

COVID-19 Frequently Asked Questions

A resource prepared for members of LeadingAge Ohio

Last updated: March 27, 2020. This version of our FAQs includes additions from the March 20 all-member call, as well as significant reorganization and renumbering of items, to improve readability. Additions and changes from the previous version are underlined and in red.

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Personal Protective Equipment (PPE)

PPE1. Q. Our facility is nearing exhaustion of certain PPE. Who should we reach out to?

PPE1 A. The first contact should be your local health department, which will have the latest information of PPE supplies in your local area. Additionally, the Ohio Department of Health also recommends reaching out to the [Regional Healthcare Coalition](#) for your county. 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.

PPE2. Q. I haven't had success in finding PPE resources with my local department of health. What should I do next?

PE2. A. Reach out to the [Emergency Management Agency in your area](#). All county EMAs are on this link.

We understand the regional Ombudsman offices are assisting the EMA with collections from dental offices, veterinarians, etc. Another option is reaching out to local nail and hair salons, and tattoo parlors that have recently been closed.

PPE 3. Q. Do you have a brief document that explains whether the use of standard masks is acceptable as long as breathing treatments are not being administered?

PPE 3. A. Here it is directly from CDC website: [Checklist for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during the COVID-19 Response](#)

Personal protective equipment and respiratory protection should be used as part of a suite of strategies to protect personnel, complementing the use of engineering and administrative controls as needed.

Use surgical N95 respirators only for healthcare personnel who need protection from both airborne and fluid hazards (e.g., splashes, sprays). If needed but unavailable, use face shields over standard N95 respirator.

Use alternatives to N95 respirators where feasible (e.g., other disposable filtering facepiece respirators, elastomeric respirators with appropriate filters or cartridges, powered air purifying respirators).

PPE4. Q. Is there a formula to use to calculate your PPE utilization rate?

PPE4. A. A best practice would be to identify one or two people to distribute your supplies. Over a week's time, they will be able to gauge a rate on a day-to-day basis. Then, calculate the frequency based on a 24-hour time period.

[On March 24, the CDC provided a Personal Protective Equipment \(PPE\) Burn Rate Calculator. This tool assists healthcare facilities in planning and optimizing the use of PPE for response to coronavirus disease 2019 \(COVID-19\). Similarly, non-healthcare facilities.](#)

PPE5. Q. Staff are concerned about protection without N95 masks if we have a suspected COVID-19 patient. They feel without this it's like "sending a firefighter into a fire dressed in a bikini." I've reviewed the guidance on conserving PPE but I'm struggling with this when I see the drive thru testing facilities with the workers in overall hoods and a full mask. Please advise.

PPE5. A. The World Health Organization on March 3, warned of the PPE shortage and called on industry and governments to increase manufacturing by 40% to meet demand. One of the best ways to protect staff is to know your inventory, utilization, and availability of PPE. After identifying your current need, connect with your local health department and regional healthcare coalition. The Ohio Department of Health and the Ohio Hospital Association sent a letter to providers on March 12, recommending for the immediate actions for the conservation of PPE. The CDC has a webpage on strategies on optimizing the supply of PPE. Strategies such as reducing face-to-face encounters, limiting non-essential personnel, and utilizing telemedicine will conserve PPE, allowing it to be available for the direct care staff.

PPE6. Q. How are you advising organizations whose staff typically wear masks during their daily roles in the building. Are members allowing for cloth/reusable masks?

PPE6. A. Work with your local health department because they will know about access to PPE.

It is critical to educate the staff on the situation utilizing data about the crisis around PPE. Employees must understand that you know how to identify someone who is suspected to have COVID-19 and what to do right away, as outlined by the CDC in the [interim guidance](#). Communicate the importance of preserving PPE to be sure supplies are here for them when they will need it. The CDC provides [optimization strategies](#) for crisis management with PPE, including:

In "Settings where facemasks are not available, HCP might use homemade masks (e.g., bandana, scarf) for care of patients with COVID-19 as a last resort."

PPE7. Q. What other options are available for acquiring PPE?

PPE7. A. LeadingAge Ohio has partnered with Value First for group purchasing of PPE, including N95 masks, though at a significant cost. On the morning of March 26, all LeadingAge Ohio members received an email with details. Questions regarding this opportunity may be directed to cmarkham@leadingageohio.org or to covid19@leadingageohio.org.

Infection Control

IC1. Q. I have not seen a clear answer on the policy for employees returning to work who have come in contact with someone in the community who is being tested for COVID-19. I've seen policies for health care personnel who have come in contact with patients who are being tested, but what about an employee who says their friend that they spent time with five days ago is now being tested.

IC1. A. The interim guidance for [healthcare personnel with potential exposure](#) by the CDC assists healthcare facilities in making work restrictions based on a risk assessment. The local health department should be called for situations that are not clearly defined in this guidance. It is likely that procedures will change as more and more healthcare personnel are exposed to COVID-19.

LeadingAge Ohio has also asked ODH for clarity on very specific and complicated scenarios and will include those answers in future Q&A's.

IC2. Q. Should employees that have traveled out of state be allowed to return to work?

IC2. A. Out-of-state travel is no longer a significant risk factor due to Ohio having community spread of COVID-19. CDC guides facilities in areas of community spread to shift emphasis to more routine practices, which include asking healthcare personnel to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection and not report to work when ill.

The Ohio Department of Health has confirmed that travel is not as significant as direct contact with a person that is under investigation or confirmed. Guidance goes back to self-monitoring of symptoms: taking temperatures, and asking about exposure to confirmed or suspected individuals.

IC3. Q. We currently do not have any suspected or known COVID19 residents. However, in the event that we experience this in the future, we would like to know if there are any recommendations regarding how to isolate them.

IC3. A. Utilize the [Preparing for COVID-19](#) guidance which state:

If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community,

- 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.

Additionally, LeadingAge Ohio encourages members to consider designating a space/wing in their facility for caring for COVID-19 patients. Doing so will further reduce likelihood of transmission and help to conserve precious PPE.

IC4. Q. What are the recommendations in regard to mailed packages and personal items dropped off at nursing facilities and assisted living for residents?

IC4. A. On March 17, the United States Postal Service put out a statement saying there was no evidence COVID-19 is being spread through the mail. The message was based off CDC, WHO, and the Surgeon General’s guidance. The statement included the following CDC, “in general, because of poor survivability of these coronaviruses on surfaces, there is likely very low risk of spread from products or packaging that are shipped over a period of days or weeks at ambient temperatures. Coronaviruses are generally thought to be spread most often by respiratory droplets.”

Facilities should develop a drop off protocol that allows the staff member to stay six feet away from the person delivering mail or packages.

LeadingAge Ohio encourages organizations to remind staff to wash their hands after handling the mail. Organizations may choose, as an added precaution, to have staff handle mail using gloves. Addition consideration should be given to the availability of PPE.

IC5. Q. Is it okay to disinfect packages prior to them entering a nursing facility?

IC5. A. There has been no guidance on this point to date, and processing packages in this way may be seen as tampering with mail. One strategy is to limit the number of individuals who touch a package and more importantly, stay six feet away from person delivering the package, as COVID-19 is mostly likely to be spread by droplets.

IC6. Q. Do we know how long the virus lives on different surfaces??

IC6. A. The National Institutes of Health in their March 17 news release addressed how long coronavirus is stable on surfaces. The release stated: the virus that causes coronavirus disease

2019 (COVID-19) is stable for several hours to days in aerosols and on surfaces, according to a new study from National Institutes of Health, CDC, UCLA and Princeton University scientists in The New England Journal of Medicine. The scientists found that severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) was detectable in aerosols for up to three hours, up to four hours on copper, up to 24 hours on cardboard and up to two to three days on plastic and stainless steel.

IC7. Q. Is there an approved sanitizer/cleaner to put in carpet extractors for cleaning carpets in hallways, other care areas?

IC7. A. The CDC provides the following guidance: For soft (porous) surfaces such as carpeted floor, rugs, and drapes, remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. The CDC provides [environmental cleaning and disinfection recommendations](#). The above guidance on soft surfaces can be found in the [Interim Guidance for Environmental Cleaning and Disinfection for U.S. Households with Suspected or Confirmed Coronavirus Disease 2019](#).

IC8. Q. Is alcohol 70% or greater (like isopropyl alcohol 70% to 99%) approved for long-term care use for COVID-19? Also, is there a wet time indicated for alcohol 70% or greater? Our research is that alcohol based hand sanitizers indicate that 20 seconds of rubbing the hand sanitizer on hands is effective, but it would be nice to find an approved providing guidance for isopropyl alcohol on a cotton ball or cotton pad.

IC8. A. Alcohol-based hand rub with 60% ethanol or 70% isopropanol is effective and approved for long-term care. The CDC has provided [hand sanitation and Alcohol Based Hand Rub guidance](#) for healthcare personnel. Healthcare Personnel should perform hand hygiene by using ABHR or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR. This guidance is in [the interim Infection Prevention and Control Recommendations for Patients with confirmed or suspected Coronavirus \(COVID-19\) in Healthcare Settings](#)

IC9. Q. Is there any guidance you can offer on using china versus carryout containers?

IC9. A. Nursing Homes are already held to a high food sanitation standard in the [Requirements of Participation](#). The purpose of this high standard is to assume all dishes are potentially contaminated and Universal Precautions should be maintained. Using china will hold food to the correct temperature. The use of china also creates a dignified dining/meal experience. Review your organizations dish washing policy to ensure it meets the following F-tag 812 requirements:

- Machine Washing and Sanitizing - Dishwashing machines use either heat or chemical sanitization methods. Manufacturer's instructions must always be followed. The following are general recommendations according to the U.S. Department of Health and Human Services, Public Health Services, Food and Drug Administration Food Code for each method.
- High Temperature Dishwasher (heat sanitization):

○Wash - 150-165 degrees F; Final Rinse - 180 degrees F; (160 degrees F at the rack level/dish surface reflects 180 degrees F at the manifold, which is the area just before the final rinse nozzle where the temperature of the dish machine is measured); or 165 degrees F for a stationary rack, single temperature machine.

- Low Temperature Dishwasher (chemical sanitization):
 - Wash - 120 degrees F; and Final Rinse - 50 ppm (parts per million) hypochlorite (chlorine) on dish surface in final rinse.
- The chemical solution must be maintained at the correct concentration, based on periodic testing, at least once per shift, and for the effective contact time according to manufacturer's guidelines.

IC10. Q. Are there best practices for communicating if an employee is diagnosed with COVID19? We want to be prepared for if/when this situation arises.

A10. A. LeadingAge has prepared this for a media statement when a resident is diagnosed, which providers may use in communication with the media

“Earlier today (**ORGANIZATION NAME**) discovered that one of our residents has contracted the COVID-19 Virus (Coronavirus). As the safety and well-being of the residents and patients is our foremost priority, we immediately isolated the resident to ensure essential medical treatment, and notified the State Department of Public Health of this finding. We have also notified residents, family members and staff of this discovery, and are working closely with state officials to determine that all necessary steps are taken, including potential testing of residents and staff. The patient is currently being treated at **XXX (name of facility)**, and medical officials on-site at (**ORGANIZATION NAME**) are working to determine if any other residents there have been impacted. Any other media inquiries regarding this particular patient should be referred to the State Department of Public Health.”

IC11. Q. Our local health department has indicated they no longer want to be contacted regarding suspected cases, only confirmed cases. If we have a suspected case, and the doctor doesn't want to test, what actions should we take?

IC11. A. There are [3 key components](#) to managing a suspected case of COVID-19. First, limit the spread by reducing physical interactions. Utilize alternative methods of communicating such as through a telephone. Use telemedicine for any scheduled follow-up appointments. Second, if in a facility, isolate the suspected person in a well ventilated private room with door closed and a private bathroom. If in a private home, have them self-isolate. Lastly, educate staff on hand hygiene and PPE, in a facility, identify cohort residents, and limit the number of staff caring for this individual.

IC12. Q. Should anything be done differently for new hospital admissions that do not have COVID-19, but may have come from a hospital that has positive cases?

IC12. A. The CDC webpage: [Preparing for COVID-19: Long-term Care Facilities, Nursing Homes](#) advised nursing homes to:

- [Ask residents to report if they feel feverish or have symptoms of respiratory infection.](#)
- [Actively monitor all residents upon admission and at least daily for fever and respiratory symptoms \(shortness of breath, new or change in cough, and sore throat\).](#)
- [If positive for fever or symptoms, implement recommended IPC practices.](#)

IC13. Q. How long does alcohol have to be left on non-critical patient equipment to be effective?

IC13. A. It can be effective after one minute, but there is concern of it being ineffective in different scenarios such as coronavirus that is in a substance (like feces), because it is harder to kill and therefore, CDC's guidance is to use an [EPA-registered product to clean non-critical patient care items](#).

On page 26 of the May 2019 update of the [Guideline for Disinfection and Sterilization in Healthcare](#), it states:

[Because the SARS coronavirus is stable in feces and urine at room temperature for at least 1–2 days, surfaces might be a possible source of contamination and lead to infection with the SARS coronavirus and should be disinfected. Until more precise information is available, environments in which SARS patients are housed should be considered heavily contaminated.](#)

The CDC has provided an updated list ([List N: Disinfectants for Use Against SARS-CoV-2](#)) on March 19 for products to use for COVID-19. This list includes [products and the contact times](#). This list represents what should be used to disinfect surfaces.

List N includes products that meet EPA's criteria for use against SARS-CoV-2, the novel coronavirus that causes the disease COVID-19.

CDC has provided the [Coronavirus Disease 2019 \(COVID-19\) Preparedness Checklist for Nursing Homes and other Long-Term](#) that includes the following recommendations for cleaning of supplies:

[Facility ensures HCP have access to EPA-registered hospital-grade disinfectants to allow for frequent cleaning of high-touch surfaces and shared resident care equipment. Products with EPA-approved emerging viral pathogens claims are recommended for use against COVID-19. If there are no available EPA-registered products that have an approved emerging viral pathogen claim for COVID-19, products with label claims against human coronaviruses should be used according to label instructions.](#)

IC14. Q. Where can I find the infection Control Survey that was developed by CMS and CDC to perform a voluntary self-assessment? This document may be requested by surveyors.

IC14. A. CMS released the [QSO 20-20-All](#) memo on March 20 directing State Agencies to focus surveys on infection control and advise nursing homes to complete the self assessment that is included in the memo. This document can also be found on the [LeadingAge Ohio COVID-19 HUB](#) on our website.

IC15. Q. Has the temperature threshold changed to lower than 100.4?

IC15. A. ODH sent to all provides a bulletin on March 26 with a packet of information titled: ODH Assessment Tools, PPE, and Guidance 3.26.20. The information contained in this packet utilizes a temperature threshold of 100.0 rather than previously-identified 100.4. The CDC provides further explanation on temperature monitoring in the [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 \(COVID-19\)](#):

Fever is either measured temperature >100.0oF or subjective fever. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of patients in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<100.0oF) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) based on assessment by public health authorities.

Caring for Individuals with COVID-19

CA1. Q. What actions should a provider take if they have a suspected or confirmed case of COVID-19?

CA1. A. 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.

CA2. Q. We have residents that are exhibiting symptoms consistent with COVID-19. How do we access test kits?

CA2. A. 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.

CA3. Q. 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?

CA3. A. 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.

CA4. Q. Other states have begun to develop triage protocols which identify whether COVID-19 patients are eligible for life-sustaining treatment. Has Ohio begun to have these discussions?

CA4. A. LeadingAge Ohio is aware that across the country, other states and health system leadership have begun to develop these clinical protocols to determine how to allocate scarce equipment and resources. To date, these discussions have not been part of policy discussions at the state level in Ohio.

Q. What changes have been put in place related to handling of deceased positive COVID cases or potential COVID cases? Regarding removal from home? Transport to funeral homes?

A. We have not heard anything on this at this point. We will definitely add this to the process map. More information on this will be added to the LeadingAge Ohio COVID-19 HUB on our website.

Best Practice from the State of Washington shared on the CMS call - recommended facilities have a communication plan completed in advance and ready for notification of health department; EMS providers; Hospitals, transport companies; and funeral homes.

Staffing & Workforce

SW1. Q. 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?

SW1. A. 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.***

SW2. Q. 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?

SW2. A. 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.

SW3. Q. 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?

SW3. A. 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)

SW4. Q. 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?

SW4. A. 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](#).

SW5. Q. To what extent can we use volunteers?

SW5. A. 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.

SW6. Q. We are thinking of using nursing students as aides. Do you know of any additional documentation needed to do this?

SW6. A. Nursing students that meet the criteria in OAC 3701-17-07.1 are allowed to work as a nursing assistant for four months. The OAC rule states:

(6) The individual is enrolled in a prelicensure program of nursing education approved by the board of nursing or by an agency of another state that regulates nursing education.

has provided the long-term care facility with a certificate from the program indicating that the individual has successfully completed the courses that teach basic nursing skills including infection control, safety and emergency procedures and personal care, and has successfully completed the competency evaluation program; or
(7) The individual has the equivalent of twelve months or more of full-time employment in the preceding five years as a hospital aide or orderly and has successfully completed a competency evaluation program.

Before allowing an individual to serve as a nurse aide for more than four months in accordance with this paragraph, a facility shall receive registry verification that the individual has met the competency requirements under this paragraph unless the individual can prove that he or she has recently met the requirements and has not yet been listed on the registry. In the event that an individual has not yet been listed on the registry, facilities shall follow up by contacting the nurse aide registry to ensure that such an individual actually becomes listed on the registry. Once the facility receives written registry verification, it shall maintain such verification on file.

The Ohio Department of Health provides the following Q&A response to nursing students sitting for the nurse aide testing:

Can I sit for the state test without completing a NATCEP?

Yes, if you are a current nursing student or have worked as a bedside aide in a hospital, including military facilities, for one full year within the past five years, you may qualify to sit for the test. Contact [D&S Diversified Technologies](#) for more information.

Pandemic Childcare

CH1. Q. If childcare centers close, what options are available to our staff who need childcare in order to keep working?

CH1. A. On March 18, the Ohio Department of Job & Family Services announced 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.

CH2. Q. Will there be a list of “approved” daycare providers who have been approved as Pandemic childcare centers that we can partner with to provide childcare for our staff members?

CH2. A. Yes. ODJFS will be compiling a list of licensed pandemic child care centers, and posting to its [Pandemic Child Care Center website](#). LeadingAge Ohio anticipates it will have a complete list by the time they announce closing of childcare centers

CH3. Q. Can you run a daycare center in your facility or would the children be in violation of the no visitor restriction?

CH3. A. You can have a childcare center on your campus but not in contiguous proximity of where residents are living. Separation requirements will have to continue to prevent transmission of infection. You will need to avoid violating the ban on visitors to the healthcare facility. The children and the workers in the pandemic child care center would not be considered visitors. There will need to be dedicated space as to not violate the requirements.

CH4. Q. No license required until you are watching seven or fewer children?

CH4. A. The State of Ohio does not license childcare centers providing care to fewer than 7 children, so providers wanting to set up a babysitting service for employees are not prohibited from doing so.

CH5. Q. In a SNF/AL can we provide child care for our staff only without the special license? Or is a license required for all pandemic child care centers?

CH5. A. In Ohio, a license is required for entities providing childcare to more than seven children at a time. ODJFS has stated

”The temporary license is available for existing providers and those new organizations that want to set up short-term child care services. In our transmittal letter we did highlight that buildings with current building certificates of occupancy and fire inspections will be the most expeditious. This would include but not be limited to: hospitals, churches, schools, Boys and Girls clubs, YMCA/YWCA.”

CH6. Q. Can churches apply for the TPCCC license?

CH6. A. Yes. See CH5.

CH7. Q. How are pandemic childcare centers paid for? Will the individual employee be responsible, the employer, or is it a government program?

CH7. A. At this point there is no subsidy provided for the pandemic child care center. LeadingAge Ohio has advocated for funding to offset the increased costs of childcare for essential personnel.

CH8. Q. Has there been any discussion of subsidizing the costs of childcare for affected workers, particularly those who have school-age children?

CH8. A. LeadingAge Ohio has advocated to the Ohio Department of Job and Family Services for relief for frontline healthcare workers who have unanticipated childcare costs due to school closures, but no details are yet available as to whether this relief will be granted.

Background Checks

BC1. Q. Background checks for new hires have been suspended by the entity we rely on to complete background checks. How do we move forward with getting new hires on board if we're unable to complete the mandated fingerprinting for health care workers?

BC1. A. This is an issue that LeadingAge Ohio has raised, both as it relates to nursing homes being unable to “staff up” for the anticipated surge, as well as for childcare workers who are essential to enable health care personnel to continue reporting to work. The Ohio Departments of Job & Family Services, Aging, Medicaid and Job & Family Services are working together and in partnership with federal entities to move a solution forward.

In the meantime, LeadingAge Ohio has identified members across the state who have offered their webcheck to other members, in an effort to expedite hiring. If your organization either has webcheck capability or is in need of background checks, please email Karen Lowe at klowe@leadingageohio.org, who is connecting members.

Telehealth

TH1. Q. What services are approved to be delivered via telehealth, in light of the COVID-19 pandemic?

TH1. A. Medicare has [issued guidance](#) on those services which may be delivered via telehealth, noting three different types of visits: Medicare Telehealth Visits, Virtual Check-Ins, and E-visits.

For more information, review the [Medicare Telemedicine Health Care Provider Fact Sheet](#) and [Frequently Asked Questions](#).

In addition, the Ohio Department of Medicaid [filed an emergency rule](#) which expands the professional services, originating sites, and mode of delivery of services via telehealth.

TH2. Q. Are dietary and nutrition services included in the current waivers & emergency rules related Medicaid telehealth?

TH2. A. In the Ohio Department of Medicaid [emergency telehealth rule](#), dietitians as defined in Chapter 4759 of the Revised Code are one of the billable services under telehealth.

TH3. Q. Can nursing facilities bill for services delivered via telehealth?

TH3. A. Yes, nursing facilities can be an [originating site of service for telehealth](#) for professional services delivered there.

TH4. Q. Can the initial history & physical be done through telehealth?

TH4. A. Yes. For both [Medicare](#) and [Medicaid](#), the first-visit requirements were waived, and care can be started via telehealth.

TH5. Q. Can we complete Part B visits for our community palliative care patients with telehealth?

TH5. A. If it is a practitioner (physician, APRN, PA, CNS) is doing those visits then the answer is yes, you should be able to bill for telehealth visits.

Regulatory Relief & Flexibility

RR1. Q. Will survey and oversight visits be suspended for nursing homes, assisted living, and other healthcare providers & housing operators?

RR1. A. 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.

RR2. Q. Do hospices still need to perform:

- **An in-person face-to-face visit for recertification or can they use telehealth?**
- **An in-person nurse visit every 15 days for the completion of the comprehensive assessment for the update to the plan of care?**
- **5% volunteer level of activity?**

RR2. A. 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.

RR3. Q. Can our nursing facility admit a Medicare Part A resident without a 3-day hospital stay?

RR3. A. Yes. This was a blanket waiver announced by CMS on March 14, which states do not need to apply for. According to a [recent memo](#):

Section 1812(f): This waiver of the requirement for a 3-day prior hospitalization for coverage of a SNF stay provides temporary emergency coverage of SNF services without a qualifying hospital stay, for those people who are evacuated, transferred, or otherwise dislocated as a result of the effect of disaster or emergency. In addition, for certain beneficiaries who recently exhausted their SNF benefits, it authorizes renewed

SNF coverage without first having to start a new benefit period (Blanket waiver for all impacted facilities).

RR4. Q. Has there been discussion of waiving the nursing home bed tax payment, or other financial relief for providers that are seeing escalating costs related to the pandemic?

RR4. A. LeadingAge Ohio joined the Ohio Healthcare Association in a letter requesting a 25% increase to Medicaid payments to offset the escalating costs of PPE, staffing, and other pandemic-associated expenses, but to date has not received feedback on ODM's strategy to support providers.

RR5. Q. Will you please clarify what changes are occurring with quality measures during this time?

RR5. A. CMS announced relief to providers on the quality reporting programs on March 22 in a [press release](#). In the release, CMS stated they are granting exceptions from reporting requirements and extensions for clinicians and providers participating in Medicare quality reporting programs with respect to upcoming measure reporting and data submission for those programs.:

Screening & Access to Nursing Homes

AC1. Q. Where can I find guidance that has been issued on nursing home access?

AC1. A. 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.

AC2. Q. What personnel and contracted staff should be permitted access to a nursing facility?

AC2. Q. 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.

AC3. Q. What are the requirements for screening individuals (visitors, suppliers, personnel, etc.) entering a nursing home or assisted living facility?

AC3. A. 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.

AC4. Q. Are hospice staff considered "absolutely necessary," in light of the Governor's order? What does CMS guidance say about end-of-life visits?

AC4. A. 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](#).

AC5. Q. How should assisted living treat home care companion services that are paid privately by a resident?

AC5. A. See AL3.

Visitation to Nursing Homes

VI1. Q. Should a nursing home restrict all resident visitation?

VI2. A. 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. “

VI2. Q. 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?

VI2. A. 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.

VI3. Q. Can families be permitted into a nursing facility to receive training for patients being discharged to home? Training would include tube feeding, transfers, IV training etc.

VI3. A. ODH has clarified that training necessary for safe discharge is considered essential, and should be permitted. These family visitors should be screened similarly to staff, and to mitigate the risk, a nursing home could designate a separate area for that training.

Gatherings & Congregate Dining

DI1. Q. Has anything been released in regards to cancelling Resident Council Meetings till further notice?

DI1. A. 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.

DI2. Q. If communal dining is no longer permitted, should nursing facilities/assisted living close their dining rooms?

DI2. A. 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 to Nursing Facilities

AD1. Q. What protocol should be in place for patients returning from a hospitalization?

AD1. A. 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](#).

AD2. Q. Should a facility continue to admit new residents?

AD2. A. 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.

AD3. Q. How should a facility accommodate individuals & families who are requesting tours of a facility, in anticipation of admission?

AD3. A. An advisable practice would be to use technology to provide a virtual tour of the facility.

RCF/Assisted Living Questions

AL1. Q. If a family member sets up a resident's medication, are they allowed to enter and do that medication set-up?

AL1. A. 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.

AL2. Q. If a resident dies, are the family allowed to come in and remove belongings (both in Nursing Home and RCF)?

AL2. A. 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.

AL3. Q. How should assisted living treat home care companion services that are paid privately by a resident?

AL3. A. 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.

Hospice & Home Health

HH1. Q. Can you guide us as to what are essential services and what are not? Also, what language should be in care plans?

HH1. A. For hospice, the Core Services are: 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."

HH2. Q. Are there specific guidelines for the number of family members permitted in facilities and IPUs, and how next of kin is defined?

HH2. A. 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.

HH3. Q. We have severely limited patient visitation for hospice social workers and chaplains, instead having them contact patients and families via a zoom platform, in coordination with the nurse case manager. Is this sufficient to meet requirements for the comprehensive assessment regularly updating the plan of care?

HH3. A. The hospice conditions of participation do not require that the social work and chaplain portions of the comprehensive assessment has to be completed in-person.

What you described sounds like a great way to get involvement from the social worker and chaplain. Remember that social worker phone calls are to be reported on the claim. Make sure any and all contacts from your chaplains and social workers are documented well.

We are hopeful that CMS will significantly relax certain Conditions of Participation, in light of the coronavirus outbreak.

[Palmetto provided guidance to hospices who have been unable to visit patients-- particularly those residing in nursing homes-- during the COVID-19 pandemic. According to Palmetto, they should refrain from discharging patients and instead make every effort to use video and audio conferencing to assess patients, as well as participate in remote care conference with nursing home staff, and thoroughly document the reasons in-person visits are not possible at this time.](#)

HH4. Q. Can a home health face-to-face visit be done via telehealth for both Medicare and Medicaid?

HH4. A. Yes, a home health face-to-face visit can be done via telehealth for both Medicare and Medicaid recipients. The National Association for Home Care & Hospice has shared resources for both [Medicaid](#) and [Medicare](#) requirements.

HH5. Q. For hospice staff that need their annual competencies completed, can we note in the personnel file that the annual competency wasn't completed timely due to COVID19 restrictions?

HH5. A. We are waiting on the word back from regulators related to waiver requests. For now, document well why the annual competencies were not done due to staffing and COVID pandemic.

Housing

HO1. Q. Has anyone heard from HUD if their freezing recertifications or extending them to protect office managers and our residents?

HO1. A. HUD has not yet suspended recertifications, but LeadingAge has made this request. Our understanding is that doing so would require congressional action, so it is not something that HUD can do on its own.

HO2. Q. Will housing staff be included as “essential staff” for pandemic childcare centers?

HO2. A. LeadingAge Ohio has asked the DeWine Administration to include housing property managers, maintenance staff, and service coordinators to be included among essential staff, so that they may continue to support the older adults residing in their communities.

HO3. Q. Has HUD issued any guidance related to visitation in HUD 202 or multifamily settings?

HO3. A. HUD has not issued guidance related to restricting visitation to individuals residing in subsidized housing. LeadingAge Ohio has asked Governor DeWine to directly address older Ohioans in senior living communities, asking them to restrict visits by friends and family to reduce the likelihood of transmission of COVID-19.