Centers for Medicare & Medicaid Services
COVID-19 Call with Nursing Homes
Moderator: Alina Czekai
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Alina Czekai: Good afternoon. Thank you for joining our May 13th CMS COVID-19 Weekly Call with Nursing Homes. We appreciate you taking time out of your busy schedules to join us today. We are also very happy to be with you during a week where we take the time to celebrate the hard work of nursing home care team as we care for some of the nation's most vulnerable patients.

This is Alina Czekai, working on Stakeholder Engagement on COVID-19 in the Office of CMS Administrator, Seema Verma. Today, we are joined by CMS and CDC leaders as well as providers in the field who have offered to share their best practices with you all.

I'd first like to turn it over to Administrator Seema Verma for an update on the agency's latest guidance in response to COVID-19. Administrator Verma, over to you.

Seema Verma: Thank you very much and thank you all for joining us today. I appreciate you taking time out of your busy schedules. You know, this week is Skilled Nursing Week and I just wanted to start out by expressing my sincere appreciation and gratitude to each and every one of you for your unwavering, dedication and commitment to keeping residents' safe. These are truly unprecedented times, and you all have done an amazing job.

This has been an incredibly difficult time for you and your staff. It's been difficult to keep people safe. The number of deaths has been hard on your staff and yet, you know, people are there, day in and day out not only just doing the routine work that you have done in the past, but I think also, the staff has always been a source of care and comfort, but even more so serving as almost family members.

And I appreciate all the work, the stories that we hear about nursing home staff on the frontlines, communicating with families, getting them calls, setting up a Skype meeting, so that patients can talk to their families. That's really incredible work and it shows how much you really care for your patients.

I also wanted to just take a special moment to thank, Mark Parkinson, who's just been a great partner. He has been working with us on the administrative level and communicating a lot of the concerns and challenges that you all had been going through from testing to supplies. He's just been available any time I called him.

And I wanted to take this time to actually tell a story about Mark because we've all been working through this and I think it was a Saturday morning and I just called him and I said, Mark, tell me what's going on, tell me what I can do to help. And he was talking about testing challenges, he was talking about PPE challenges.

And throughout that weekend I must have called him three or four times, he always took my call. He is very prepared, very organized. He gave me a list that weekend of all of the nursing homes. He had it organized with all their pertinent information, the size of the nursing home, the number of staff. And it actually had a PPE calculator in that and I was able to take his spreadsheet and give that to FEMA.

And so as many of you, hopefully, are receiving some of the packages that FEMA has put together to augment your supplies. That's kind of how it happens. It was a very simple transfer of information. We're just talking to FEMA about it, but a lot of it had to do with the leadership of the Association and because Mark was so organized and he had all that information at his fingertips. We could just hand it to FEMA and they were really happy to be able to deliver the packages.

We're getting updates and hearing that they're delivering that all across the country. And so, we hope that is just a symbol of our appreciation for all the hard work that you all have done. And I think that story with Mark really

speaks to the partnership that we had over this enormously difficult time and this challenging situation. We also, as part of the FEMA effort, we got to deliver the packages and I met a nursing home owner in Virginia.

And he was telling me about the fact that they had COVID in some of their facilities, they learned a lot, they'd figured out how to control the spread of the virus in the nursing home. And so while it had been a difficult time, it was a great example of nursing homes that are doing incredible work across the country and we felt really grateful to be there and to listen to their stories. And I'm glad that we were able to talk about some of the great work that nursing homes are doing.

So from our standpoint, we hope that the work that we've been doing with the nursing homes represents a partnership, and these are challenging times. We're all learning new things about the virus. We hope that all of the guidance and regulations and information that we've been giving is really intended to support your efforts. I can tell you that the CMS nursing home team has been working around the clock pretty much every weekend since all of this started.

They meet daily with the CDC team and they have been really working hard to make sure that everything is updated and based on the latest science and information. We appreciate your great cooperation with the surveys. I think we really intended those to be problem solving, an opportunity to identify issues to help you serve your patients better.

And just to identify issues and work in collaboration to ensure that patients are safe,so we really appreciate the strong support and your cooperation with all of those surveys that had been going on. And the team has used a lot of the information that they received from that to inform other types of guidance. So, we want to continue that partnership with you. We're very excited about the President's commission on quality and safety for nursing home patients.

We really hope that's going to be an opportunity for all of us to just step back from what's been going on in the day to day and try to identify those best practices. So, that we can ensure that not only patients are safe but they're

getting the best quality of life. And this is going to be an ongoing battle. We know coronavirus, unfortunately, isn't going anywhere for a while.

And while we are seeing reductions in cases all across the country, it's something that we're going to have to continue to be vigilant on. And so we're hoping that the commission and some of those individuals can kind of give us some awesome outside perspective and we're excited to ensure that we have nursing home representation on the commission.

But, I think ithopefully, it marks new way of us trying to figure out what's the best way to increase quality, patient quality of life and ensure that all patients are safe. So, we're excited to begin that process. I think this week we'll be announcing the process for nominations as well.

And then the other thing I wanted to mention that the team has worked on is that we put out a toolkit this week and the toolkit really just summarized all of the efforts across states and all the different things that they're doing to support nursing homes. Some of them, as you know, some of the governors have asked our National Guard to help nursing homes with cleaning and disinfection.

This week we called for support for states to help nursing homes get their nursing home residents tested and to support your efforts to identify patients that may have the COVID virus. We've also increased reimbursement in Medicare for testing and something that we've never done before is we allow labs to go to patients that are home-bound, which would include our nursing home residents, and to conduct that testing.

And so that's something that we hope will support your efforts to identify patients quickly and be able to isolate them. So again, I want to make sure you have time to talk about all the best practices and great work that you're doing, but again I just wanted to say a sincere thank you. We really appreciate all the hard work you're doing and we look forward to continuing to work with you.

Thank you very much and with that, I'll hand it over to Jean.. Thank you.

Jean Moody-Williams:. Thank you, Administrator and we really appreciate all that you are doing as well, and welcome everyone to our weekly call. I would like to add my congratulations and thanks for National Skilled Nursing Care Week. It certainly is an observance that we've been recognizing for the entire week and so stay tuned throughout the rest of this week as we continue to do the recognition and provide information.

So, the Administrator outlined a number of things that we had in the works and things that we've rolled out. And as I usually do on this call, I like to let you know about some of the flexibilities that we are also rolling out because most of those come from your requests, your requests for waivers or things, questions you had from this call. And so I'm going to name a couple of those but I'm not going to spend too much time because we do have a reallyfull agenda.

But one of the things, just to mention, we did do some changes to the Life Safety Code requirements for skilled nursing facilities and nursing facilities. Some of the things that we needed to waive related to the prescriptiveness of alcohol-based handrubs and where they're placed. The dispensers, we recognized in this time it's more important that you'd be able to get to those alcohol-based handrubs when you need them versus where they're actually posted.

I mean there's a reason whenever we have these kinds of things. It's ethyl alcohol, it's flammable and so there's a reason for the regs that are in place, but we are waiving most of those with the exception that there is still a restriction on the storage for the large containers because it is flammable. So, just check that waiver to see what is involved there, as well as the quarterly fire drills.

We have waived that. It's still important to include that in your orientation but we recognized now is not the time to be moving a mass number of patients from place to place. And also, some of the temporary walls and barriers there with our Life Safety Code, please note.

We revised the ESRD flexibilities as well to include assisted living facilities. Prior to this time, we had done some of the waivers as it relates to long-term

care facilities, but now the dialysis care can be provided in assisted living facilities and similar types of facilities.

The last thing I think I want to note that we'll have some relationship to your work is that we placed a waiver on related to swing beds. We've expanded the ability for hospitals to offer long-term care services and swing beds for patients who do not require acute care but did not meet the SNF's requirement level of care.

And this allows hospitals to establish SNF swing beds to provide additional options. When it's not possible to obtain a long-term care bed within their area that they usually worked with, we know that there's been a few issues with that. So, those are the flexibilities that we have put out within the last week or so. Please check our website for additional information.

But I want to turn to Evan Shulman, the Director of the Division of Nursing Homes within our Center who's going to provide some updates from the survey process and data reporting. Evan…

Evan Shulman: Thank you, Jean, and Happy Skilled Nursing Week to everyone out there. We really appreciate your efforts. I'm going to just give an overview of some of the updates that we have for some of our programs here. First on surveys, I think everyone knows that with the memo that we released on March 23rd, we've altered the types of surveys that are being conducted.

Since that time, states and federal surveyors have only been conducting surveys that are triage at the immediate (inaudible ) and also the infection control surveys that we have released (inaudible) for. To date, states have conducted over 6,800 surveys across all of our states that's hitting approximately 44 percent of our more than 15,000 nursing homes. Of course, it's going to vary by state.

We have some states that have conducted surveys in almost all their nursing homes and we have some states that have not conducted as many surveys as other states and are conducting a very low percentage of surveys. Of course, this can be due to multiple factors. It could be due to the availability of PPE

or a state need to use surveyors in other capacities due to their clinical background.

But, what we're seeing on these surveys is interesting and we are seeing providers doing a lot of great work. So, a big thank you to everyone out there who is doing fantastic work in preventing the spread of COVID-19, for using the guidance that we have put out and in conjunction with the CDC. CMS and CDC have been putting out guidance and it's well before the COVID-19 pandemic hit. We've been putting out tools and other resources for facilities to use.

So, thank you for using those and of course leveraging any other resources that you may have access to. We are still seeing some cases where facilities are not doing everything that we believe they should be doing to prevent the transmission of COVID. These are some of the things that we have had longstanding requirements and expectations about. Things such as hand hygiene and making sure that hands are disinfected when they should be.

Using PPE appropriately, and this is not about whether or not a facility has or does not have PPE and is not using it. These are cases where the surveyors are observing facility staff with the appropriate level of PPE, they're just not using it appropriately or donning and doffing it appropriately. We're also seeing some cases of noncompliance where the facility is not notifying the physician timely, related to a changing condition.

And then one of the more prominent things that we needed to do over the course of this pandemic is cohorting and isolation. And I know that this can be challenging because of the structure and the makeup of some facilities, of how they're structured, but we have seen occasions where, again, even though the facility has the ability to cohort or isolate residents in the right way, they're still not doing it.

So, I know that this is difficult work, and again a lot of you,most of you, are doing a great job at it. I think the message is, don't let your guard down. For those of you that think you got it and you're doing it right, are you making sure that everyone is doing it right.

Do you know exactly how every single one of your staff is donning and doffing PPE in some far unit of your facility? And if not, then you may want to check on that. So again, great work for everyone. We continue to see some sporadic noncompliance related to our expectations and we're hoping that we can shore those up as soon as possible.

The other thing,again a reminder about the guidance that we've released, please make yourselves as well-versed as possible in all guidance that CMS and the CDC have released. This includes the self-assessment that we recently updated on May 6 and this update includes some information about a new requirement that I'm going to spend some time talking about which is the reporting requirement.

But, the self-assessment is intended for you to be able to conduct your own survey and look exactly at the same things that the surveyors would be looking for. And the survey and self-assessment are based off of longstanding guidance and regulations but also the latest information that we know about how to prevent the spread of COVID-19 in nursing facilities.

I also mentioned I'm going to highlight the new requirement that effective May 8, all facilities are required to do two types of reporting. One is reporting to residents, resident representatives and family members and the other reporting is to the CDC. All of you know that we had a longstanding requirement for facilities to know whom and when to report, cases of communicable diseases too, in this case, it would be COVID-19 to your state or local health department.

And this reporting just layers on top of that. First,on the family reporting. All facilities are required to report COVID-19 information to residents, resident representatives and their families. And what we're really just trying to get at here is answering the questions that family members are asking, what is happening in the environment that my loved one is in. And we believe strongly that they have a right to know, that's really what that is aimed to do.

The second requirement is reporting to the CDC through the National Healthcare Safety Network or NHSN and this is critical for our national

surveillance for the trajectory of the disease in our country. We know that states have their own type of reporting but there's no national standardized way to collect nursing home COVID-19 information across our country.

And this is the first ever way to collect this type of information, so we as a nursing home community can know how the disease is moving and where we are on the hump, as they say, of the curve of this disease. So, this will give us the ability to see where we are. It is critical that every single one of the nursing homes enroll and start reporting information as soon as possible. The requirement is to report at least once a week. You can report more than that but it starts with enrolling.

Thousands of nursing homes have already enrolled to submit information through the NHSN system,but we still need thousands more to enroll. Thousands have also started to report and we still need thousands more to report. CMS will be making this information public. We will also be enforcing noncompliance if nonreporting. So again, I urge all of you to look at the CDC website.

There's very easy to follow instructions on there. If you have questions, they have a help desk that can help. But we,based on what we're seeing with thousands of facilities having been able to enroll, enrollment should not be a barrier.

So with that, thank you again for all of your hard work out there. We as a nursing home community are all in this together and so we really appreciate your collaboration and again your hard work, particularly during this week, the Skilled Nursing Week.

Jean, I will turn it back to you.

Jean Moody-Williams: Thanks much Evan. I appreciate all the information and now I want to move to observations from the field. First from the federal perspective, but then we will quickly move as well into hearing from our guest speaker today.

Lauren Reinertsen, I'm going to turn it over to her, is the Division Director for our Northeast Survey and Enforcement Division. And in her role, she provides supervision, direct supervision to the federal surveyors, as well she works really closely with the state surveyors and the state survey agencies. And so I've asked her to give us an overview of some of the things that they had been finding in the field over the past several weeks.

And then when she completes her statements, she will turn it to Dr. Nimalie Stone who's been with us on a couple of occasions, the medical epidemiologist for long-term care from the Center for Disease Control and Prevention, to talk about some promising practices that she's seen as well.

So, Lauren and then to Dr. Nimalie Stone.

Lauren Reinertsen: OK, very good. Hello everybody, I'm Lauren Reinertsen. As Jean mentioned, I represent the Northeast Division of Survey and Enforcement and it actually represents 14 states, activities in 14 states and includes Puerto Rico and the U.S. Virgin Island. So in our area, we have had COVID-19 hot zones as I'm sure all of you are aware. We also have had several high media cases from outbreaks that have garnished a lot of attention.

And we also have from our work as federal surveyors and also with the state agencies, we have information from the CMS-focused infection control surveys. So, we all know that we have a commitment, all of us here on the call, have a commitment to take care of the residents in this COVID-19 emergency. And it's one of our highest priorities and we all know how foundational strong infection control practices are.

From our experience, we've seen nursing homes meeting infection control requirements and doing a marvelous job under some very challenging experiences and conditions. But, I did want to share today a few areas in which perhaps more attention or oversight might be applied to improve some outcomes. And as Evan Shulman had mentioned and I'm sure that you all also are cognizant of it, there seem to be three major areas that we see repeating opportunities that are available to reduce infection spread.

And one of the first areas is hand hygiene and we're all only as good as our weakest link and we really need to make sure that we pay attention. We educate our staff and observe them and remind them and make hand hygiene a readily accessible type of activity and keeping an eye on them. And I know everybody is working hard and trying to work fast to get the job done but we have seen quite a bit of problems with hand hygiene.

And the other area is actually donning and doffing of PPE and when you have the PPE, we've seen – I'll go into a little more detail in a minute, but we've seen people taking off PPE incorrectly. You know, not really donning it properly, masks that are not on right with their nose exposed and various other things. So, that's one of the areas that donning and doffing with PPE that we all can use reminders on to make it easy.

Hopefully, you will have adequate supplies available but educate your staff, and make sure that they're doing the donning and doffing appropriately. There also is the concept of that separation and cohorting and signage and making sure that there is an overall awareness of your staff for these infection control actions that we're all working so hard to make sure are available to the residents.

So, the big three are hand hygiene, the donning and doffing of PPE, and the signage and the cohorting and that separation and making sure that everybody is aware of it and following those actions.

So, specific opportunities, you may be doing this already, but I'm going to be mentioning some of the things that we have seen in various surveys and experiences in the skilled nursing facilities.

So, in terms of surveillance, there's an opportunity to have more robust resident monitoring which goes beyond taking temperatures but also taking other vital signs on a routine schedule.

We've seen some facilities, they only document in monthly notes unless the resident starts to complain or has a temperature. And there seems to be little documentation in the clinical records often of stomach issues, headaches,

other vital signs, and the types of signs and symptoms of COVID-19 that the CDC has issued expanded guidance on.

We also have seen cases where staff screening was not adequate. And we also have seen social distancing not present upon the main entrance into the facility.

So, in the area of infection control, we need to have nursing homes consider having backups to key roles in infection control. We've seen several cases where the infection control nurse might be absent with illness or COVID-19. And we have seen issues where the infection control nurse was assigned to staff nurse duties instead. And then that role of infection control and that oversight is held vacant.

So, we also have seen situations where first line staff are not informed of a possible COVID infection, a lack of signage in the areas where COVID-19 residents are. We've seen the cohorting of COVID-negative residents or uninfected residents with the COVID-positive or the PUIs or suspected COVID-positive residents.

And then, we also have seen staff who provide services in a COVID room then go into a COVID-negative room without washing hands or changing PPE, gloves, and that. We've also seen that not only in the nursing staff but also in housekeeping and support services. So, that's another area that is an opportunity that you can keep an eye on.

The hand hygiene, I mentioned, the housekeeper we've seen going from one resident room to another without washing hands. And we also have had during interviews a staff express that they don't understand that if they touch items in a resident's room that they also need to perform adequate hand hygiene.

And we have seen circumstances where hand sanitizer is not readily available, that soap was not available. So, these things really can be solved with observation and vigilance and management.

We've seen facilities that do provide N95 masks but they have not fit tested their staff for the appropriate size. We've seen one mask issued for the entire day and that is difficult when the staff are working with COVID-19 with acute symptoms.

As I mentioned before, we've had staff not wearing masks and not appropriately covering their mouth and their nose, not changing gloves appropriately, single-use gowns that were being reused but not washed correctly, and then gowns with holes or tears, one gown a day and the individual would be walking through the entire facility in and out of COVID-19 positive and negative rooms, and then only issued a new gown if it gets soiled.

And then, there are issues also that staff have not been instructed on how to handle PPE when they go on lunch breaks or to the restrooms.

And we did have a couple of facilities where there wasn't adequate cleaning of resident care equipment between COVID-positive and COVID-negative residents. And that equipment included thermometers, pulse ox machines, blood pressure cuffs, a Hoyer liftand that.

And then, we have an instance also where the staff didn't know how to use the temporal thermometer according to the manufacturer's directions. And so, the calibration was a concern.

The environment, we have seen the lack of wiping down surfaces frequently. Trash, sometimes, was not removed and floors were dirty.

And then just basically, we have also seen that education is extremely important, that the staff at times were needing additional understanding of how COVID-19 would be spread. And we have had circumstances where they were really not aware that their own practice of not changing gloves or gowns appropriately could be spreading the disease to other residents.

So, these are some of the weaknesses that we saw but we're sharing those with you so that you would be able to find opportunities within your own facilities in order to increase the control of infection spread.

And then,finally, on a more macro level, it is an opportunity for management in the facilities to really reevaluate the risk assessments for your skilled nursing facility, to reevaluate your PAR levels, your staffing plans, your capacity, your capabilities.

And with all these opportunities that you might be able to consider, we really feel that paying attention to your staff and the way infection is handled and monitoring that creates a very good opportunity to really control and protect the residents that are in your care.

So, we really thank all of you for the good jobs that you are doing. It's not easy to do these important tasks. But we do hope that some of the items that I mentioned might be taken into consideration as you continue your good work in infection control.

So, I'd like to now turn it over to Dr. Nimalie Stone of the CDC. And I thank you for the time here today.

Nimalie Stone: Hi. Thank you, Lauren. Hi, everybody. This is Nimalie Stone and I'm very grateful to my colleagues at CMS for the opportunity to spend a few minutes with you and to hear your feedback and learn from you and all of them so that we, as a community of partners, can work together to make our residents and our staff in long-term care safe.

I want to just say a couple of things about what Lauren just shared because it's so important, some of the key actions that she raised. I'm going to point out three.

The first is her comment about N95 respiratory use and fit testing. Something that people don't always know about N95 respirators is there's a whole medical evaluation that goes into the fit testing and respiratory protection program. And that's because there aresome of our healthcare team members who may not be comfortable or safe using an N95, especially for prolonged periods of time.

So, I think that is a really critical piece of the safety of our personal protective equipment and one of the reasons why it's been raised often about having a fit testing program and a protection program.

The second thing, just building on the whole concept of respiratory, is to emphasize her comment about the importance of doing regular vital signs, symptom screening, and documenting those findings so that you can go back and build the picture of how a resident's clinical course has been, and in particular, being able to trend some of those vital signs to see patterns that might be early warning signals that a resident may need to be moved to a higher level of care or receive additional closer follow-up.

So, in addition to the typical vital signs we're used to doing, I also hope you're all adding pulse oximetry, which is a measure of the oxygen in people's blood. This has become a very importance piece of detection of the early respiratory distress that can come with COVID-19 infection.

And the third thing I want to say is to put a plug into her comment about having a backup person to support infection control in your building. And I'm going to go one step further because I can, as a public health advocate, say I would really consider making your infection preventionist a full-time role right now during your COVID response activities.

If you think about the incredible amount of work that somebody has to do, there's surveillance, there's screening of the staff and the residents, there's reviewing those screening to make sure that they detect early any new cases, reinforcing the infection prevention practices that Lauren pointed out through observation on the units, and doing coaching and just–in-time training for front line staff and environmental and housekeeping staff because a lot of this equipment is new, unfamiliar.

We know there's a lot of stress going on in the building, just a heightened vigilance. Everybody's on edge. And some of your centers are short staffed. So, there's really a hard shift in terms of people getting fatigued after working long hours or double shifts. So, having somebody who's dedicated to the safety in your building is a really important part of this response.

So, thank you, Lauren, for those points and the opportunity to sort of build a little bit on what you said.

The other thing I want to build on is some of the comments from AdministratorVerma about celebrating the successes of our provider community across the country. We are immensely grateful for the work that you're all doing and your front line staff and your residents and your families and everything you're doing to support them.

And I want to share with you that CDC is starting to compile a list of success stories, different tiny anecdotes that illustrate how centers have been able to implement some of the key COVID prevention strategies that we have been promoting throughout the response; things like keeping COVID out from entering the facility through staff screening and reinforcing things like social distancing among staff even when they are on breaks and/or hanging out after hours to just remind people that we want to be mindful of not sharing germs with our colleagues.

The identification of infectionsearly and the rapid implementation of those infection prevention precautions to stop the spread, as well as managing and optimizing our supplies and helping do the monitoring to prevent severe illness.

Those five key strategies are sort of the scaffolding, if you will, that we're going to use to build some of our success stories. And I'm just going to share one that illustrates an example of early detection and early action.

There is a center that shared with us that they learned to trust their gut and really advocate for testing when it's your initial exposure or your first case and there may be some skepticism about whether you should be considering COVID.

This center noticed that one of their residents had a constellation of symptoms that seemed very concerning and consistent with COVID infection even though they had not had any known cases. And so, they hadn't already kind of had a lot of COVID circulating in the community.

Because of their high suspicion, they placed that resident in precautions quickly and started advocating to get testing, which at the time that they experienced this, was not very accessible, back in early in mid-March. We know a lot of people; a lot of facilities couldn't get their hands on testing.

So, they had to go through their public health program and really push the request multiple times to convince the public health program that yes, it was legitimate COVID and we should test for it.

And in the interim, they minimize the number of caregivers that were interacting with that resident. They were using all the PPE that they had on hand. But again, as a lot of us realized early in the response, most of our facilities did not have all of the full PPE. For example, this center did not have eye protection, either goggles or face shields. So, they were using masks, gowns, and gloves. They were being as cautious as possible for the staff that were working with the resident but there was still risk.

And after they finally got COVID testing for that resident and confirmed that this was a diagnosis of COVID-19, they then identified the staff that were the most exposed, had them go on furlough or voluntary sick leave for the recommended 14 days following their exposure, their last time caring for that resident.

And they immediately reached out and contacted all of the residents' families and other team members, other staff in the building to make everybody aware, either by a phone call or through personal communication.

And bottom line, because of their early identification, they're trusting their gut on what this resident might have and really treating that case appropriately, they did not have any other residents or team members diagnosed with COVID or become infected.

So, a lot of good lessons buried in that story. And we are looking forward to hearing your stories as well as we build up our website and the platform for sharing. We will be letting you know how we can hear more from you and share your experiences and lessons. Thanks so much.

Jean Moody-Williams: Thank you so much, Dr. Stone. That is a perfect lead in to our last speaker of the day. Larry Slatky is the executive director of Shaker Place Rehabilitation and Nursing Center in Albany in New York. So, I'll just turn it right to you, Larry.

Larry Slatky: OK. Thank you very much and I am joined by our Director of Nursing, Rebecca Luce, and our Assistant Director of Nursing, William Redmond, who's a specialist in infection control. And thank you for having us. We're going to talk a little bit about best practices.

But first, I want to talk, which I think is very important and it goes to some of what the speakers have been saying about cohorting and the structure of ones nursing home, which I think is very important.

We're going through,and I'll quickly go over this, a renovation where we're adding on to our existing nursing home units and three are done and three are not done. So, three units are in our highrise with approximately 120 beds and three units are downstairs, 120 beds.

And wherever the downstairs units, which should have been renovated and it goes to social distancing, and I can't really emphasize how important that is, downstairs with 120 residents, we've had three residents test positive since January. Upstairs where we have the same 120 residents on the same three units, we've had over 50 residents test positive.

So, it shows that the social distancing, which we're capable of doing downstairs versus the traditional nursing home, is basically 140-bed corridor, is virtually impossible.

And then, we've also learned how difficult cohorting is because we do cohort, but you have residents with DIM scores of two who are wondering around and will not stay in their room or have the door shut and they open the door and they're walking around the units.

So, it becomes extremely difficult to take care of 40 residents or 35 residents on a 40-bed unit. And at the same time, OK, try to keep everyone in line with

infection control who's a resident living here where in a – restraint-free environment. So, it becomes very, very cumbersome for the staff to deal with.

So, we've developed some protocols to follow, but it was and still is difficult to cohort on our traditional nursing home unit.

And the last thing which I'll state before I turn it over to Rebecca is that we started everything way early on. Meaning, we didn't wait for any guidelines. We didn't wait for any releases from CMS or CDC because I believe and I think most nursing homes have all of these procedures for infections whether it be a flu in place already.

And we started early on with screening of all new employees coming in to our nursing home, taking temperatures, monitoring sick calls, looking at people's symptoms, and starting – even when we started to do testing, we started testing, yes. But if someone had the symptoms, we immediately started treatment. We didn't wait for the result with the assumption was that they're going to test positive.

So, we used what we had. And then, when we got the guidelines, that assisted us in furthering what we had in developing what needed to be in place to better supervise the COVID-19 virus and make sure our residents are properly protected.

So, I'm going to turn it over to Rebecca now and go over some more specifics.

Rebecca Luce: Hi. I'm Rebecca the Director of Nursing. I want to say that early on, the New York State Department of Health came in and they tested a team here and educated us on obtaining the test ourselves.

We initiated a respiratory assessment to include symptoms and monitoring of the resident's temperature every shift. If a resident had any symptoms or a temperature of 99 or above, we added pulse oximetry to them and we tested them.

We monitor our COVID residents' oxygen saturation every four hours and we start oxygen therapy early. And we also do IV in placeof therapy early.

At this point, we've tested all of the residents in our building and we're happy to say that we have 19 that are in the recovered phase of the COVID virus.

So, I think that – what was that for us is that we're able to test and we test very quickly. We get our results very quickly. We have access to the results. It usually takes less than 24 hours. And then, we start treating their symptoms.

Larry Slatky: What about staff?

Rebecca Luce: We're also testing our staff. We started screening before the guidance was given. We monitor their symptoms. We monitor their temperatures. If they have any symptoms, we have a medical director here and Bill Redmond, our infection preventionist.

And we send the staff home and then they come back and they're tested duringour testing. So, we saw them at the door. We don't let them come in. And we also test them and get access to their results very quickly.

Larry Slatky: And another thing which I think is important and I think this was also mentioned.We have,and I don't believe that every nursing home has the type of staff members that are part of our administrative and nursing team,which really truly helped us get ready and just jump into this.

Not only do we have a director of nursing, assistant director of nursing – the assistant director of nursing is an infection control specialist – even though we don't have a ventilator unit, we have a full-time respiratory therapist on our staff and we have a full-time M.D. – medical director – all of which work in concert with our three RNs, who are in the education department and quality assurance.

So, that team was able to immediately create the type of protocols that needed to be followed by our staff and then education, education, education, follow through, follow through constantly and even as we speak today, four, five months in, we still do this almost every single day. Thank you.

Jean Moody-Williams: Thank you. That is really truly amazing, all the things that you did and especially as you said, you didn't need guidance to know to do those things. So, we truly appreciate that.

Operator, I think we have time for maybe one call. And so, if you could get that queued up and one question. And while we are doing that, again, let me thank everybody. We extended this to an hour because we knew we had so much rich information and we have certainly, I think, used that hour well.

So, let's see, are there any – is there one question from the field?

Operator: Yes, we have one question from the line of Terry Harman. Your line is now open.

Terry Harman: Thank you. My question actually is relative to the blanket waivers and the state waivers and when they actually – some clarity around when they expire. I think that Secretary Azar, I know, did an extension of the emergency situation. But there's really no clarity and I've looked everywhere to see when they actually expire.

Jean Moody-Williams: So, that would have to be declared or as was mentioned, extended. We don't have information on that at this point, but we will, rest assured keep you posted on that.

Terry Harman: Yes, that would be great. And if we could get something in writing that would be even better.

Jean Moody-Williams: OK. Thank you for that question.

Terry Harman: Thank you so much.

Jean Moody-Williams:: OK. Well, Alina, let me turn it back to you to close us out.

Alina Czekai: Great. Thanks, Jean. Thanks everyone for joining our call today. We hope that you'll join us for our CMS COVID-19 Office Hours tomorrow, Thursday, May 14th at 5:00 p.m. Eastern for technical Q&A with our CMS subject matter experts.

Please continue to direct your questions to our e-mail box, which is covid-19@cms.hhs.gov . Again, we appreciate all that you are doing for nursing home residents and their families around the country as we address COVID-19 as a nation. This concludes today's call. Thank you.

Operator: This concludes today's conference call. Thank you for your participation. You may now disconnect.

End