OR meal delivery.

Here are ideas for residents in independent living:

- Arranging a meal pick-up time with staggered times by last name (i.e. A's – F's: 5:30 – 5:45; G's – L's 5:45 -- 6:00; M's – S's 6:15, etc.)
- Limiting menu options to facilitate meal delivery to all

## Returning & Admitting Patients

**Q9. What protocol should be in place for patients returning from a hospitalization?**

**A9.** Residents be allowed to return to a facility following a hospital discharge. The individual should be screened according to the criteria provided, and if there is an indication of illness, placed in isolation according to protocol described in CMS guidance.

**Q10. Should a facility continue to admit new residents?**
**A10.** None of the recent guidance restricts a nursing home or assisted living from admitting new residents. New residents should be screened according to the protocol described in Q3 as part of the admission assessment.

Nursing homes have an important role in ensuring the health care system does not become overwhelmed. It is critically important that nursing homes continue admission practices, caring for those individuals who are most appropriate to this level of care.

**Q11. How should a facility accommodate individuals & families who are requesting tours of a facility, in anticipation of admission?**
**A11.** An advisable practice would be to use technology to provide a virtual tour of the facility.

## Caring for Individuals with COVID-19

**Q12. What actions should a provider take if they have a suspected or confirmed case of COVID-19?**
**A12.** ODH wants providers to immediately call the local health department after they contact the physician. The local health department has received guidance and will advise the provider on next steps.

The Centers for Disease Control & Prevention has released Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes on when a patient is confirmed or suspected with COVID-19 in a healthcare setting.

Additionally, the CDC has long-term care-specific guidance available to help nursing homes: Preparing for COVID-19: Long-term Care Facilities, Nursing Homes.

Place a patient with known or suspected COVID-19 in a single-person room with the door closed. The patient should have a dedicated bathroom.

LeadingAge Ohio encourages members to consider designating a portion of their facility to care for COVID-19 patients. This will be an important step in conserving PPE and limiting transmission within your facility.

Additionally, nursing facilities with excess space (for example, a vacant wing or a skilled unit that has seen decreased referrals), are encouraged to reach out to their local health departments, that may soon be identifying facilities that can be dedicated to caring for COVID-19 patients, OR for patients that would have otherwise been cared for in a hospital, in order to free up hospital capacity.

**Q13. We have residents that are exhibiting symptoms consistent with COVID-19. How do we access test kits?**
**A13.** ODH has clarified that the first call should be to the resident's physician, who would write the order for the testing. The local health department should be the next call. That person will

direct the provider on the current status in terms of where to access test and/or whether to test or to self-quarantine.

**Q14. Our nursing facility does not have a reverse-pressure isolation room equipped to care for individuals with COVID-19. What should we do if we identify a likely case?**

**A14.** Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.

Room sharing might be necessary if there are multiple residents with known or suspected COVID-19 in the facility. As roommates of symptomatic residents might already be exposed, it is generally not recommended to separate them in this scenario. Public health authorities can assist with decisions about resident placement.

Facilities should notify the health department immediately and follow the Interim Infection Prevention and Control Recommendations for Patients with COVID-19 or Persons Under Investigation for COVID-19 in Healthcare Settings, which includes detailed information regarding recommended PPE.

## RCF/Assisted Living Questions

**Q14a. If a family member sets up a resident's medication, are they allowed to enter and do that medication set-up?**

**A14a**. No. The Ohio Department of Health has shared that an RCF should complete any tasks that can be done by staff. Alternatively, the facility nurse could take the medications to the family, meet them at the entrance, and then the family could fill the pillbox at home, and then deliver them back to the RCF.

ODH has shared that if a family member normally does any kind of task, but it is a task that RCF staff can do, then the RCF should take over this task for the time being. This includes catheter change, dressing change, and medication administration, as well as housekeeping, laundry, dusting and other duties.

**Q14b. If a resident dies, are the family allowed to come in and remove belongings (both in Nursing Home and RCF)?**

**A14b**. Yes. The family would be allowed to remove belongings following an individual's death. Similarly, if an individual is being admitted, the family is permitted to move furniture and personal items in.

**Q14c. How should assisted living treat home care companion services that are paid privately by a resident?**
**A14c.** ODH has since clarified that any services that a residential care facility *can* provide, it *should* provide. This includes assistance with any activities of daily living which may have previously been provided by a private duty caregiver or family member.

Ask the question "Is our facility able to provide the service?"

- If yes, then the family/volunteer is not essential.
- If no, a nurse is not onsite and family is able to do the service, then yes it is essential.

For example, if an RCF does not have a nurse when an RCF resident needs to have a specific care or services that would be provided by a nurse, but the family is able to do it, then this would be considered essential. This is an example when the RCF did not have a nurse during that time.

## Staffing & Workforce

**Q15a. If we have a suspected or confirmed case of COVID-19, should we quarantine staff? If a staff member presents at the nursing home and they have a fever, what actions should a provider take?**
**A15a**. The CDC have provided ***very*** specific guidance for staff potential exposure. Note, in particular, the final two paragraphs copied below speak to the fact that employees who believe they may be symptomatic should leave work immediately.

Having a fever would fall under potential communicable disease and them not coming in. With COVID-19, ODH is recommending ruling out any other underlying cause. So having their primary physician do a health assessment and definitely an influenza swab would be important.

> *While contact tracing and risk assessment, with appropriate implementation of HCP work restrictions, of potentially exposed HCP remains the recommended strategy for identifying and reducing the risk of transmission of COVID-19 to HCP, patients, and others, it is not practical or achievable in all situations. Community transmission of COVID-19 in the United States has been reported in multiple areas. This development means some recommended actions (e.g., contact tracing and risk assessment of all potentially exposed HCP) are impractical for implementation by healthcare facilities. In the setting of community transmission, all HCP are at some risk for exposure to COVID-19, whether in the workplace or in the community. Devoting resources to contact tracing and retrospective risk assessment could divert resources from other important infection prevention and control activities. Facilities should shift emphasis to more routine practices, which include asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection and not report to work when ill. Facilities should develop a plan for how they will screen for symptoms*

*and evaluate ill HCP. This could include having HCP report absence of fever and symptoms prior to starting work each day.*

*Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks.* ***If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work.***

**Q15b. What supports are available for non-essential staff that we have had to lay off? What supports are available for individuals who are sent home to self-quarantine, in terms of unemployment?**

**A15c.** The DeWine Administration waived the one-week wait period to receive unemployment benefits from the state of Ohio, and has made unemployment compensation available to employees who are quarantined due to signs/symptoms or a positive test for COVID-19. More information is available at www.unemployment.ohio.gov.

Additionally, on March 18, President Trump signed the Families First Coronavirus Response Act, which made significant changes to FMLA policies and sick leave policy.

**Q15b. What do we do if a clinical employee (STNA, Nurse) refuses to provide care to a resident/patient that has been exposed to COVID19 and/or has tested positive for it?**

**A15b.** Given appropriate policies/procedures and PPE for employees, there should not be any reason that an employee can choose not to care for an individual that is infected with COVID-19. If they refuse to take care of the individuals on the assignment, we would encourage employers to utilize their disciplinary protocols for the refusal to care for an individual with an infectious disease. Employees must perform their assignments within the structure of their job descriptions. (Guidance provided by Benesch, 3/16/20)

**Q15c. Currently, we are screening all employees for COVID-19 symptoms and exposure at the beginning of each shift, but in the future, as more people are tested or exposed, how will we continue to manage our workforce?**

**A15c.** Your local health department is still the best source for the most current information for your county and for guidance in the event of COVID-19 exposure or positive test. Additionally, the CDC has provided Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease.

**Q15d. To what extent can we use volunteers?**
**A15d.** Providers should be utilizing only personnel who are absolutely necessary for the operations. Emergency Preparedness plans should be implemented. For nursing homes, if a volunteer is needed to meet an operational need, implement according to SOM Appendix Z E-24.

During a call with ODH on March 17, they learned that many homes are utilizing volunteers to screen employees because of smaller staff. Providers need to make sure they are conducting the same screening for that volunteer as they do for staff.

## Childcare

**Q15e. If childcare centers close, what options are available to our staff who need childcare in order to keep working?**
**A15e.** On March 18, the Ohio Department of Job & Family Services annouced a new "pandemic childcare center" license available to any licensed childcare center in the state of Ohio. Providers are encouraged to reach out to the childcare centers used by their employees and ask them to consider applying to become a pandemic childcare center.

At this point in time, ODJFS is not permitting long-term care providers to offer on-site childcare, if they did not operate a child care center previously.

## PPE Availability

**Q16. Our facility is nearing exhaustion of certain PPE. Who should we reach out to?**
**A16.** The first contact should be your local health department, which will have the latest information of PPE supplies in your local area. Additionally, your Regional Healthcare Coalition may be a resource in coordinating exchange of PPE between local healthcare providers/organizations. ODH has encouraged providers to complete the survey it sends out each Monday via the EIDC system, to ensure ODH has an accurate account of PPE stores within the community. Additionally, the local Ombudsman program may have access to PPE, so they may be a helpful resource for providers as well.

In addition, the CDC has a webpage specific for healthcare that provides guidance on Healthcare Supply of Personal Protective Equipment. On March 18, the CDC released updated guidance on strategies for optimization of PPE.

## Regulatory Relief & Flexibility

**Q17. Will survey and oversight visits be suspended for nursing homes, assisted living, and other healthcare providers & housing operators?**

**A17.** Currently, the following survey and oversight activities are suspended:

- Residential care facility surveys, except for two-day complaint surveys.
- Ombudsman visits. Ombudsman will continue to work with families and residents via phone.
- MDS Exception Reviews in nursing homes.
- REAC Inspections to HUD properties

Furthermore, LeadingAge Ohio is anticipating in the near future, CMS will suspend all recertification surveys except for those involving immediate jeopardy citations, but this had not been released as of the last update of this document.

**Q 18: Do hospices still need to perform an in-person face-to-face visit for recertification or can they use telehealth? Are they still required to have an in-person nurse visit every 15 days for the completion of the comprehensive assessment for the update to the plan of care and 5% volunteer level of activity?**

**A 18**: The four national hospice associations,LeadingAge, NHPCO, NAHC and NPHI have signed on to a collective letter asking for regulatory relief for hospice. The letter addresses a number of areas where home health and hospice need relief. For hospice, it is the timeframe for the comprehensive assessment, volunteer 5%, face-to-face encounters to completed telephonically and visit frequency on the plan of care, to mention a few..

What the four associations have asked for is a blanket waiver which would apply to all hospice providers. In this case, each individual provider would not have to ask for a 1135 waiver individually.

## Hospice & Home Health

**Q19. Can you guide us as to what are essential services and what are not? Also, what language should be in care plans?**

**A19**. For hospice, the essential services are considered the Core Services: nurse, social worker, chaplain and physician as well as medications, durable medical equipment and supplies. The non-core services are volunteer, hospice aides, therapies and alternative therapies.

If you are not sending a given discipline into nursing facilities at this time (many hospices are significantly limiting in-person visitation), then you should write a hold order for those discipline visits. Sample order language could be: “Volunteer visit on hold due to the COVID-19 pandemic and visit orders will be resumed once the pandemic restrictions have been lifted.”

**Q20. Are there specific guidelines for the number of family members permitted in facilities and IPUs, and how next of kin is defined?**

**A20.** Nursing facilities have been given the directive to not allow any visits in the facilities, unless it is a compassionate care visit/end-of-life visit, but the guidance is not specific to the number of family members that should be permitted. LeadingAge Ohio strongly encourages all of its members to work to educate families to minimize visits to the greatest extent possible.

In the Ohio statute, next of kin is defined as the individual's spouse, adult living children, siblings, nieces/nephews/aunts/uncles or other relatives.