FAQs

COVID-19

RESIDENTS

Q Can residents/clients/tenants leave the building? If they do, how do we handle re-entry?
Yes, residents have the right to leave your building. You should document that you educated the resident and any companions about the risks of COVID-19 in the community, as well as the high risk for elderly and those with underlying medical conditions. Notify them that they will be screened for signs and symptoms of COVID-19 upon their return, and certain isolation procedures will be applied if symptoms are present, or if they may have been exposed to any persons with COVID-19. We continue to seek additional clarification from MDH regarding this issue.

Q Can we refuse to admit new residents?
You cannot refuse to admit a resident due to a respiratory diagnosis or a COVID-19 diagnosis if the facility is able to follow CDC guidance and physician orders for care. However, if the resident’s plan of care requires something you are unable to provide, such as an airborne infection isolation room (AIIR), you can refuse the admission because you are unable to provide the required care. If you find yourself in a situation where staffing does not support the addition of any new residents, then you should not admit additional residents. The decision to not admit any residents should be made in coordination with your Regional Health Care Preparedness Coordinators (https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html) (RHPCs), who may be trying balance and coordinate the use of beds and resources across the entire healthcare system.

Q What do we tell family members who want to bring their loved ones “home” for safety?
Generally, we tell families NOT to move their loved ones—any transfers in living environment can be difficult for seniors. Secondly, unless family members plan on exercising ongoing self-isolation with their loved one—and no visitors—they will be in contact with individuals in the community who could be carriers. Certainly, moving them is a personal choice, but with our screening protocol, enhanced infection control, and visitation restrictions we think our settings are safer than being out and about in the community (we have tools on our website you can share with family members—letters, signs, and a video here: https://www.careproviders.org/COVID-19).

Q Can residents still participate in communal dining?
CMS guidance (https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf) directs facilities to cancel communal dining and all group activities, such as internal and external group activities. We have been working on specific guidance for communal dining with our national partners and federal agencies on further interpretations of the communal dining restrictions, and you can find that guidance here: https://www.careproviders.org/members/2020/AHCACommunalDiningApproaches03162020.pdf.

Q Can residents still participate in group activities?
Activities should focus on small gatherings with residents and staff remaining six feet apart when possible; larger group activities should NOT take place. We encourage members to increase one-to-one visits. Since this means religious services should also be canceled, we encourage you to distribute religious service materials, and/or notify residents of the availability of religious services on television. When possible, use one-to-one visits to help residents stay in contact with loved ones via FaceTime, Skype, email, phone, etc.

Q How can we help our residents with potential social isolation as a result of visitor restrictions?
See if staff can bring in laptops or iPads to coordinate FaceTime/Skype type of video communication with family and residents. Help residents with phones calls to family members. Use your activity staff to assist in whatever communication the residents and/or families are comfortable with—writing cards, calling, connecting by social media. Remember to sanitize computers/tablets between use!
**FAQs | COVID-19**

**STAFF**

**Q** Should we be screening our staff when they arrive for work?  
Screen all staff at the beginning of their shift for fever and respiratory symptoms. Actively take their temperatures and document absence of shortness of breath, new or change in cough, and sore throat. If they are ill, have them put on a face mask and self-isolate at home. Note: The CDC changed the temperature in the screen very recently—a person has a fever when one has a measured temperature of at least 100 degrees. View the screening tool here: [https://www.careproviders.org/COVID_ScreeningTool](https://www.careproviders.org/COVID_ScreeningTool).

**Q** What about staff that work at multiple facilities?  
Facilities should identify staff that work at multiple facilities (e.g., agency staff, regional or corporate staff, etc.) and actively screen and restrict them appropriately to ensure they do not place individuals in the facility at risk for COVID-19.

**Q** What about staff with signs/symptoms that have not been tested?  
- Healthcare providers (HCP) who have signs and symptoms of a respiratory infection should not report to work  
- Any staff that develop signs and symptoms of a respiratory infection while on-the-job, should:  
  - immediately stop work, put on a face-mask, and self-isolate at home;  
  - inform the facility’s infection preventionist, and include information on individuals, equipment, and locations the person came in contact with; and  
  - contact and follow the local health department recommendations for next steps (e.g., testing).

**Q** When can staff, who have been sent home due to signs & symptoms of COVID-19, return to work?  
Exclude from work until:

- at least three days (72 hours) have passed since recovery—defined as resolution of fever without the use of fever reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**  
- at least seven days have passed since symptoms first appeared.

Returning staff should wear a mask until symptom free for 14 days and should not be assigned to high-risk patients.

**Q** If there is a case in our facility, can we require staff to stay?  
No, you cannot require people to stay, according to the Department of Labor and Industry Hours FAQ ([https://www.dli.mn.gov/business/employment-practices/hours-faqs](https://www.dli.mn.gov/business/employment-practices/hours-faqs)). The Nurse Practice Act does restrict patient abandonment, but that does not apply necessarily apply to unscheduled work. Generally, the board identifies that patient abandonment results when a nurse has accepted responsibility for an assignment within the scheduled work shift, but the nurse does not either fulfill that responsibility or transfer it to another qualified person. This failure to fulfill a nursing responsibility may result in unsafe nursing care. Failure to practice with reasonable skill and safety is a ground for disciplinary action.

**Q** Can my employer require me to work overtime and fire me if I refuse to work overtime?  
The employer has the authority to establish the work schedule and determine the hours to be worked. There are no limits on the overtime hours the employer can schedule. Employees who refuse to work the scheduled hours may be terminated. Advance notice by an employer of the change in hours is not required.

**Q** What can we do if staff refuse to come to work?  
You need to follow your current employment handbook; employee policies and procedures; and your bargaining agreement (if one is in place).

**Q** If staff need to stay home due to closure of schools or daycare, can we require them to come in?  
No. But you can see if they are available for other shifts or times if partners/spouses/family are available to watch the kids at other times of the day. Can you or they make accommodations to help your staffing?
FAQs | COVID-19

STAFF continued...

Q  What do we do when schools close and my staff don’t have day care?
Governor Walz implemented executive order 20-02 (https://www.leg.state.mn.us/archive/execorders/20-02.pdf) closing schools for a specific period of time. Included in that order was that schools, during their normally scheduled days, provide care to school-age children—12 years old or younger—of healthcare workers and emergency responders. “Healthcare staff” includes staff at nursing facilities and assisted living communities.

Q  If staff are exposed and become positive, it is a workers’ comp claim? How about unemployment?
We believe so. Both the state of Minnesota and the federal government are working on additional workers’ compensation and unemployment benefits needed as a result of COVID-19.

Q  How will we handle staff shortages with the combination of no new staff in the pipeline, current staff needing to isolate due to exposures, and/or staff not working due to PPE shortages?
We have been doing a few action steps:
• Asking for additional funds for increased staff costs such as overtime, pool costs and “hazard pay”
• Asking for regulatory relief from a series of state and federal requirements
• Specifically asking for quick on-boarding of any direct care/nursing staff who may have been furloughed from working in clinics/other setting due to the cancellation of non-elective medical procedures

Our waiver requests include allowing professionals to work across state lines.

Q  Should we be limiting staff who have been traveling from work?
The screening guidance changed when the virus became community-spread several days ago—traveling doesn’t matter anymore because we assume it is active in every community. We encourage you to use the screening document we have updated on our website: https://www.careproviders.org/COVID_ScreeningTool.

VISITORS

Q  Can we restrict all visitors?
Facilities should restrict all visitors and non-essential healthcare personnel, except for certain compassionate care situations, such as an end-of-life situation. In those cases, visitors should be limited to a specific room only. Facilities are expected to notify potential visitors to defer visitation until further notice (through signage, calls, letters, etc.).

For individuals that enter in compassionate situations (e.g., end-of-life care), facilities should require visitors to perform hand hygiene and use personal protective equipment (PPE), such as face masks. Decisions about visitation during an end of life situation should be made on a case-by-case basis, which should include careful screening of the visitor (including clergy, bereavement counselors, etc.) for fever or respiratory symptoms. Those with symptoms of a respiratory infection (fever, cough, shortness of breath, or sore throat) should not be permitted to enter the facility at any time (even in end-of-life situations).

Those visitors that are permitted, must wear a face mask while in the building and restrict their visit to the resident’s room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.

Q  What about family members who are caregivers of our residents on a consistent basis?
We recommend you allow them to come when family members play an essential and official part of their loved ones caregiving team providing cares. As with all visitors, family members must agree to and pass the screening. Family members that do housekeeping and laundry would NOT be considered essential caregivers.
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VISITORS continued...

Q Can we have residents stand by the window with the window open to visit with family?
   Perhaps. It is very tempting to reach out and touch, and we do know that the virus can stay “alive” on surfaces such as windows and screens. IF both residents and family stay the proper distance away from the window, this would be a good way to connect—encourage signs and phone calls while observing through the window from a distance.

Q Can we let family members in to install electronic monitoring devices?
   Family members have a right to install a camera in a resident’s room per state law. Family members who want to install a camera should be allowed access to their loved ones’ room under two conditions: first, they must pass the screening requirements you have established in your setting; secondly, they must agree to limit their building access to their loved ones’ living unit/apartment only and not have free access to the rest of the building. The consent and notification requirements of the electronic monitoring law remain in effect.

Q Can we lock doors so that all potential visitors must go to one entrance?
   Yes, but the doors must be able to be opened from the inside as a means of egress for emergencies.

Q What about other healthcare workers that come to our building?
   Hospice workers, EMS personnel, dialysis technicians, laboratory technicians, x-ray technicians, home care workers, physicians, APRNs, etc. should be permitted to enter the building once they have been screened for fever and respiratory symptoms.

Q What about other officials such as ombudspersons or case managers?
   The CMS latest guidance, which has also been applied by the Minnesota Department of Health, to licensed congregate settings such as assisted living, only has an exception to the visitation restriction for nursing facilities for healthcare workers (defined in the guidance) and surveyors with certain restrictions. Along with compassionate care (end-of-life) situations where the visitor is symptom-free. Ombudspersons are permitted to assist residents with advocacy needs using remote communication methods. Case managers should be addressed on an as-needed basis, with an emphasis of not visiting.

Q What would you recommend in terms of tours for prospective tenants?
   We recommend you do not do real-time tours at this time and suggest a virtual tour of your building.

MISCELLANEOUS

Q What is the priority of PPE for staff use with suspected or confirmed COVID-19?

Q We do not have enough PPE. What do we do?
   First, try to utilize your common PPE supply chain sources to get more. Try to receive incomplete orders rather than full orders. Look for alternative vendors. Secure current PPE supplies to reduce pilfering and limit use to only when necessary. Finally, contact your Regional Health Care Preparedness Coordinator: https://www.health.state.mn.us/communities/ep/coalitions/rhpc.html. They may be able to assist. They will have you fill out an online form to determine if they can assist you to access any of the limited Minnesota or National supplies. Implement the interim CDC recommendations for using PPE (http://bit.ly/33xZBv9), and strategies for optimizing the use of PPE (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html).
MISCELLANEOUS continued...

What materials do we need for specimen collection?
You will need the following supplies to collect specimens for testing. If possible, acquire these supplies in advance of an outbreak so you will be ready to collect and submit specimens when an outbreak is first identified. MDH will provide more detailed instructions on the collection and submission of specimens in the event of an outbreak:

- At least five nasopharyngeal (NP) swabs and five oropharyngeal (OP) swabs
- 10 vials of viral transport media (VTM)
- Transport materials that allow specimens to be kept cool, such as a Styrofoam cooler and ice pack

Identify a method to transport specimens from the facility to MDH. For MDH Public Health Laboratory guidance and answers to frequently asked questions, see Coronavirus Disease 2019 (COVID-19) Specimen Guidance (https://www.health.state.mn.us/diseases/idlab/labcovid19.html).

As a provider of healthcare services, what MDH number do we call with questions?
The MDH COVID-19 provider hotline number is 651-201-5414. The general number for non-healthcare providers is 651-201-3920.

Should we still call MDH after influenza has been ruled out for a resident, but signs/symptoms still exist to get directions on testing for COVID-19?
Yes, call 651-201-5414. They will help determine if the resident is appropriate for a COVID-19 test.

When do we report to MDH of suspected outbreak?
Report to MDH when your facility sees an increase in respiratory illness in residents and/or staff that cannot be attributed to influenza, RSV, or other known respiratory pathogens.

- Call MDH at 651-201-5537 or 1-877-676-5414 and tell the operator you need to report a respiratory outbreak in a long-term care facility
- An outbreak is defined as two or more residents and/or staff with a recent onset of respiratory illness within the same unit or ward that have tested negative for influenza and have no known etiology
- Discuss details of the outbreak with an MDH epidemiologist
- Provide MDH with a line list of ill residents and staff


How do we treat family members who serve as primary caregivers as part of the care team in assisted living?
Family members who serve in this role should have access to your building and their loved one, but they must abide by the same screening and infection controls protocols you have implemented for your staff.

Will we see changes in hospital admissions and discharges to SNF/NF settings as a result of COVID-19?
We have been participating in calls with all of our healthcare partners on a near daily basis as the outbreak evolves and there are concerns about hospital capacity, especially hospital ICU beds, should there be a community-wide outbreak.

When and how will we be able to get access to the emergency funds we need for all of our increased costs? How about regulatory relief—any guidance on when we can access non-certified staff?
We know the Department of Human Services sometime during the week of March 23, 2020, will host a webinar to instruct nursing facilities how to apply for their “COVID grants.” We have stressed to the administration the critical need to move quickly on our waiver requests as well as emergency funds for non-nursing facility long-term care settings.
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MISCELLANEOUS continued...

Q If there is a positive case of COVID-19 in our building, are we required to inform families that this has occurred?
The Department of Health (MDH) has developed a standard letter that they will give to facilities once there is a confirmed case in your building, and will ask you to distribute this letter to other residents/families. MDH will want to explore how widespread the outbreak is, and make sure those who have been exposed—whether other residents, family members or staff—know that they should be self-isolating.

Q Are any background checks being processed?
The fingerprinting sites have been closed down due to COVID-19 transmission concerns, but they are still processing the paper “cards”—we know this takes too long and have asked for waivers of the background check requirement.

STAY INFORMED

The Care Providers of Minnesota website has a page set up solely for updated information and links to current guidance from the Centers for Disease Control & Prevention (CDC), Centers for Medicare & Medicaid Services (CMS), and Minnesota Department of Health (MDH).

Visit the Care Providers of Minnesota COVID-19 page: careproviders.org/COVID-19

Other helpful resources to stay informed:
- Centers for Disease Control & Prevention COVID-19: http://cdc.gov/covid19
- Minnesota Department of Health COVID-19: https://www.health.state.mn.us/diseases/coronavirus/
- AHCA/NCAL COVID-19: https://www.ahcancal.org/Coronavirus
- CMS guidance updates to state agencies: https://go.cms.gov/2ISXB75
- Status of COVID-19 penetration in Minnesota: https://www.health.state.mn.us/diseases/coronavirus/situation.html

Questions? We’re here to help!

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