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McKnight's
LONG-TERM CARE NEWS

Heroes in the Hot Zone: How Measures We Took Led to Direct Admit of COVID-19 Residents

The following is an account of how Brooke Grove Rehabilitation and Nursing Center in Sandy Spring, MD has taken measures to ensure the safety of its senior population throughout the first few months of the COVID-19 outbreak.

Written by: Rene Gomez & Kimberly Malin

7/10/2020

March 4, 2020, was the day our executive director sent out a notice to all residents, families and staff that the coronavirus was a reality and it would be impacting our scenic 220-acre continuing care community in Montgomery County, Maryland. This is the story of how our campus, which serves independent living residents, along with 108 assisted living residents and 190 skilled nursing and rehabilitation patients, dealt with COVID-19.

Following the letter and over the next several weeks, we implemented staff screening guidelines, disinfection measures, personal protective equipment distribution and recommended infection control Guidelines provided by the Maryland Department of Health and Centers for Disease Control and Prevention. All went well until one resident developed a fever on March 28, 2020. The patient was placed on isolation precautions pending COVID testing, conducted with the assistance of our local health department. The devastating results indicated positive for COVID-19.

Our director of nursing's, assistant director of nursing's and unit manager's leadership guided staff by example in how to manage this patient's care by providing direct care and even disinfecting the room surfaces including walls, floors and furnishings as part of their daily routine. We implemented daily monitoring of residents including temperatures and Pulse Oximeter readings. Anyone with fevers had tests to rule out COVID-19 and identify their illness. At this time, all staff were provided a gown and a KN95 or N95 respirator (dependent upon availability) to be covered with a cloth or surgical mask.

Three weeks later, our community had a challenging decision to make. Our assisted living group homes, located in seven different buildings on our campus had an outbreak with twelve residents requiring isiolation and advanced care needs. Should we direct admit positive COVID-19 patients? We knew our answer. We needed to help our fellow team members by providing the skilled care these residents needed.

Initially, we planned on having one COVID-19 positive wing in one of our rehabilitation units and one wing for Persons Under Investigation (PUI), where new admissions would be placed for 14 days of observation prior to being cleared for transfer to a "clean" unit. Meanwhile, I, Rene Gomez, nursing home administrator, approved a source for COVID-19 testing that could yield results much faster than the 4-5 days the county was taking to return test results. Once this was in place, we began testing residents and staff. We identified 31 residents and 11 staff who were asymptomatic positive for COVID-19. Once the additional patients were identified, we increased our capacity for COVID-19 patients to three wings.

On May 19, 2020, Maryland Governor Larry Hogan (R) announced the approach of requiring a Strike team from the National Guard to conduct a site visit in every Maryland nursing home. Our facility was ahead in implementing strategies to prevent the spread of the virus by testing all of our residents and majority of our staff. Our team began preparations for the strike team's visit by reviewing current COVID-19 best practices for infection control standards.

I, Administrator Gomez, identified the method of designating cold, warm and hot zones within our building. We instituted three hot zone areas: one wing in our rehabilitation unit, a second wing in our long-term care area, and a third wing in our long term care dementia unit. The cold zone (green signs) were wings that housed patients who had tested negative for COVID-19 and ancillary services.

A temporary wall with doorway was installed to designate the "warm zone," which was designated with a yellow sign. This area was utilized to prepare for entry into the hot zone and to store PPE supplies, trash and laundry receptacles for soiled PPE, a hard surface chair, if needed for sitting during application of shoe covers, and a table to hold surface disinfectant spray and hand sanitizer and for the exchange of supplies.

A short distance beyond, a second temporary wall was installed labeled with a red sign indicating the "hot zone," which was the area that housed our COVID-19 positive patients. Here, transmission-based precautions for COVID-19 were implemented including standard, contact and droplet precautions. Included in the posting was a sign indicating the PPE staff had to wear in order to enter this area (gown, N95 respirator, covered by a surgical mask, hair cover, shoe cover and face shield). These patients were isolated in their rooms except for necessary medical procedures until they met criteria for the discontinuation of transmission-based precautions. The hot zone area had to be adapted by designating a patient room to be a staff storage and restroom area, the dining room was converted to a nursing station and residents were to remain in their rooms with doors closed.

The staff that worked in the hot zone received a pay differential, free meals and snacks. Hot zone staff were informed to not re-enter the remaining units that day. A stairwell exit was used for staff to leave at the end of their shift. Whenever staff needed supplies to be picked up or delivered, the exchange took place in the warm zone. Meals were delivered on carts brought to the warm zone by culinary staff and when the meal was finished, the carts were sanitized in the warm zone and then taken back to the dietary department.

The zone system resulted in successfully preventing in-house acquired COVID-19 cases. Within three weeks, we were able to close one of our hot zone units, keeping our wing in the rehabilitation unit for new admissions with COVID-19 and our smaller wing on the dementia unit for any residents with elopement risk. Our team members have faithfully worked long hours to deliver loving care to our patients and to ensure the safety of our heroic staff. We have successfully touched many lives and are proud of the many long-term care heroes who serve our residents in or out of the Hot Zone on a daily basis.

McKnight's LONG-TERM CARE NEWS

Facilities Lack Sufficient Tests to Meet COVID-19 Recommendations, Senate Report Finds

Addressing the lack of testing materials is something that Congress wants to make a priority. Many states have fallen behind the recommended guidelines due to lack of funding and resources to test at a proper rate.

Written by: Danielle Brown

7/13/2020

Long-term care facilities don't have enough access to testing in order to meet the federal government's weekly COVID-19 testing recommendations, according to a new report released by Democrats with the Senate Committee on Health, Education, Labor & Pensions.

The Trump administration issued the recommendation for universal testing at long-term care facilities in May. It calls on nursing homes to test all residents, once a suspected case is realized, on a continued weekly basis until all residents are negative. All staff members should be tested weekly, the administration added.

States and lab companies, however, have found that there are significant limits on the number of tests available in order to reach and sustain this level of testing. They are skeptical that leaders and providers can meet the federal testing standards, the report noted.

"Many states are not able to meet the recommended testing levels in congregate care settings and are working to detect outbreaks with less frequent testing," report authors explained. "Only one state reported being in a 'pretty good' place with testing all staff and residents at congregate settings, although some other states were hopeful about the monitoring systems they have in place."

The report recommends that the federal government establish testing guidance for facilities that accurately reflect continued testing shortages. Officials also should develop strategies that reflect current testing capacity to prevent disease outbreaks, authors said.

"Such strategies should incorporate recommendations for testing frequency for both residents and staff. While the supply of tests remains limited, state and federal entities should prioritize tests for facilities that are experiencing active outbreaks," the report urged.

SavaSeniorCare Sees COVID-19 as Wake-Up Call: Nursing Homes Must 'Rethink Our Business Model'

SavaSeniorCare is taking a different approach to the current COVID crisis. Looking ahead to the future, their leaders believe that they have to be prepared for anything, including a complete overhaul of their previous interactions with their patients. In order to prepare for future outbreaks and other infectious diseases, the entire industry may have to change course.

Written by: Maggie Flynn

7/9/2020

The COVID-19 pandemic has led to severe occupancy hits for skilled nursing facilities, with two major operators seeing significant declines over the course of the past few months. And no aspect of the business — from short-term rehabilitation after elective surgeries to long-term care to capital expenditure — has been left untouched.

Aid from the federal government, in the form of funding from the CARES Act and other sources has, helped SNFs survive the immediate short-term crisis, Ray Thivierge, executive vice president and chief strategy officer at SavaSeniorCare, said on a Thursday webinar hosted by the National Investment Center for Seniors Housing and Care (NIC).

But the long-term implications of the pandemic will forever alter how SNFs function, not least because that federal and state aid will not necessarily last forever.

"If you strip away COVID, the good and the bad — the expenses and the added financial incentives — you've still got a situation where we're dealing with an impact to our long-term care days through this fire. That's going to take us a long time to come back from," Thivierge said on the webinar. "The sector was already trending down on long-term care, and the fact of the matter is this virus has done two things: It has eroded our long-term care base. But it has made people much more fearful of the environment."

That fear comes as COVID-19 hits occupancy at seemingly every level, in addition to the effect on long-term care days. SavaSeniorCare has seen a 10% decrease in total occupancy, for 14,100 in total occupancy now. Of those, 20% consist of "premium mix," or non-Medicaid residents — roughly what it was prior to the pandemic, Thivierge noted.

The financial incentives are providing the cash flow for operators to survive the hits, he said. But they're also having an effect on the longer-term outlook for the SNF sector.

"Longer range, those incentives are providing us an opportunity to get through the day and get through this period," Thivierge said. "But they're also forcing us to rethink our business model and rethink what it looks like. How are we going to operate these centers at a lower occupancy and still sustain the level of service we need to provide to our residents?"

The occupancy decline was similar at industry giant Genesis HealthCare (NYSE: GEN).

B.J. Hauswald, senior vice president of strategic development at Genesis, said occupancy varies greatly depending on the market, but the two main factors were admission holds due to COVID-19 and "the fact that hospitals were essentially cleared out," she explained. Referrals are still roughly 80% of what they used to be pre-COVID, Hauswald said, while admissions are about "50% to 60% of what they were."

Genesis has about 400 SNFs, assisted living facilities, and rehabilitation centers in 25 states, and Hauswald cited that footprint as a challenge when dealing with various strategies for dealing with COVID-19.

The Atlanta-based Sava is not as large, though it's not clear how many facilities it has; a June 2016 report from Provider magazine estimated it at 200.

Genesis has received about $190 million in federal funds, Hauswald said, including about $8 million from the sequestration suspension for this year and about $30 million from state increases of the Federal Medical Assistance Percentage (FMAP). The Kennett Square, Pa.-based Genesis also accessed the Medicare Accelerated and Advanced Payment Program to add about $160 million, though those funds are temporary; repayment is scheduled to begin in August, Hauswald noted.

"We're hopeful and we're having conversations about the potential deferment of that until next year, like it was for hospitals," she said.

Expenses have increased, whether there's COVID-19 in a facility or not, with most of the expenses stemming from staffing, Hauswald said. This includes increased agency staffing and higher pay for staffers — but also relates to inefficiencies stemming from the smaller units.

"A facility used to operate one facility; now you have essentially three facilities in one," she said. "You might have your COVID-positive facility, dedicated staffing; COVID-negative, dedicated staffing … and PPE [personal protective equipment]. So there are incremental expenses and inherent inefficiencies in the way we're operating today."

Those expenses are not likely to go away any time soon. Testing access and costs, as well as securing supplies of PPE amid price increases, remain top concerns for operators as COVID-19 shows no signs of slowing. But the pandemic is forcing skilled nursing operators to rethink everything from building layout to ventilation systems, to say nothing of how everyone from the general public to physicians view the nursing home setting, Thivierge explained.

And as scientists note the possibility of the coronavirus surviving for longer periods in the air, that means recalculating everything from PPE to implementing filters and redesigning and reengineering buildings, to create a safe environment for residents and workers, he added.

None of that will come free, but the COVID-19 situation makes the value of these investments more apparent, Thivierge argued.

"We are a modern health care industry, and yet the only way for us to provide safe visits for our families right now, because of the state of our environments, is to have folks wave at their loved one through the window," he said. "That's a wake-up call. It's got to be a wake-up call. If the pandemic does that for us as a broad sector and provides a realignment of some resources to help us get that done, we'll all be better off for it."

Former CMS Consultant: Nursing Homes 'Need to Know Exactly What We Expect of Them'

There is a lot of uncertainty around the COVID virus and the tactics that we are taking to prevent the spread of the disease, especially in the healthcare field. Karen Hoffman speaks about her experience working on the front lines for CMS with a focus on infection control measures.

Written by: Alex Spanko

7/8/2020

Until researchers come up with a COVID-19 vaccine, infection control will form a key pillar of nursing homes' efforts to contain the virus's spread — and nursing homes have historically struggled in that domain.

It's a challenge that will only increase as case counts spike in certain regions, and facilities reopen their doors to visitors. But the Centers for Medicare & Medicaid Services (CMS) has made clear that infection control will be the top priority of surveyors during this time period, rolling out increased fines for facilities with a history of citations and beefing up enforcement for lower-level issues.

For the most recent episode of SNN's "Rethink" podcast, we decided to call in an expert to help provide top-level guidance to operators looking to navigate the "new normal" of fighting an invisible, untreatable virus at every turn. As a CMS contractor specializing in infection control for a decade, Karen Hoffman was on the front lines of improving safety in nursing homes at the federal level. She also serves as a clinical instructor of infection control the University of North Carolina in Chapel Hill, and was the 2019 president of the Association for Professionals in Infection Control and Epidemiology (APIC).

Hoffman spoke about the need for clear, easy-to-understand federal benchmarks for nursing homes to meet around infection control — while also acknowledging the endemic challenges of keeping a virus from spreading among vulnerable elders in close quarters.

Excerpts from the discussion are presented below, but be sure to check out the full episode on SoundCloud, iTunes/Apple Podcasts, or Google Play — and subscribe if you like what you hear.

Why is it so hard to prevent infections in nursing homes? And what are the biggest problems that kind of led us to where we are today?

We have, in nursing homes, the most fragile patients — patients that would have been in hospitalized care a decade or two ago. My background before infection prevention was actually in the ICU, and it's really amazing how critically or seriously ill a lot of these residents in nursing homes are. They have central lines, they have ventilators; they just have a lot of things that require a really intensive amount of work, and just put them at serious risk of infection.

Then the other thing that happens is, as these people come through the health care system over and over again — they go to hospitals, they go back to nursing homes — they often pick up multi-drug-resistant organisms. Before COVID, the problem that we were really looking at was the multi-drug-resistant organism problem. Recent studies have shown that as many as half of all nursing home residents have a multi-drug-resistant organism on their skin or in their mucous membranes, like their noses. When they get to a vulnerable stage, they might catch a cold or they might get a wound — that turns into a major infection.

It's just very difficult for the staff, in terms of their staffing levels, to really be able to keep up with all the basic infection control practices that we know are most important. That is the time to take hand hygiene between residents, the time to wear appropriate PPE.

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As someone who's worked with CMS, what's the best strategy for improving this? Resident advocates say it's just a matter of increasing fines, but we also know that funding — particularly for facilities that specialize long-term care — is extremely tight.

We've been trying to figure that out. We actually did a pilot study with CMS, initiating work with the quality improvement organization to look at how we could maybe make a change for improvement. With the nursing homes, we actually created an infection control worksheet, and that worksheet had about 40 pages of the key things that could prevent residents from getting an infection.

We piloted that in 40 nursing homes, along with 40 hospitals, to see if they could, with assistance, actually implement and improve the care measures — and in less than a year's time, with just minimal interaction of some phone calls and assistance from the quality improvement organizations, which are funded by CMS, they were able to make significant improvements.

Sometimes we see that our APIC chapters, working in their own state, will try to have that assistance provided. There's programs through the QIOs.

It takes additional outside expertise — and then working with someone in the facility, we find, is critical. [Someone] who is designated to do infection prevention that can answer these questions ongoing, and keep the focus on infection prevention and control because, like everything in health care, there's just so many people pulling in so many directions, that sometimes infection control gets lost in that.

The media has certainly reported on the persistent infection-control challenges in nursing homes, but obviously COVID raises the stakes — with something like the flu, it can be dangerous, but you have weapons to fight it when it does break out. With COVID, testing and control are all you have.

No one is immune to COVID in the world's population, so that's the biggest issue — and it is a respiratory-spread organism. That makes it easy to move around from person to person, particularly in any congregate setting like a nursing home, or even schools and prisons and industry like the meat processing plants — anywhere we get people so close together, they can share those respiratory droplets.

We're having problems, which really brings us back to basic infection control practices [that] we know work being instituted in each of these settings.

What are some of the top things that operators should be focusing on now that economies are reopening, and even the essential workers who may be entering and exiting buildings may not have the same kind of group protection they had during the lockdowns?

This is really where having an IP in the long-term care facility, that's dedicated, is essential. It's actually recommended by the CDC at this time, with the COVID outbreak, to have a designated infection preventionist if you don't already have one in your facility, because they can really bring that high-level overview of what needs to be done.

For example, do you have an alcohol-based hand rub outside of each door and inside of each room available? That's a basic work practice that we can institute that can help compliance with hand hygiene, which we know is one of the major things that prevents not only COVID but also every other kind of infection control issue we have — multi-drug-resistant organisms and food-borne pathogens and noroviruses. We're coming into that season as well.

A simple thing like that — that is something that we've been encouraging nursing homes to implement for a long time, and it's just been difficult for them to do.

Simple work practices, something than an on-site person can evaluate — the use of PPE being put on and taken off correctly is also problematic if you don't have somebody there that can train and monitor for competency and compliance, doing audit for use and giving feedback when they see things go wrong.

That's why that's so important. Then you've got somebody who could actually work with the communicable disease or emergency preparedness or the resources that you have in your state to stay up-to-date because this is a very evolving outbreak we're dealing with right now. Recommendations are changing. We've been seeing minor changes almost day to day, or week to week, that help us do a better job, and so you really need somebody to be totally focused on that aspect.

Do you think that's going to inform policy going forward? There's been some attention on the fact that CMS moved to ease some of the new IP rules under the last round of the Requirements of Participation (RoP) updates.

I can't really say how that decision is going to end up. But what's happened up until now is that they did publish, in 2016, new regulations that required all skilled nursing facilities to have a trained IP in place by November 2019, and it could have been a full-time or a part-time position.

The change that occurred was that they changed the language a little bit to make it more nebulous — to say that they [must] have an IP for a sufficient amount of time, which I think would be difficult for surveyors and facilities to know exactly what that means.

What is the sufficient amount of time as opposed to requiring them to work part time? How much time do they really need to spend in their nursing homes to accomplish the best infection control practices that they should be doing?

What are some of the challenges around surveying for infection control, and how do you think the survey process should change as we go forward?

I think this outbreak has shown that we really need to make more proactive emphasis on infection control. We need to spend more time assessing it. The surveyors are challenged with having many, many things to look at when they come into a facility — of which infection control is just one of them.

I will say that it is the most frequently cited, or the second most frequently of all the different regulations that they look at, but it's cited at a pretty low level. It gets the attention of administrators and nursing home operators when you tend to get the higher-level citations that can actually result in fines of substantial amounts.

I'm not saying they should be fining at substantial amounts across the board as they come in. But we need to figure out a better way of motivating nursing homes to implement things like putting up hand hygiene dispensers.

There actually needs to be more work together between the owners, operators, the associations representing them, and the recommendations from CMS and from CDC, so that we're all on the same page — particularly around simple things like alcohol-based hand rub dispensers, where they can and can't go.

Cleaning and disinfecting agents has also been a problem. We know that when you live in a house with family members, how easy it is to share colds. Well, it's kind of the same thing in nursing homes, because they'll share the same recreation, the same communal dining room. They go up and down the hallways, and use the handrail.

So the cleaning strategy with shared equipment that goes from room to room, they really need to make more emphasis on that, and get better agreement on what is and isn't acceptable. Then across the country [it's important] that we get accepted agreement on practices, because there are — from state to state agencies — differences in how they interpret the regulations and the interpretive guidance, which has also been difficult for facilities to know what to do.

With COVID-19, I think we're seeing how a quote-unquote "low-level" citation can escalate quickly, just because of what we discussed before — the lack of any effective treatment once an outbreak occurs.

The mortality is very high, and that tends to get the attention of surveyors; they key in on anything that causes serious harm. That's what they're supposed to do. So COVID definitely causes serious harm and has a high mortality, morbidity, and they tend to focus their attention when they see those kinds of things reported.

You talked about the challenges around design, how shared rooms and spaces really accelerate the spread of diseases like COVID-19 — but we haven't seen a ton of new investment in physical plants over the last few decades, really. What are some of the top things that you would want to see in terms of design based on lessons from this pandemic?

Well, that is a very big question. I can tell you the single most important thing I would do if I could design a nursing home — besides, obviously, making them single rooms — is the bathroom situation. Shared showers, shared bathroom facilities — a lot of the older facilities, there may be only one showering room, so everybody has to be brought to that one shower or bathing room.

You can imagine the risk of something warm and moist, continually, where people are being bathed — the risk of cross-transmission, and the importance of cleaning and disinfection in the shared, semi-private, or quad rooms where they have to share a bathroom in between. Now we've got four residents who have to share one bathroom, and so if one person is ill with something that's communicable — particularly if it's communicable through stool — the level of contamination and cleaning in between would be difficult to maintain.

That's what I would primarily focus on if I could control the world.

This interview has been condensed and edited for clarity.