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FOCUS POINT NEWSLETTER
FOCUS POINT 7/6/2020

Virginia Department of Health – FAQs on Re-Opening Guidance for Nursing Home

On Thursday, July 2, 2020, VDH published on their website Frequently Asked Questions about reopening Virginia nursing facilities. The information is divided into 5 categories: Testing, PPE, Infection Prevention and Control, Resident Placement/Cohorting, and Phase Progression and Regression. Click here for full article, once in the article, click on the "+" sign in each of the gray bars to expand the discussion on the topic. FAQs noted below:

Question	Answer
Testing	
Which type of test, viral or antibody, should be performed when testing is indicated by the recommendations? ***7/2/2020***	An FDA EUA viral diagnostic test should be performed when testing is indicated. Antibody testing should not be used in this context. There are two types of viral diagnostic tests, molecular (e.g., PCR) and antigen. ▪ Molecular tests are preferred over antigen tests. ▪ Positive results from antigen tests are highly accurate, but negative results do not rule out infection (false negative). Thus, negative results are considered presumptive and must be followed up with a confirmatory molecular test.
Are there other types of specimens that can be collected that don't involve swabbing the nasopharynx? ***7/2/2020***	Swabbing can take place in a variety of ways, depending on the specimen collection method that is validated by the laboratory performing tests for your facility. A common method is a nasopharyngeal (NP) swab, where a thin, flexible swab is inserted far back into the nose to obtain material for testing. If the procedure causes more than mild discomfort, then the swabbing technique should be reviewed. ▪ It is also important to ensure that swabs intended specifically for NP swabbing are used; these swabs are thinner and more flexible than swabs intended for other specimen types. Other specimen types depend on the test and laboratory, and these may include a nasal swab (inserted about an inch into the nose), a saliva specimen, or an oropharyngeal (OP, throat) swab. Acceptable specimen types should be discussed with your laboratory, as it depends on their typical testing methodology.
Do staff or residents with a previous positive viral test who have recovered still need to be tested when indicated by the recommendations? ***7/2/2020***	***Asymptomatic*** individuals with a previous positive viral test do not need to be re-tested when facility-wide testing is indicated, however this recommendation might change as VDH releases Phase II and Phase III testing guidance. ▪ A recent update to CDC guidance states staff or residents who had a positive viral test over 8 weeks ago should be retested as part of facility-wide testing, regardless of symptoms. A facility can follow those recommendations at this time if they so choose. Residents and staff who had a **positive viral test at any time and become symptomatic after recovering from the initial illness should be re-tested and placed back on the appropriate Transmission-Based Precautions (TBP) or excluded from work, respectively.**
Do staff or residents with a previous positive antibody test still need to be tested when indicated by the recommendations? ***7/2/2020***	**Yes.** Results of antibody testing **should not be used** as the sole basis to either diagnose acute infection or make recommendations on limiting social or environmental exposures or changes to work related policies. We do not yet know if the presence of antibodies to SARS-CoV-2 provides any level of protection against reinfection with the virus. However, this recommendation may be reconsidered at a later time for previously COVID-19 positive individuals as more is learned about immunity following COVID-19.
If staff work at multiple facilities, do they need to receive a viral test at each facility?	No, staff do not need to be tested at each facility. If documentation of the test result is provided to each facility, the results from one setting are adequate to meet the testing recommendations at any facility. Each facility should maintain appropriate documentation of test results.

7/2/2020	Staff should be encouraged to tell facilities if they have had exposures at other facilities with recognized COVID-19 cases. **Similarly, staff who become symptomatic should alert each facility and be tested as soon as possible.**
Can facilities use a point prevalence survey (PPS) that was conducted prior to the guidance being released as their first round of testing for the Phase I recommendations? ***7/2/2020***	Facilities that completed a COVID-19 PPS for residents and staff can use the PPS as their first round of testing as long as all the following are met: ▪ PPS occurred on or after May 15, 2020 ▪ All staff and all residents were given the opportunity to be tested at that time
If the first week (i.e., first round) of testing all staff and all residents reveals NO positives, does testing need to be repeated for a second week (i.e., second round)? ***7/2/2020***	**Yes.** A facility should test all staff and all residents that have not previously tested positive for at least two consecutive weeks, or two consecutive rounds in some instances where the baseline test was conducted more than a week prior. Testing should c**ontinue weekly until there are no new cases among staff or nursing home-onset cases in residents for the previous 14 days.**
Which staff members should be tested when indicated by the recommendations? ***7/2/2020***	The definition of staff that should be tested is defined in the VDH Nursing Home Guidance for Phased Reopening. However, staff who are working from home, or on leave, or otherwise not at the same site as residents, do not need to be tested as long as they remain offsite.
If a staff member receives a test from an outside entity (e.g., community testing location, drive-thru pharmacy, private practitioner), does that meet the testing recommendation? ***7/2/2020***	**Yes.** Diagnostic tests of nursing home staff that are performed outside of the facility meet the testing recommendation, so long as the employee has the appropriate documentation to provide to the nursing home administrator and the test was conducted in a reasonable time frame (e.g., 3-7 days) from when the test was recommended.
How should facilities approach staff who decline testing? ***7/2/2020***	If **staff with symptoms consistent with COVID-19** decline testing, they should be presumed to have COVID-19 and excluded from work. Return to work decisions should be based on COVID-19 return to work guidance at the discretion of the facility's occupational health program. If **asymptomatic staff** decline testing, work restriction, if any, should be determined by the facility's occupational health. **All staff should be trained in proper use of personal protective equipment, including universal facemask policies, hand hygiene, and other measures needed to stop transmission.**
How should facilities approach residents who decline testing? ***7/2/2020***	**Residents, or their medical powers of attorney, have the right to decline testing.** Clinical discussions about testing may include alternative specimen collection sources that may be more acceptable to residents than nasopharyngeal swabs (e.g., anterior nares). Providing information about the method of testing and reason for pursuing testing may facilitate discussions with residents and their medical powers of attorney. **If a resident has symptoms consistent with COVID-19, but declines testing**, they should remain on Transmission-Based Precautions until they meet the symptom-based criteria for discontinuation. If a resident is **asymptomatic and declines testing** at the time of facility-wide testing, decisions on placing the resident on Transmission-Based Precautions for COVID-19 or providing usual care should be based on whether the facility has evidence suggesting transmission (i.e., confirmed infection in staff or nursing-home onset infection in a resident).
PPE – Personal Protective Equipment	
Does the facility have to supply PPE to visitors? ***7/2/2020***	Visitors are required to wear a facemask or cloth mask for the duration of their visit. Because of PPE shortages, visitors should bring their own masks. If the resident being visited is on transmission-based precautions (TBP), other PPE like gowns or gloves might be required for

	entering their room. In such a scenario, before giving permission to visit a resident on TBP, the facility should ensure that enough PPE is available.
Does the facility have to supply PPE to VDH staff (e.g., OLC surveyors, local health department communicable disease nurses or epidemiologists)? ***7/2/2020***	The facility under conventional conditions might supply all required PPE to VDH staff visiting the facility. However, while PPE supply is limited, VDH staff shall bring their own PPE. VDH staff should avoid entering a resident room without wearing the appropriate PPE.
Infection Prevention and Control	
Where can I find more details regarding staff and resident screening for COVID-19 symptoms? ***7/2/2020***	The VDH Nursing Home Reopening Guidance is a supplement to other guidance documents that have been previously disseminated. An updated symptom list and details regarding screening can be found in the VDH Guidance for LTCFs. Watch for any change in the resident that might indicate a new infection. Symptoms may include: ▪ Fever (temperature > 100oF), ▪ Cough (new or different), ▪ Shortness of breath, ▪ Chills, ▪ Muscle pain, ▪ New loss of taste or smell, ▪ Vomiting or diarrhea ▪ Sore throat ▪ In addition, atypical symptoms may occur in older persons: o New/worse tiredness or discomfort o New dizziness, increased falls o Confusion
What qualifications does the infection preventionist (IP) in the nursing home need to have? ***7/2/2020***	Each nursing home should assign an individual with training in infection prevention and control (IPC) to provide onsite management of all COVID-19 prevention and response activities. A detailed training module has been developed by CDC and CMS and is available free of charge; it provides 23 training courses on core activities of effective IPC programs. Click here for more information. More training might be available, as more federal dollars are being designated for that purpose.
What infection prevention and control practices should be implemented when serving a meal or delivering a food tray to a resident with a suspected or confirmed COVID-19 infection? **7/2/2020**	Facilities should develop policies for safely conducting food service activities. ▪ Only essential staff are permitted in units/care areas for suspected or confirmed COVID-19 cases, and food delivery can be done by nurses/CNAs. ▪ Extended use of gloves between residents is not recommended. ▪ When delivering food to a resident with suspected or confirmed COVID-19, staff should perform hand hygiene, don PPE (gloves, gown, mask, eye protection), drop off food, take off and dispose of PPE and perform hand hygiene. Repeat this process between each room of a resident with suspected or confirmed COVID-19. When delivering food to a resident without suspected COVID-19 signs and symptoms, staff should perform hand hygiene and don gloves, then remove gloves and repeat hand hygiene if staff has contact with the resident or any surfaces in their room.
What are VDH recommendations for distant or outdoor visitations? ***7/2/2020***	While we want to ensure social distancing and protect residents from exposure to the virus, there is also a need to find ways to maintain overall physical and psychosocial health. Facilities should consider the current COVID-19 situation in their facility and community when making decisions about relaxing certain restrictions. The following should be considered when incorporating visitations off-site or spending time outdoors into the plan of care: ▪ **Only asymptomatic residents and residents** who meet criteria for discontinuation of TBP are allowed to have visitations outside the facility. ▪ Residents should always maintain social distancing. ▪ Residents should wear a face mask if able to do so. Visitors should wear a face mask. ▪ If the resident requires physical assistance or supervision, an appropriate staff member should be present to assist. The staff member should wear a face mask. ▪ Increase the frequency of cleaning and disinfecting benches and other frequently touched outdoor surfaces.

	▪ Encourage residents to perform hand hygiene before and after spending time outside of the facility. ▪ Visitations should occur in controlled areas, not in the general public. More information can be found in the CMS FAQ on Nursing Home Visitation.
What should a facility do if a large number of symptomatic residents or positive COVID-19 cases have been identified? ***7/2/2020***	When conducting facility-wide testing, a large number of residents might be identified with COVID-19 infection and cohorting them can be complicated and might increase the chances of cross-contamination. “Shelter in place” is a practical solution in these circumstances if the following conditions are implemented: ▪ **In shared rooms, the distance between resident’s beds should be at least 6 feet and curtains can be used as a physical barrier.** However, staff should don and doff the appropriate PPE between residents in the same room. ▪ Increase the frequency of environmental cleaning and disinfection. ▪ Do not cohort residents based on symptoms only.
CMS has now mandated all certified nursing homes must receive an onsite focused infection control survey by July 31, 2020. Do earlier assessments from the local health department (LHD) or other assessment teams satisfy this requirement? ***7/2/2020***	**No.** This is an independent regulatory requirement from the Centers for Medicare & Medicaid Services (CMS).
What is VDH guidance in regards to resuming onsite physical therapy in nursing homes during phased reopening? ***7/2/2020***	During **Phase 1**, physical therapy should be conducted in the resident's room taking into consideration wearing full PPE if the resident is on Transmission-Based Precautions. However, facilities should create a plan to gradually reintroduce health care services, emphasizing those that are time sensitive, prioritizing patients with urgent needs. **During phases II and III,** access to an onsite physical therapy room should be limited to COVID-19 negative or asymptomatic residents or residents who meet criteria for discontinuation of transmission-based precautions, but residents may use physical therapy equipment with social distancing (limited number of people in the room and spaced by at least 10 feet), hand hygiene, and cloth face covering or facemask. Staff should wear a face mask as well as a gown and gloves while conducting physical therapy. Gown and gloves should be changed between residents. Physical equipment should be properly cleaned and disinfected between each use. The use of telehealth and its potential expansion should be maximized wherever appropriate.
Resident Placement / Cohorting	
Where should a facility place residents receiving hemodialysis or leaving the facility on a regular basis for necessary medical care? ***7/2/2020***	Residents leaving the facility frequently for necessary medical care are at an increased exposure risk to SARS-CoV-2. They should be screened very closely for signs and symptoms of COVID-19 and they should be prioritized for testing whenever testing capacity is limited. <u>Facilities should not put these residents on new admission units.</u>
Phase Progression / Regression *VDH acknowledges the science regarding SARS-CoV-2 is evolving and plans to update information regarding Phase Regression as more information is known.*	
Can a facility use a date prior to June 19, 2020 as the start of Phase I? ***7/2/2020***	VDH recognizes the effort and measures that have been implemented prior to the release of the Nursing Home Reopening Guidance on June 19, 2020. **A facility can use the date when all recommended criteria for Phase I were met, including if it was before June 19**. Please enter the date the facility started Phase I when you submit the attestation form. The facility is still encouraged to seek consultation from their LHD.
Does the local health department (LHD) need to approve phase progression? ***7/2/2020***	**No.** However, facilities should submit a Phase Change Attestation to their LHD when they meet all the criteria to move from one phase to another. Facilities are encouraged to seek consultation from their LHD when moving from phase to phase. The LHD will acknowledge receipt of the attestation

Why does a positive staff case not trigger phase regression? *7/2/2020*	Healthcare workers have multiple exposure risks including their job, the community, and potentially their household. One positive case in a staff member does not suggest the infection was transmitted at the facility and therefore should not hold bearing on whether a facility should regress. A positive staff case would trigger testing of staff and residents as is indicated in the Nursing Home Reopening Guidance; if through those testing efforts a nursing home-onset case is identified, the facility should regress to Phase I. In the event two or more staff are epidemiologically linked and tested positive, the LHD might recommend regression to Phase I until the outbreak is contained.
The guidance states a facility should have access to adequate PPE as indicated in NHSN to progress in a phase. Does VDH recommend phase progression if the facility is still relying on the Healthcare Coalition or Local Health Department to maintain adequate PPE? ***7/2/2020***	**Yes**. Adequate PPE is defined as having enough supplies and PPE (i.e., N95 masks, surgical masks, eye protection, gowns, gloves, and alcohol-based hand sanitizer) for the next seven days, whether the supplies are received through their normal channels or from the Healthcare Coalition or the LHD.
The guidance states a facility should have adequate staffing as indicated in NHSN to progress in a phase. Does VDH recommend phase progression if the facility is still relying on MRC resources to supplement staffing? ***7/2/2020***	Each facility should identify staffing shortages based on their facility needs and internal policies for staffing ratios. The use of temporary staff does not count as a staffing shortage if staffing ratios are met according to the facility's needs and internal policies for staffing ratios.

VDH Updated the guidance for Re-Opening Virginia Nursing Homes on 7/2/2020. Click here for details. A summary of changes / updates includes:

- Page 1, **added link for VDSS Recommendations for Reopening Assisted Living Facilities**; additional information here.
- Page 4, **clarified the trigger to regression** to change the language from "surrounding community" to city or county facility is located
- Page 5, **updated PPE optimization strategy link** (pages 10-14) to updated VDH LTCF Guidance
- Page 8,**clarified Phase 1 testing recommendations**; more information can be found in FAQ
  - Immediately test any resident or staff with symptoms.
  - Before or during Phase I, test all staff AND all residents weekly, except those previously testing positive. Testing should continue weekly until there are no new cases among staff or nursing home-onset cases for the previous 14 days (at a minimum weekly testing should occur twice).
  - Once facility is no longer testing staff and residents weekly:
    - Immediately test any resident or staff with symptoms.
  - The trigger to resume weekly testing is identification of a
    - Nursing home-onset case OR
    - Case in a staff member.
  - Testing should continue weekly, except for previously positive
- Page 12**, clarified Regional Healthcare Coalitions should be notified about PPE shortages, not testing** supplies
- Pages 15-16, **deleted the copy of the Phase Change Attestation Form for Virginia Nursing Homes. Please use the REDCap link here or the link to the paper form on Page 14.**

The 7/2/20 updated recommendations may be found here.

Lessons Learned This Week

Nursing Facility Attestation Statement for Re-Opening - The local health department only acknowledges your phase change attestation and does not provide approval. See additional information under Phase Progression / Regression on page 4 of this FOCUS POINT.

Nursing Facility Enhanced Enforcement for Deficiency Citations at F-880 Infection Control

- In the FOCUS POINT of Friday July 2, 2020, we emphasized the CMS guidelines for Enhanced Enforcement of survey citations at F-880. These enforcement actions consistently include guidance for variety of things in order to achieve compliance. Often, there is a requirement for a DPoC in addition to the required PoC [Plan of Correction]. The cover letter with the 2567 will include information if you are required to submit a DPoC and there will be an additional document in your e-mail or on e-POC outlining the specific components that must be included in the DPoC.
- The POC and DPoC have different time frames for submission and completion.
- The DPoC is something that Virginia has used rarely in the past as an enforcement action.
- What is a DPoC?
  - A Directed Plan of Correction is one in which the survey agency requires that:
    - The POC has to be submitted within 10 days receipt of enforcement letter
    - The DPoC has to be completed with 15 days receipt of the enforcement letter
    - The DPoC instructions will include a variety of actions that the facility must complete and reference in the submission of the DPoC. Such actions may include:
      - Completion of a RCA [Root Cause Analysis] relative to the cited regulations
        - ***Stay tuned for more information on how to complete a RCA from HQI [Health Quality Innovators -- https://www.hqi.solutions/***
      - Completion of targeted or focused education to specific health care workers and/or residents
    - The DPoC does not have a designated timeframe for completion, but the facility cannot be found in substantial compliance until the DPoC is fully completed.

The CHC team has experience in helping facilities complete DPoC requirements including completion of the RCA, supporting targeted education, and developing a DPoC that is reflective of the analysis and reasons for non-compliance related to the deficiency. CHC reached out to Kim Beazley at VDH to confirm our understanding of the DPoC and RCA requirements and for some additional clarification of DPoC requirements. We will share Kim's responses to the following.

- Is there any special format that must be used, or would we use the same format as the POC?
- Do we also submit the RCA or just reflect that it was done and the actions in the DPoC are reflective of the RCA?
- Is a re-visit required for scope/severity of D, E or F or is there potential for desk review?
- Please contact Mary Chiles, Sarah Marks, or Val Thomas if you have questions or CHC can be of assistance with your DPoC. Mary@chileshealthcare.com; Sarah@chileshealthcare.com or Val@chileshealthcare.com.