EOHHS Responses to MSCA Questions

May 21, 2020

Testing

1. **Full testing of all staff and all patients is not part of this Bulletin 145; correct?**

   Testing is not part of the checklist. But the 90% testing threshold is part of the requirements for the enhanced funding (of which the checklist audit itself is a part).

2. **With the new requirement to test all employees, we could find positive employees who were never symptomatic who are well past the 10-day quarantine required of asymptomatic employees (if they had been tested earlier on). What are your thoughts on antibody testing of asymptomatic positive staff to try to establish an older infection or presumed immunity now and avoiding having staff out of work unnecessarily? Is there any CDC guidance around this?**

   MA DPH guidance is that if these staff were previously tested and were positive, there is no need for a re-test and their clock of days from infection starts at the original swab or symptoms of illness.

   If they are newly asymptomatic and positive, they need to exclude from work for 10 days per the CDC 10d/72hr criteria, and if there is an acute staffing-based issue arising, NF should be in touch with DPH.

3. **Who is responsible for testing temporary/agency staff?**

   The bulletin clarifies testing for these staff: https://www.mass.gov/doc/nursing-facility-bulletin-146-covid-19-baseline-testing-requirements-for-nursing-facilities/download

NEW

4. **Does a nurse need to witness a temperature check being performed during screening?**

   A separate staff member should witness a temperature check (i.e. the person having their temperature taken should not self-attest their temp). But that staff person is not required to be a specific training level.

Staffing

5. **Can staff on your dedicated COVID unit work on a non COVID unit on another day?**

   Only in extreme conditions. If working a double shift in such a scenario, staff should move from negative to positive units across double shifts, not positive to negative units.

6. **Do sick leave policies supersede our facilities policy which is a return to work note after 3-day leave. Also, if we do not get notes of positive tests how do we report? (Update)**

   There is no DPH or EOHHS policy on a provider note being needed. The checklist item requires a non-punitive allowance to leave work due to COVID-19 and to be able return to work, without a separate physician’s note being required to do so. However, facilities may seek staff COVID-19 results for the sake of state reporting without being in conflict with the checklist item.
If the facility does not have proof of a test result, that person’s orally stated reported result cannot be used per the 90% threshold.

7. **Have you allowed volunteers - family members in to help with staffing issues?**

   Staff need to be appropriately trained and hired. For instance, for CNAs, they need to be trained CNAs if providing care, and staff need to be CORI’d, and checked on the CAN registry etc., as is done with any other new hire.

8. **Can a nurse work with recovery resident and negative residents?**

   Assuming this question is asking can a nurse work with a known COVID positive but recovering patient, and work with negative patients on the same shift? The answer differs a bit based on how long out from recovery the positive patients are.

   If patients have not met the 14day/72hr criteria previously given, these should absolutely be different staffing cohorts as the positive patients are considered actively positive and should be in the dedicated COVID positive unit, and a nurse should not work with mixes of these positives and negatives. This is a firm requirement.

   However, if the patients have recovered beyond the 14day/72hr criteria, they can leave the COVID positive unit and step down to the quarantine unit (encouraged) or rarely the negative unit. In that scenario, the nurse on those units can work between these sufficiently recovered patients and other patients on that specific unit.

9. **Is there an algorithm for factors of keeping staff out of work due to: exposure; living with someone who is positive; visiting someone in a hospital; has symptoms but COVID test was negative. There are many varying factors that we screen for, but guidance would be helpful.**


10. **How is punitive defined on sick leave?** The guidance issued discussed requiring a doctor’s note for example may be punitive, however, the MA Paid Sick Leave has defined circumstances in which a Physicians Note can be required. Is the MA Sick Leave Act fall under public health policies?

    From DPH perspective and per this checklist, a physician note is not required.

11. **Will the Commonwealth provide actual nurses or Nursing Assistants to all of us if we cannot get staff?**

    The rapid response teams when sent out by the state include RNs/LPNs/CNAs but fill in short-term staffing issues. National Guard staff include clinical and non-clinical staff based on need also for short-term needs.

    As the checklist states, facilities are expected to have their own staffing emergency plans and contingencies (the state resources should not be the immediate plan B). The RRT and MA NG teams above are limited resources, and we do not want to give an impression that for 360 facilities, they are available for everyone as an immediate back stop.
In addition, the facility should be engaging with the state on reporting of staffing shortages on the horizon including engaging with the Long Term Care Staffing portal:
https://covid19ltc.umassmed.edu/Home/Intake/

12. Is it ok to have same nurse to care for COVID test pending patients and other patients?

Pending patients should be moved to a quarantine unit ideally. At the very least, to a dedicated quarantine room with its own bathroom and no sharing of that space with patients of different status (positive or negative).

If the site has a quarantine unit, it should have its own dedicated staffing. If a quarantine room is on a different type of unit (within a larger positive or negative unit), then the staff can work with other patients on that unit but must absolutely change PPE between different types of patients.

13. What about Rehab staff that might have to see residents on multiple units in the course of a day?

Ideally, staff should separate staff so that different staff work with the different cohorts of patients (different staff for negative units, and positive units, etc.)

If this is not possible, rehab staff must wear appropriate PPE per the unit they are in. Per shift, rehab staff should first work in negative units, and work later in positive units.

14. (Updated language to clarify, no functional change intended)

Per DPH - When possible, a long-term care facility should establish designated quarantine space within the facility to care for residents who tested positive for COVID-19, were placed in the COVID-19 dedicated space for fourteen days and are no longer exhibiting any symptoms of COVID. Staff are no longer required to use full PPE when caring for such residents. How does a facility operationalize this? I already need 3 separate units - dedicated COVID, non-COVID, isolation for hospital discharges because of unknown status. Where do I put the recovered?

See background from Questions 6 and 9 above.

Confirmed positive patients should not be in the quarantine unit, they should be in their own dedicated positive unit. We want to be clear too, this is not a when possible requirement. Confirmed positives must be in a different physical space from confirmed negatives. This is a must-pass item at the start of the audit checklist that facilities have attested to.

After the 14d/72hr criteria are met, those positive patients can then "step down", ideally to the quarantine/isolation/recovery space given that many of these patients tend to require higher needs after illness. More rarely, they may also go back to the negative space. Per current trends, they are not considered to be infectious if (and importantly to the checklist, if and only if) they meet the 14 day/72-hour criteria. Per the 04/29 guidance, it is correct that staff are not required to wear full PPE with these patients once 14d/72hr criteria are met.

15. If a staff member tests positive, do we have to quarantine all residents on his/her assignment?

Contact your DPH epidemiologist for guidance on this. Guidance will differ per specific facility. Per the checklist, they are required to respond to the situation by quarantining residents who were in
prolonged, close contact with the staff member. But per exactly where the cut off is on who is quarantined and who is not, can be directed by DPH epi guidance.

16. Do staff need to be rescreened after they go outside of facility for smoking or coffee break? Or after taking out the trash?

Yes. To maintain a screening effort that is not porous, these staff should be re-screened. A facility can refer to their previous screen form for their symptoms (if confirmed unchanged from prior in the day), recheck temp, and expedite re-entry. But a rescreen is expected, no one should skip the queue entirely.

17. Auditors are expecting to see the verbiage “COVID 19” on the sick leave policy rather than confirming that the sick leave policy is not punitive. Please clarify what is expected in a sick leave policy.

The sick leave policy does not need to be a COVID-19 specific policy. But the policy, if it is a general policy, should reflect that it has been updated in light of the COVID situation (or if no changes were necessary, that it was reviewed in light of the COVID situation).

PPE

18. If facilities, despite their best efforts, are forced to be in gown conserving mode, is it acceptable for them to implement the CDC endorsed best practice of not utilizing gowns on a negative unit?

Auditors know to ask a facility if they are in critical shortage of PPE (within days of running out) if a facility is not utilizing gowns on a negative unit in a facility with community spread (facilities doing so should also volunteer that such is the case). Auditors will assess how severe the critical shortage of PPE supply is at the facility and about the facility’s efforts to procure additional PPE.

19. What does “no PPE is used across shifts” mean? Can staff wear the same PPE if working a double shift on the same unit?

A double shift on the same unit where the same PPE standard is applied for all patients could continue wearing that PPE across both shifts. But whether across a continuous double shift, or on an individual shift, other PPE rules apply (particularly to gloves and gowns below; faceshields should be wiped as often as examples below; and we realize that for N95s or other masks, facilities may stretch those but should have a uniform policy for how they do so):

- PPE should be changed between care of patients of different status (positive versus quarantine or negative versus quarantine).
- PPE should be changed if soiled.
- PPE should be changed when leaving a patient care area.
- PPE that is substituted for gowns (such as lab coats or johnnies) should be changed as often as gowns (changed each shift at minimum; do not reuse the same lab coat the next day).
- No PPE should be used across multiple shifts that cross into another day (i.e., do not reuse yesterday’s gloves, gowns, or gown-equivalent without cleaning them if cleanable; do not re-use faceshield without cleaning it).
- No PPE should be shared by two individuals (e.g., sharing a lab coat or gown).
20. Is it appropriate for facility to have one precaution cart for more than one room or for group of rooms with positive patients within the same area?

This is appropriate. Staff should be able to access this PPE without crossing into any patient area or hallway area that involves patients of another type (quarantine, etc.).

21. How long can we re-use the KN95 mask?

Your facility should have a policy for extended use, if needed, and appropriate storage. Regardless N95s should be discarded if they become visibly soiled or dirty. Particulars on this is not specified or assessed by the checklist.

22. Is it recommended to re-use disposable gowns? And if so, where should the gowns be stored when not in use?

The checklist does not differentiate between launderable or disposable gowns (disposable gowns more recommended but given many supply chain issues, a facility may use non-disposables pending they are cleaned between shifts/uses). The requirements for storage and accessibility are equivalent across both.

23. Where is the guidance written that a two-week supply of PPE must be on site at the facility?

See item #10 of the checklist.

24. If a facility is part of a multi-facility organization, can some of the two-week supply be centrally coordinated for deployment (i.e., one week available on-site, and one week available centrally to deploy to a facility)?

This is acceptable, but storage of two-week supplies centrally should not overlap with other facilities (i.e., cumulatively, each part of the organization should have an accountable two-week supply at the central location).

If a facility ends up requiring state assistance for PPE that is discordant with the answer supplied to the auditor of having two weeks of PPE using a central supply for one week, it will be noted by the state and subject to penalties.

25. What about the DPH guidance on PPE usage, part of their guidance was not changing masks and not touch the mask and keep on without touching.

We are not sure what the question is per the checklist here. It is basic infection control across multiple sources that people should not touch the front of their mask. If the mask is touched, that person should use hand hygiene immediately afterwards.

It is a requirement of the checklist that all staff at facility are wearing a facemask at all times. Any staff members (clinical or not) visualized not wearing their masks other than in a socially distanced meal, will be docked for the facility.

Home-made masks are not acceptable for staff at these facilities. Medical masks (surgical mask or N95, etc.) must be worn. Home-made masks should not be worn on top of or below medical masks.
26. When a facility has a designated COVID wing with the wing on precautions, can linen and trash bins be located at multiple intervals in hallways as opposed to inside the rooms? We are utilizing a linen company with water soluble bags (not enough soluble bags to place in each room).

For a dementia unit, trash cans can be located outside of rooms given patient medical necessity.

For this particular case that appears to be a special circumstance, the facility should note the reasoning to the auditor. In this case, the auditor would reach out for centralized guidance for clarification and we could give allowance given the special circumstance. The travel to get to trash cans should be minimized and should not require staff to walk across any hallway areas or other areas that involve patients of different status (PUI, etc.).

27. If facilities do not have enough gowns, is it acceptable to wear johnnies?

It is allowed. But these should be changed as often as any other gown (i.e., do not wear across shifts, or share a johnny with another staff person).

28. To conserve PPE can the face shield be left in the room on a hook with the isolation gown for the dedicated staff to use for the next encounter?

For the next encounter in the same shift, yes. But the gown should not be used across shifts. And staff should not share these PPE with other staff (two people cannot use the same gown). The face shield can be wiped down between shifts or zones however.

29. Staff is wearing the jump suits throughout the building then applying a gown or johny over to go into residents' rooms. Is this acceptable? (Update)

Staff should be changing PPE when seeing patients of different statuses. So, they should not wear a jump suit that is used to treat a COVID positive patient or room, into a negative or PUI room. It is upon the facility to make sure these patients are segregated accordingly or that PPE is being changed inclusive of the jump suits. Said again, if two layers of gown or gown-substitute PPE are used to see one patient type, both must be changed before seeing a different patient type.

With that said, if staff are caring for patients of the same status (all COVID positive patients on a unit), they can continue wearing the jump suits room to room (as they also could do just for gowns).

30. We are donning a second gown while entering each resident room. Is it okay to maintain mask and faceshield on if caring for like organisms?

In line with the response to the question above, the same applies for the first under-gown. Staff can wear masks across multiple rooms. Wipe face shields when going across rooms of patients that are different statuses.

31. Are KN95 masks being allowed as a replacement for N-95 masks?

The checklist does not differentiate on this point.
32. If you have multiple patients on one quarantine unit that are being tested for COVID, can they share an isolation cart or does it have to be separate?

Staff may get PPE from the same isolation cart and should wash hands before accessing PPE. But different PPE should be worn between quarantine patients, given it is unknown which will turn out to be positive, negative, etc.

33. Is a hair cover needed, i.e., bonnet?

The checklist does not differentiate between wearing or not wearing hair bonnets.

34. Do we need signs outside of residents’ rooms if we have signs outside of the entire COVID positive unit? Or the opposite, if we have signs on every residents' door in a COVID unit, do we need a sign on the entrance door to the unit?

If all patients are uniformly of the same status (no PUIs, is a dedicated COVID positive or negative unit), a universal sign at the entrance to the unit is sufficient, which is interchangeable with room by room signs. Auditors are aware of this. But signs must be clearly visible. If patients of different status on the ward, they need their own signs.

35. (Update) Please explain why you need a sign on a COVID negative resident door and what specifically that sign should say?

The checklist item is as follows:
"13. Signs are posted immediately outside of resident rooms indicating appropriate infection control and prevention precautions and required PPE per Department of Public Health guidance."

If there are not positive patients in the unit, and there are no PUIs, and there is no community spread, then the PPE requirement is at status quo for the facility other than the requirement that all staff must wear masks. In such a case, the facility does not need additional signage to be put up. For other cases, the PPE requirement is higher, and appropriate signage should be used.

In addition, a sign saying “See nurse/staff before going in” or similar is insufficient per the requirements of checklist item 13. The sign must include the specifications in item 13.

36. Please define “PPE Coaches”. What are their responsibilities. Must this be a free-floating position for an entire shift dedicated to this task only? Can they have other responsibilities? Can it be the Nurse Manager or Nursing Supervisor? Can it be the Charge Nurse or a Staff Nurse who has other duties such as Medication Administration but are able to visualize other staff during this time?

The PPE coach can have other duties. PPE coaches can be assigned for the whole facility per shift (including must be assigned to overnight shifts) or be assigned per unit per shift. But if assigned as one single coach per facility, then the Coach must have visualized PPE practices of other staff across the various units on that shift. The checklist does not specify a specific training level or other role required of a PPE coach.

37. Can staff wear cloth over surgical masks?

No cloth masks of any kind should be used for staff in the facility.
38. Can staff reuse the same gown all day?

See responses above.

39. If facilities do not have enough gowns, is it acceptable to wear johnnies?

See responses above.

40. In a non-COVID unit if individual reusable gown substitutes were used, could we hang the gown in that room for the next encounter by same caregiver that shift? Then next room, do the same - new gown substitute for use in just that room, hang it and exit room, etc. At end of shift all rooms gowns collected and washed. Is this OK?

As above. This seems suitable given gowns collected at end of shift.

41. We have a resident on quarantine because they returned from ER. The trip to the ER was unrelated to COVID and was for behaviors. Since patient will be put on precautions just due to quarantine recommendations, do we need to wear gowns for every resident? We currently have no active COVID in the building.

Yes, staff should wear gowns. If the patient is worthy of quarantine status, gowns and gloves are merited.

42. My staff is concerned that gowns don't go much below the knees! Should this be a concern?

This is not an item the checklist is evaluating for.

43. On COVID negative units - do staff wear gown, gloves and eye protection with all patients? Just have not seen good education to staff for constant glove use or use of two gloves, etc.

Full PPE is gown, gloves, eye protection, and masks. The guidance for negative units is discussed in the community spread slides provided. The checklist does not look for 2 separate sets of gloves being used.

44. All residents on a COVID dedicated unit are now 19 days past test date and continue to be asymptomatic. According to CDC, special droplet precautions can be discontinued. Is full PPE necessary on this unit in order to be in compliance with the checklist and to pass this CORE Competency stating, "full PPE for care of ALL residents in the facility if a COVID positive person is in the facility?" We still have a small number of COVID positive residents on another unit.

Per above. If all are of same 14 day/72-hour recovery status in a single unit, then full PPE for specifically this recovered cohort is no longer required.

45. Do you recommend gloves in hallways of positive units?

We are not sure what is meant by "recommend"? Full PPE for positive units includes gloves being required for all patient encounters. They should be readily available as they are likely to be soiled or need changing during a shift. Hallway standards are further specified below.
46. Can you please clarify the 4/29 guidance on the use of PPE for recovered COVID residents in a facility with facility transmission?

Per above.

47. Is the Pathway Health “Interim Policy for Optimizing the Supply of Isolation Gowns – Covid-19 Pandemic acceptable to use for nursing homes in MA?

We cannot comment on this, not direct question of the checklist.

48. Can the facility still have smoking groups at scheduled times outside using social distancing? The residents wear masks until they are outside.

Social distancing is required of any activity. Non-medical activities should be minimized. Facility should provide all other tobacco alternatives first. If the alternative is that residents would be non-adherent, the facility can do scheduled, socially distanced, continuously monitored smoking groups outside. The groups must be socially distancing and monitored, or auditors will dock points.

49. (Update) (MassHealth generated question) Can you clarify standard for wearing PPE in hallways?

Staff wearing PPE in hallways of units is not expressly required. However, there are a lot of cases where it makes sense. For instance, it is allowed in a fully COVID positive unit, and may conserve PPE supply to do so, with them only changing PPE if they encounter a patient of different status (PUI) or if the PPE becomes soiled. In a dementia unit (positive or negative with community spread) it may also make sense to wear PPE in the hallways given inevitable amount of patient interactions that happen in the hallways.

Given that the PPE supply is limited, auditors are not judging facilities universally on whether or not they wear or do not wear PPE in the hallways, but instead on if patient care is happening with the appropriate PPE in the hallways. As different sites have different degrees of PPE availability, this is the minimum threshold for the checklist audit. While it is preferable to change gowns between all patients (or use the same dedicated gown 1:1 per patient throughout a single shift) if a facility has enough PPE in order to be able to do so (and some facilities may elect to do so), this is not minimum threshold that the audit is specifically evaluating all facilities for.

As one caveat to the above, if a facility elects to expect that clinical staff should wear PPE in the hallways of particular units, the expectation will be the same for non-clinical staff going into and through the unit. In these cases, auditors are assessing for concordance of execution on a facility’s own practices. Such non-clinical staff should absolutely wear full PPE in any room of a patient where full PPE would be expected as well (even if not giving direct patient care).

In these ways, auditors are judging based on a true infection control deficiency that they have seen, rather than a single universal standard that interplays with limited PPE supplies. EOHHS staff go over auditor submissions and clarify even after audits are completed to make sure that this was the standard used by the auditor; this review is in addition to giving the same guidance presented here to auditors.
50. (MassHealth generated question) We have gotten guidance from DPH that nursing stations should not have PPE worn at them, but that auditors have asked about why we’re not wearing PPE at them.

See item above for standard on hallways. This applies to nursing stations as well. Clarifying the DPH guidance. For example, if a nursing station is fully enclosed in a single unit, and that unit has only one type of patient (positives for example), and that no staff from other units use the station, and the facility does not otherwise consider it to be a clean zone - if all of those are met, than staff could wear PPE at that station. But if any of those are not met (station is shared with other staff), than staff should not wear PPE to the station. This has been clarified with more nuance with DPH colleagues.

51. N95 masks 3M models 8511 and 9211 have been told have a one-way valve (protecting the wearer only). If the person wearing it is asymptomatic and/or COVID+ their exhaled air is being released. If this is correct, can these N95 masks be utilized with a surgical mask over them?

The checklist does not differentiate between this scenario and would not change scoring. This question should refer to previous DPH guidance or discussion with the DPH epidemiologist line.

52. Do staff need to wear full PPE in non-resident care areas if there is community spread?

Staff are not required to wear full PPE in these areas. Some facilities may choose to. The checklist does not differentiate between doing so in these areas. Masks must be worn in these areas regardless though, and social distancing must be maintained.

53. When will DPH/EOHHS begin to develop guidance related to recovered residents - clear guidance on PPE, discontinue TBP, remove restrictions for these residents, etc.?

Many facilities now have many recovered residents.

The chart gives guidance on PPE expectations for these patients. Further guidance is being considered. The standards on the checklist remain as per previous guidance until new guidance is issued.

54. We are confused about the guideline in the table that says: “Must change for PUI or symptomatic patient. Can wear for multi COVID neg patients though.”

Does this statement mean that staff can wear the same PPE at all times in a COVID-negative unit, going from patient to patient with the same PPE. According to the CDC and, I believe the MA DPH intention, they should change PPE for each resident in a COVID-negative unit because the resident could have asymptomatic COVID-19. Could you please clarify this so we can send a clear message to various facilities?

Per the checklist, a facility will not be docked if wearing the same PPE across multiple negative patients who are considered the same status (none are PUIs or Positives). It must be changed for interaction with a PUI or symptomatic patient and not doing so is dockable per the checklist.
Given that different sites have different degrees of PPE availability, this is the minimum threshold. It is indeed preferable to change gowns between all patients (or use the same dedicated gown 1:1 per patient throughout a shift) given that a facility has enough PPE in order to be able to do so, but this is not minimum threshold that the audit is specifically evaluating for.

Some facilities may choose to change PPE per individual patient in a COVID negative unit in a facility with community spread. Doing so is not in conflict with the checklist. The checklist is setting a minimum standard for adherence on the items in the checklist, facilities may pursue a higher standard if they choose.

55. **(Update)** Similarly, there is confusion about whether gowns should be changed for each patient encounter on a COVID-negative unit. For example, in a previous Q&A a facility asked if they could “hang a gown substitute in a resident’s room for the next encounter by the same caregiver that shift? Then next room, do the same - new gown substitute for use in just that room, hang it and exit room, etc. At end of shift all rooms gowns collected and washed. Is this OK?”

Previous guidance stated: “This seems suitable given gowns collected at end of shift.” The facilities are seeing conflicting messages between the Table, which implies you can go between rooms with the same gown, and the answer above, which says the gowns should be hung in one room.

Re-usable gowns should be treated as equivalent to any other disposable PPE. They should be washed or disposed of without any difference in use expectations.

The question being asked, and answer quoted are conflating two separate issues at play.

The answer noting such is suitable (allowed) given gowns are collected at the end of shift, is noted for a case where a facility used the same washable gown, for one staff member seeing one patient, throughout that shift, and then gowns are collected for cleaning. Such a gown can indeed be re-used for a future shift with a new staff member and patient. But as previously stated, gowns should not be used for multiple staff members between a cleaning. The cleaning of this re-usable washable gown is what the answer was speaking to in noting suitability.

The question asked here is if a gown can be worn across multiple negative patients. A re-usable gown is no different from a disposable gown in its expectation of use and the answer referenced in the question further above about gowns on negative patients and in the chart remains the same whether a gown is used, or a disposable gown is used.

PPE guidance does not change for gowns, johnnies, or lab coats. They are expected to be changed and cleaned as often as any disposable PPE would be disposed of.

**NEW**

56. **(MassHealth Generated)** When a facility has had its COVID-19 positive residents subsequently recover or no longer reside at the facility (i.e., the facility has no further actively COVID positive residents and all have fallen into recovery status), when can it return to a mask only PPE level for its general population? In other words, what is the checkpoint at which the facility is no longer in community spread status (aka facility transmission for an NF)?
The facility must wait a minimum of 14 days after the most recent specimen was collected that was resulted as COVID-19 positive and all COVID-19 positive residents must be at least 72 hours since last exhibiting symptoms or requiring anti-fever medications, without new cases and with no current PUIs (i.e., all PUIs must be confirmed negatives). The facility should also not have had any known COVID positive staff working shifts during that interim period, and no newly tested positive staff in the last 14 days or staff that remain with tests pending.

In addition to the above, a facility will continue to be considered in community spread status until DPH has announced that there is not ongoing transmission within the larger community (i.e. outside of the facility's walls) in the geography that the facility is located.

Both requirements above must be met before a facility can step down from a community spread status (aka facility transmission for an NF). This provision is subjective to change based on future MA DPH and CDC guidance.

57. (MassHealth Generated) Some staff bring N95 to the car and store in paper bag, another stores theirs in a plastic bag in their desk drawer? Are these practices allowable?

For storage of N95s and face shields, it is dockable if staff wear PPE outside of the unit or facility it is meant to be worn within; they should doff and store such PPE before leaving the room, unit, or facility accordingly. Carrying the PPE outside of the facility is allowable, as some staff may work across multiple sites. The facility should utilize a uniform method for how staff carry PPE outside of care areas.

NEW

58. (MassHealth Generated) Can a staff member take off their mask in their own office?

A staff member should not be interacting with any other staff without a mask and should not put themself at risk of such an interaction easily occurring. Auditors will assess for if any and all staff are failing to wear their face mask. A staff member could be in their own personal office, with the door closed, and take off their mask. But if they do so, they would not be seen by the auditor. If the auditor however sees any person in a room without their face mask (i.e. the door was open), they will deem this insufficient.

Per the May 21st, 2020 DPH Comprehensive PPE Guidance, that particular guidance is directed widely across the care continuum. In further clarification to NFs, it is still expected particular to all NFs that face masks are worn by all staff in all areas of the facility (i.e. this standard did not change with the May 21st guidance).

Cohorting

59. Core Competency 6 refers to ALL congregate spaces have been closed. What about a dementia unit where the residents’ safety is in jeopardy if we can’t use the sitting room? Minimal use in sitting room and 6+ feet social distancing?

This specific instance is allowed. Auditors know to make appropriate allowances for dementia units (such as trash cans directly outside of room instead of in the room at entrance) and per inability to do individual dining with this population.
Auditors will monitor though that the facility is trying to maintain 6+ foot social distancing and that staff are monitoring these patients to make sure that is maintained to the best of ability (checklist item will be failed if the facility does not monitor or is lax about maintaining social distancing).

Per CMS guidance, even if a dementia unit is all positive patients, social distancing is required. And per CMS guidance, if a non-dementia unit is all positive patients, communal dining is not allowed.

60. If the dementia resident is positive, and it is only safe to do so, can social distancing be done in dining?

For dementia residents, if they are within their own dedicated space (which must be either a positive or negative space, not a mixed space), they can dine in a space if supervised social distancing is implemented. Auditors know about this caveat.

61. Regarding congregate spaces, is it permissible to allow high risk dementia residents sit in dining room as long as tables are six feet away and only one chair per table? Also, can this be done at nurse’s station - if safety risk.

See responses above.

62. Are residents allowed to go outside or come out of their rooms and walk the halls if they are COVID negative?

Can be in halls if negative and not on PUI but should be minimized. Same for going out. Any activities outside of rooms by residents should be monitored and maintain social distancing and require face masks. Auditors will dock if any activities are not monitored. Group activities should not be occurring.

63. Do doors need to be closed which is on the general droplet precautions guidance? This is dangerous in the setting of dementia. Judgement. On a dedicated COVID unit, everyone is in PPE so is there a need to keep the door closed?

For a dementia unit, the auditors are aware of special medical needs for this population. This includes doors, patients wandering (as such, staff should likely wear PPE at all times including hallways), and meals (meals should be monitored to maximize social distancing, auditors will dock if meals are unmonitored).

64. Surveyors had told facilities to put gates in front of door to prohibit residents from wandering. Please clarify how this is safe and does not conflict with regulatory guidance?

Please feed back to us the specific facility where this occurred. We will discuss with the auditor on giving such guidance.

65. (Update) Do facilities need to put up barriers/walls on units to separate the positives from the negatives?

Our auditors and the checklist do not recommend a specific barrier requirement to providers, any specific type described is provided as an example which can include other suitable options. What they are assessing for includes the following:
• For units with mixed status residents (positives and negatives), a physical separation of some sort is best (i.e double doors, etc.).

• If separate physical separation cannot be done, there needs to be a way for residents and staff to be separate and distinct using a visually apparent demarcation that communicates that a certain zone is positives and a certain zone is negatives. Staff working a shift with either patient type should not cross that demarcation and interact with staff or patients in the other zone. Auditors will dock points if such occurs.

• Rooms should not be intermixed throughout the unit; they should be grouped together on the unit.

• Facilities may discuss with DPH Life Safety staff to determine if their specifically used physical separation is allowed per other regulations, or if a waiver may be pursued.

66. Does this congregate space allowance also apply in COVID negative environments?

Yes

67. “An infection control lead has been designated”…a surveyor is now saying it can't be a DON. Please clarify?

Please feed back to us specific facility where this occurred. We will discuss with the auditor on giving such guidance.

Auditors evaluate the Infection Leads (IL) based on their ability to adequately and competently perform the role. We have seen facilities where the IL exclusively only does that role, where they have one single other role, and others where the IL has 5 separate roles (is the DoN, and makes the schedules, is the IL, and is a charge nurse, and PPE coach, etc.).

The auditor will evaluate if the IL is able to do the role competently and adequately and is not struggling to balance this with other roles. In addition, the IL needs exclusive time to do the IL role during work hours (not juggling multiple tasks).

We understand that facilities may have staff who leave, or get ill, so we are not faulting facilities specifically for back-filling the role in a pinch, but it is a requirement that it is done well.

NEW

68. What should a facility do if they have two residents, both are negative and have never been positive that refuse to move from a COVID positive unit?

Patients are allowed to refuse being moved, though effort should be made to convince them to do so. Facilities should be in touch with all affected other patients and families/HCP. These patients should be assumed positive for sake of cohorting. They should not be wandering hallways of any potential negative space given their uncertain status.

69. Our facility has a COVID Positive patient who was in the hospital for 14 days and now has the 2 negative tests – can they go to the recovery unit or to a negative unit or do they need more quarantine?

Such a patient has met criteria to be considered recovery status and may go to either a negative or a recovery unit.
**Clinical**

70. **We are required on the 28-point checklist to do vitals BID. If we have no COVID patients must we continue that process?**

   Yes, close monitoring for possible spread of COVID even in currently negative facilities is paramount. No exceptions.

71. **Resident who have recovered, do they still need two times daily vital signs?**

   Yes. Given the unclear nature of long-term outcomes and subsequent adverse susceptibilities from COVID, these patients should continue to get at least twice a day vital signs or more per provider discretion.

72. **Does a positive need a re-test to come off precautions or can 14 day no symptoms release from precautions?**

   Either the CDC test-based criteria (subsequent negative tests on different days) or the MA DPH 14 day from first symptoms + 72 hours asymptomatic and not needing meds criteria; either of these are sufficient. Once these are met, the patient can leave the dedicated positive unit and full PPE for them is no longer required.

73. **How do we determine an asymptomatic positive resident is negative if we do not test?**

   See response to question #17 above. Facilities are expected to test and isolate all persons under investigation until test results are back. If a negative result is yielded on a PUI and there remains high suspicion, a second test is encouraged while continuing to keep the patient isolated.

   If an asymptomatic resident is found to be positive on testing across the facility, they should be moved to the dedicated positive ward until they have met the 14 day / 72-hour criteria, or re-test criteria. The clock starts from the day of the initial swab that found them to be positive.

74. **(Update) Are the facilities to perform vitals every 4 hours on all shift for all residents or just COVID Positive?**

   COVID Positive and those isolated as persons under investigation must have at least every 4 hour vitals during the daytime and evening shifts. Can return to two times a day vitals for those who have recovered and met 14d/72hr criteria. During at least every 4 hours vitals, it is insufficient if vitals between the final evening check and first day time check are widely apart (i.e. a 12 hour gap in checking vitals is not in line with the expectations of this checklist item)

75. **If we are using a dining area as last resort, what is considered terminal cleaning between servings?**

   All surfaces must be wiped/cleaned between each meal with an approved EPA hospital grade registered cleaning product or acceptable alternative: [https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2](https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2)
NEW

76. **On the competency of "demonstrate competency of such skills during resident care" - what is the threshold?** Seeing one staff member not adhering although training documented - or for example 10% of the staff?

One staff member not adhering to the demonstrated competency is sufficient for failure on item 12. This is a core competency and is expected of all staff in NFs taking care of this high risk population.

77. **How do you define "afebrile for >72 hours without fever reducing medications" when someone takes scheduled Tylenol for chronic pain management?**

The checklist does not get into this level of specificity. We recommend a facility discuss with DPH epidemiology for if additional time without symptoms would be merited for such a patient.

NEW

78. **If a resident is COVID 19 positive and is a DNH or end of life care are we still required to do vital signs every 4 hours during the day and evening shifts? The focus for these residents is "comfort care".**

These checks may be deferred for patients at end of life care who no longer receive any treatment of medical conditions. For DNH patients who would otherwise still receive treating care at the NF such as oxygen or antibiotics, vitals monitoring is still expected to guide that care. However, documentation of DNH or end of life care must be documented in the clinical record. This delineation and requirement apply to other statuses used by facilities such as hospice or comfort care. It is still expected that facilities keep residents and families/HCPs up to date on such statuses.

NEW

79. **(MassHealth Generated) For Item #25, if the facility does not have a documented clinical criterion for emergency transfer to a higher level of care other than a general change of condition policy, how is this graded? Such a facility does not have anything specific to COVID such as if O2 sats drop so many points from baseline, temperature raises so many degrees above normal....etc.**

This item asks facilities to have a documented clinical criterion. That criteria can within itself include an MD or RN assessment as part of its decision tree, but the criteria itself cannot be only a change of condition criteria with nothing else. The criteria can be inclusive of front-line staff using a decision support tool such as an SBAR to help decide elevation of concern to a clinician.

NEW

80. **(MassHealth Generated) Which items on the checklist require a facility to have a documented policy available for review?**

Even if a facility has no COVID-19 cases, they need to have policies in place, so they know how to respond to potential cases, PUIs, and outbreaks. That standard does not change per policies that are required.

Items 5, 21, 23, 24, and 25 require documented policies that are available for review. These may be part of other documents or policies rather than independently named documents. These must be available for review during an audit (having a policy but not having it available during an audit will result as failure on the item). The version of the policy reviewed locally by the auditor will be the
standard upon which the checklist item is evaluated (having a more comprehensive company policy created but not available for auditor review will not lead to a change in an audit score).

Item 9 requires maintaining a regularly updated document available for review.

Items 11, 12, and 22 do not require specific policies in place. For item 11, the facility must still be able to show proof of their contingency plan for supply shortages (can include order forms, etc.). For item 12, the facility should have a uniform guidance on how they are using PPE. This guidance does not need to be a home-grown document and can reference documents from other sources such as CDC or DPH. For item 22, the facility does not need a document speaking to daily assessments of staffing needs, but the facility should be able to show materials for how they execute that function.