

Frequently Asked Questions (FAQs) About COVID-19

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Cohorting

Q1. *What if a resident who tested positive for the COVID-19 virus refuses to be isolated/quarantined?*

A1. Work with the resident to explain the ramifications of exposing self to others in the community. If appropriate and available, the resident's family or authorized representative, or the State Long Term Care Ombudsman's office may be able to assist. If the resident continues to refuse, contact Oregon Health Authority and immediately notify your SOQ policy analyst.

Q2. *My building hasn't had any staff or residents who have been diagnosed with COVID-19; what do I need to do to prepare?*

A2. First, identify a wing or a group of rooms in one wing that can be reserved for residents who are positive for COVID-19. Second, develop a staffing plan to identify **dedicated staff** who will work **only** in the area with COVID-19 positive residents. This plan should identify how your facility will direct care, environmental support, and other services to residents with COVID-19. It is recommended facilities develop a contract or relationship with a staffing agency to ensure you will be able to provide adequate staffing should current staff leave if COVID-19 is found in your facility. For a

more comprehensive planning tool, please refer to the [Readiness Assessment Tool Update](#).

Q3. *Several of my staff have tested positive for COVID-19 and now, many of my residents have also tested positive. However, we are not able to effectively cohort. What do I do?*

A3. Cohorting residents and dedicating staff are among the most critical interventions for mitigating the spread of COVID-19 and must be implemented as quickly as possible. It may be beneficial if the resident(s) who are positive for COVID-19 temporarily transfer to another setting. If COVID-19 has not yet entered your facility, we recommend designating other potential settings now, so that you will be prepared. Also, if you believe any of your residents would benefit by going to a hospital or Enhanced Health Care Center that specifically cares for people with COVID-19, then arrangements can be made to send them.

Admissions and Readmissions

Q1. *Can CBC residents be restricted from leaving the facility to go to a physician or other routine medical appointments?*

A1. No, residents are free to come and go from their home setting, and facilities must continue to accommodate residents' medical visits, routine or not. However, upon return from any outing, residents should be screened for potential exposure and monitored for signs and symptoms of COVID-19.

Q2. *If a CBC resident leaves the facility to visit a physician or attend other medical appointment, and the facility currently has an Executive Order (EO) and Restriction of Admissions (ROA), can the resident be allowed to return to the facility (readmit)?*

A2. Yes, the resident must be allowed to return following medical appointments; this situation would not be considered a facility readmission.

Personal Protective Equipment (PPE)

Q1. *Exactly what PPE is required, under what conditions, and by which staff?*

A1. Face masks and eye protection should be worn by staff when in the facility ([see PPE Handout for details](#)). Gowns should be worn when providing care for residents with known or suspected COVID-19. Gowns are also recommended for the care of residents under observation after a new admission/readmission (At minimum, face masks and eye protection should be worn to provide care to new admission/readmission residents.)

Q2. *Are gowns considered universal PPE? As stated by one provider, “I don’t think the State understands how many isolation gowns a facility the size of ours would use in one day if staff had to use one every time care was provided for a resident.”*

A2. Although gowns are recommended, gowns are not considered “universal PPE” and are not required.

Q3. *Are goggles acceptable substitutes for face shields?*

A3. Yes, goggles may be used along with face masks, in place of face shields.

Q4. *Do facility caregivers need to change gowns between each resident?*

A4. Gowns may be used without changing only when working exclusively with positive residents. There cannot be “crossover” between positive and negative residents without changing gowns. If staff are providing care with negative residents, then gowns must be changed after each resident. This precaution with negative residents should be taken, whether you believe all residents staff are caring for are negative or not.

Q5. *Does the facility have to provide essential visitors with PPE?*

A5. Yes. However, it is recommended that if essential visitors have access to PPE, the facility ask these visitors to bring their own PPE.

Testing

Q1. *If a facility learns of a suspected or confirmed COVID-19 case for any resident or staff, what does the facility need to do?*

A1. As soon as a facility learns any resident or staff is suspected or confirmed for COVID-19, the facility must immediately contact their SOQ policy analyst and their local public health authority **and** initiate testing for all residents and staff within 72 hours. The goal is to have completed all testing within 72 hours. However, the department may deem the facility's actions acceptable if the facility has contacted a testing lab and has made considerable progress toward completing testing of all residents and staff within 72 hours. If the facility encounters any difficulties in meeting this 72-hour deadline, the facility must contact their local public health authority and policy analyst.

Statewide Required Testing

Q1. *How much time does a facility have to complete the initial statewide testing?*

A1. All facilities must complete the first round of testing by September 30th, 2020. Also, if a facility previously completed a comprehensive round of testing, that testing must have been completed since June 1st, 2020, for the testing to be considered adequate for this statewide testing requirement.

Q2. *Does a facility have to share testing information with other parties?*

A2. Yes, facilities should inform residents, resident families, resident representatives, staff, vendors, and other stakeholders of the initial testing and the on-going testing that will take place. Also, testing results must be supplied to state and local governments, using the state testing SurveyMonkey.

Q3. *How and where do facilities report test results?*

A3. Positive test results must be reported to the local public health agency in your county, **and** to the Safety, Oversight & Quality (SOQ) Unit within DHS. Your testing progress is to be entered

into the state Survey Monkey and it is through this survey that you can indicate your current testing status, results to date, and indicate what help is needed. The survey can be found here: [LTC Testing Progress Report](#). Test results entered into the Testing SurveyMonkey are automatically sent to OHA, DHS, and the local health authorities. *However, facilities **must still immediately report suspected or confirmed cases of COVID-19** to your SOQ Policy Analyst and to your LPHA agency.*

Additionally, once you have met the testing as required by September 30, 2020 you can submit the attestation of completion by clicking here: [LTC Testing Attestation of Completion](#). When you complete this final attestation, you will be marked off as having met the requirements and no further reporting will be required other than the discovery of new or suspected COVID within your building.

Q4. *What information does each facility need to track?*

A4. The following Information must be entered into the Testing SurveyMonkey:

- The number of facility staff tested to date;
- The number of residents tested to date;
- The number of positive facility staff test results to date;
- The number of negative facility staff test results to date;
- The number of positive resident test results to date;
- The number of negative resident test results to date;
- The number of facility staff and resident refusals to date;
- The number of associated staff tested to date;
- The number of positive associated staff test results to date;
- The number of negative associated staff test results to date;
- The number of associated staff refusals to date;
- The number of associated staff that still need to be tested prior to September 30, 2020; and
- The number of facility staff that still need to be tested prior to September 30, 2020.

Q5. *How should a facility handle residents or staff who refuse to be tested?*

A5. A resident may refuse to be tested. That resident should be treated as positive and monitored for symptoms for the duration of one incubation period (14 days). Initial testing of **all staff** is mandatory, except for those who provide medical justification for declining testing from a licensed health care provider.

If staff refuse testing, and **do not** provide medical justification, the facility is required to address a refusal as a personnel matter with the individual employee. Personnel consequences for refusals to test shall be consistent with requirements under federal and state employment laws and collective bargaining agreements, if applicable. Staff cannot provide direct care to residents unless they have a negative test result or meet the local health provider authority guidelines.

Visitation

Q1. *Are facility visits allowed in outdoor patio locations?*

A1. If facility has appropriate outdoor space and an ability to host visits, we recommend facilities accommodate structured outdoor visitation. Since an alternative would be the resident going out into the community, allowing the use of patios is a safer and more practical idea, in the best interest of residents and family members as well as the facility. Prior to offering outdoor visitation, the facility must submit a plan to SOQ, describing how the facility will meet all safety criteria including scheduled visits, PPE and social distancing during visits, and disinfection protocols.

Q2. *Are US Census Bureau employees allowed to enter facilities to conduct Census interviews of facility residents?*

A2. US Census Bureau employees must be allowed to enter facilities. As with all visitors, the facility still needs to ensure they are utilizing the appropriate PPE.

Q4. *When are Chaplains allowed to visit residents during end-of-life?*

- A4.** While it is recommended Chaplain visits be performed virtually during non-end of life stages, Chaplains or other clergy members may visit the resident during end-of-life stages, with appropriate PPE and infection control protocols.

Essential Visitors

Q1. *Does the facility have to provide essential visitors with PPE?*

A1. Yes. However, the facility may recommend that, if essential visitors have access to PPE, they bring their own.

Q2. *What would constitute an exception to allowing more than one essential person to visit?*

A2. End of life situations only.

Q3. *Are nursing students and other health care professionals who are in training considered “essential” personnel?*

A3. Yes, these are considered essential personnel, and are also Associated Staff.

Q4. *Can a facility forbid Home Health from entering a facility?*

A4. If Home Health has been determined “essential” by an individual’s physician, they are considered essential medical personnel, and must be allowed. Screening and PPE must still be required.

Q5. *Are privately contracted Home Care agency staff considered essential staff?*

A5. Yes, if they are providing care-planned services to residents that have been determined “essential” by an individual’s physician.

Q6. *Are occupational therapists (OT), physical therapists (PT), and speech therapists (ST) considered essential individuals and therefore allowed into facilities?*

A6. This needs to be determined by the individual’s medical professional. (Making the determination as to what services are

essential to the individual is not a determination that falls within the scope of SOQ.) If the individual's medical professional determines these are essential for the individual, then the facility needs to allow them into the facility to provide these services.

Executive Orders

Q1. *When will an executive order be placed on a facility?*

A1. Any time a facility has a suspected or confirmed case of COVID-19 involving a resident or a staff, the Safety, Oversight & Quality program of the department will place an executive order on the facility.

Q2. *How long will an executive order remain in place?*

A2. At this time, an executive order must remain in place for 14 days following any symptoms of COVID-19 in the facility. Even if the local public health authority for a given county lists a shorter period of time as the contagious period, the department requires all executive orders be in place for 14 days.