

Question	Answer
SARS-CoV-2 Testing	
<p>Do all staff and residents need to be tested for COVID-19 before allowing any family to visit? What if testing everyone ends up taking weeks or months to accomplish because all Idaho long-term care staff and residents are trying to be tested at once? What does "if feasible" mean?</p>	<p>According to the Stage 4: Protocols for Long-Term Care Facilities (https://rebound.idaho.gov/wp-content/uploads/stage4-protocols-long-term-care-facilities.pdf), "if feasible," baseline SARS-CoV-2 (the virus that causes COVID-19) PCR (Polymerase Chain Reaction) testing of all Healthcare Personnel (HCP), regardless of any symptoms, is recommended for facilities located in counties where community spread has been identified, prior to allowing visitors. (Facilities can contact their local public health district to determine in which counties community spread has been identified.) Baseline testing of all residents in any facility and of all HCP in facilities located in counties without community spread can be considered at each facility's discretion. These are the recommendations; each facility will need to make testing decisions based on the situation in their surrounding community and the testing available. "If feasible" means if you can get access to testing, do it. If you can't, follow re-opening precautions strictly.</p>
<p>If we have not had a positive COVID-19 case and if we do not have anyone that has symptoms, are we currently REQUIRED to test all our team members?</p>	<p>You can be asymptomatic and shedding virus. If testing is accessible, we recommend the baseline testing, particularly if you are in a county with community spread. Then test at some regular interval as part of your infection control and prevention surveillance. We do recommend regular testing if you can, as you can catch those asymptomatic cases.</p>
<p>Related to the Testing Strategy for Long-Term Care Facilities in Idaho (dated June 3, 2020), when are RALFs expected to have the recommendations in Priority Group 1 in practice? Priority Group 2?</p>	<p>Each facility is asked to develop a policy for these testing strategies (https://coronavirus.idaho.gov/wp-content/uploads/2020/06/LTCF-Testing-Strategy-FINAL-2020_6_3.pdf) and implement the policy as soon as possible. The sooner the testing strategies can be implemented in your facility, the more information you will have to manage the operations of the building (i.e. admissions, staffing, etc.) A list of participating laboratories is on our website (https://healthandwelfare.idaho.gov/Portals/0/Medical/RALFCOVIDList%20of%20Labs.pdf). Priority Group 1 is to test ALL staff and residents once a positive COVID-19 test has been identified in your facility; all new admissions should be tested as well. Priority Group 2 recommends testing of individuals who leave the facility for non-medically necessary reasons, as well as routine testing of staff at some regular interval. Please refer to the Testing Strategy for further details.</p>

<p>We were told that if there is a positive case in the facility, they need to "rapidly implement" a response. What is considered "rapid"? Friday evenings we get a limited response from all providers, suggestions?</p>	<p>"Rapid" means implement a response as soon as possible. Sometimes having some of those protocols in advance of what your response will be is helpful. Have each resident's provider sign an order that if there is a positive case in the facility, the resident can be tested so you have that in advance. Take precautions as soon as possible to protect residents and staff.</p>
<p>What should we do if staff and/or residents refuse to be tested? If staff refuse the test, do we need to terminate them? If not, what options do we have to keep everyone safe while allowing staff to continue to work? If residents refuse the test, should we discharge them? If not, what interventions would you recommend to keep everyone safe?</p>	<p>If there is a current outbreak at the facility, any resident who refuses to be tested should be placed on transmission-based precautions. The guidance contains recommendations, not new rules. All citizens have the right to refuse testing. What the consequences of those refusals will be should be specified in the facility's written policy for testing strategies. For staff, per the CDC (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-faq.html?CDC_AA_refVal=https%3A%2F%2Fwww.cdc.gov%2Fcoronavirus%2F2019-ncov%2Finfection-control%2Finfection-prevention-control-faq.html), "If HCP with symptoms consistent with COVID-19 decline testing, they should be presumed to have COVID-19 and excluded from work. Return to work decisions should be based on COVID-19 return to work guidance at the discretion of the facility's occupational health program. If asymptomatic HCP decline testing, work restrictions, if any, should be determined by the facility's occupational health and local jurisdiction policies. All staff should be trained in proper use of personal protective equipment, including universal facemask policies, hand hygiene, and other measures needed to stop transmission of SARS-CoV-2." We recommend checking with the Idaho Department of Labor to find out what repercussions for testing refusals would be acceptable. It is up to the facility to decide if employee dismissal for refusals should be part of the policy. Concerning resident refusals, IDAPA 16.03.22.550.12.d, which has not been waived during the pandemic, states that each resident has "The right to refuse medical services based on informed decision making. Refusal of treatment does not relieve the facility of its obligations under this chapter. i. The facility must document the resident and his legal guardian have been informed of the consequences of the refusal; and ii. The facility must document that the resident's physician or authorized provider has been notified of the resident's refusal." Therefore, each facility must decide on their own policy for handling resident testing refusals. Keep in mind that the policy should consider the welfare of ALL the residents in the facility. Examples of things to consider for the policy are listed on page 4 of the Stage 4: Protocols for Long-Term Care Facilities. A resident who refuses testing must be made aware of the</p>

	consequences for testing refusal, based on your facility's policy, before they make their final decision on testing.
Are we going to have to gain written POA or guardian consent to do continued COVID-19 testing with residents? I had some family pushback after a round of testing when a staff became positive and the Health Department did blanket testing.	No. There is not a requirement for written consent, but residents do have the right to refuse. Consult with families when developing the facility protocols for re-opening. Use this as an opportunity to educate regarding the risks and the reasons for testing. Share those plans with families. Include what happens if they choose not to be tested.
Once the baseline is established, how often do we test thereafter?	If there are no positive cases, follow Priority 2 guidance for testing at some regular interval (i.e. every 7 days, every 14 days). If testing is limited, prioritize based on community spread.
Testing staff every 14 days could deter a lot of people from wanting to work in our facility and the cost of that over time could be very high in larger communities. We noticed in the document it says staff testing can be focused to staff who live or work in areas of community spread. Does this mean in areas without community spread that we can choose not to test? What is considered community spread?	<p>Community spread is when there is a case in a county that cannot be tracked back to a particular, known exposure (i.e. the source of the illness is unknown). Contact your local public health district to determine if your facility is in an area with community spread. It is recommended that all staff and residents be tested once a positive case has been identified in the facility, regardless of the surrounding community status. Facilities can choose to test staff even if they are not in an area of community spread.</p> <p>There are many labs available to process testing including the Idaho Bureau of Laboratories (IBL) (visit their website at https://healthandwelfare.idaho.gov/Health/Labs/tabid/99/Default.aspx), and most insurance plans are largely covering the cost of the tests.</p> <p>Each facility is expected to make a contingency plan for increased absenteeism, especially once testing of staff begins on a regular basis in the facility. Planning for absenteeism could include extending hours, cross-training current employees, or hiring temporary employees (preferably not those who work at other facilities simultaneously). Plan ahead in case an outbreak occurs in your facility.</p>
Who pays for this testing?	If the specimen is sent to IBL, they do not charge to run the test. There may be costs with shipping, but the actual test does not have a cost. Other labs may have a cost,

	<p>this may be able to go through insurance; many insurances are covering testing costs.</p>
<p>Should all new employees be tested?</p>	<p>This would be good practice. Be sure to check with whoever advises you on occupational health when developing policies for testing of staff.</p>
<p>Can we discontinue quarantine/isolation of a new admission if we test upon entrance and then approximately 24-48 hours later?</p>	<p>No. The incubation period of the virus is 2-14 days. Having a second negative test 24 hours later doesn't tell if the person is still in the incubation period and not shedding the virus. Use transmission-based precautions (full PPE) for new admissions for 14 days.</p>
<p>Does the state lab have the capabilities to handle routine testing of residents and staff?</p>	<p>Regular testing is currently only recommended for staff. IBL currently accepts specimens for anyone symptomatic, new resident admissions, and if there is one confirmed case already in the facility. Check with the lab or district health for updates and changes to this. Each facility should have an agreement with an alternate lab. A list of labs is available on the RALF website: https://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RALFCOVIDLabs.pdf</p>
<p>Are facilities expected to have a "written agreement" with a lab and the health department for testing protocols?</p>	<p>Each facility must identify a lab to work with in addition to IBL. Ensure the lab can conduct PCR testing, has an acceptable turn-around time, and has the capacity to conduct the tests you will need. Some labs may require a written agreement – keep documentation of your communication/agreement on file to demonstrate you have an agreement with a lab.</p>
<p>Who can administer the test? Are some RALFs doing the testing themselves?</p>	<p>Tests should only be administered by persons who have been fully trained and approved to do so. Failing to administer tests correctly can result in invalid test results. Check with your lab or public health district for training and/or requirements. Some RALFs do have staff who have been trained to administer the tests. Work with your health district and lab to identify who will conduct testing for your facility.</p>
<p>Where is everyone getting their testing supplies? I'm thinking it would be good to have testing supplies</p>	<p>If you have someone in house who could administer the tests, talk with your public health district about getting supplies. They get regular shipments of testing supplies from the state lab.</p>

<p>available so if and when an outbreak occurs, we can be prepared. Any advice?</p>	
<p>Is a doctor's order required to test someone?</p>	<p>It is likely required for a private lab, but an order is not needed for IBL. Work with your facility MD or each resident's provider to obtain a standing order for tests to be done should the resident become symptomatic, or if the facility identifies other positive cases. You may be able to get standing orders for all staff as well – work with your physicians. You may also ask your public health department about any options they are aware of.</p>
<p>COVID-19 Symptoms and Positive Cases</p>	
<p>What does "subjective fever" mean?</p>	<p>"Subjective fever" is when a person "feels or has felt feverish," which may include sensations of chills and/or sweats, even though a thermometer reading indicates their temperature is normal.</p>
<p>We have residents whose baseline is low oxygen saturation – is it acceptable to use a "decrease from baseline" as the criteria instead?</p>	<p>Yes, but your written policy should include this information for caregivers to follow (including how often to check oxygen saturation, what the baseline is for each resident with respiratory disease, etc.) Consult the resident's primary care physician for individual guidance for each resident.</p>
<p>Should we discharge residents who test positive?</p>	<p>It is up to each facility to decide if they are currently able to care for a resident who is suspected of having, or tests positive for, COVID-19. If a facility cannot care for such residents, according to the Stage 4: Protocols for Long-Term Care Facilities, facilities should inform residents and their families of the facility policy regarding the need to relocate a resident with suspected or COVID-19+ status to alternative facilities. Still need to provide a written discharge notice.</p> <p>IDAPA 16.03.22.152.05.a. documents, "A resident will be admitted or retained only when the facility has the capability, capacity, and services to provide appropriate care, or the resident does not require a type of service for which the facility is not licensed to provide or which the facility does not provide or arrange for, or if the facility does not have the personnel, appropriate in numbers and with appropriate knowledge and skills to provide such services."</p>

<p>What recommendations do you have for facilities in developing their policy for a positive case of COVID-19 in their facility?</p>	<p>For a symptomatic resident or a resident with suspected or confirmed COVID-19+ status, you could include the following items in your policy (again, your facility should be deciding in advance if it is adequately prepared to care for a resident in this situation). Refer to CDC guidance: https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html</p> <ul style="list-style-type: none"> • Immediately isolate the resident in their room with the door closed • Notify the local public health district • Notify the resident’s primary care physician • Notify residents, families and staff members of COVID-19 cases occurring in the facility • Serve all meals in the resident’s room • Utilize full PPE for all staff during cares and practice proper donning/doffing • Monitor resident closely, at least 3 times daily per CDC. Observations should include, but not be limited to, a symptom check with vital signs taken to watch for worsening symptoms which may require a higher level of care. • Follow directions from the local public health district for testing and to determine when it is safe to discontinue isolation
<p>When there is a positive case, does the 28 days noted in the minimum criteria begin after the date of the last positive test result or from the date when residents and/or staff last began to complain of symptoms?</p>	<p>28 days without a case is the definition of a “resolved outbreak.” The 28 days would begin after the last symptom onset at the facility. If a confirmed case was asymptomatic or pre-symptomatic, the date used is the date their test was collected. Facilities can work with their local public health district to determine when the outbreak is resolved.</p>
<p>Personal Protective Equipment (PPE)</p>	
<p>The Stage 4: Protocols say adequate PPE is “sufficient supplies for HCP to wear full PPE for the care of all residents for at least three days.” What is full PPE? Does this mean a facemask, eye protection, gown and gloves? Would the 3 days be enough</p>	<p>Yes; a facemask, eye protection, gown and gloves are full PPE. The facility should have enough of those items to take care of each resident in your facility for 3 days. Count a new set for each interaction. This is the minimum. More is better. N95 masks offer the most protection, but a facemask can be substituted if N95 masks are unavailable. Cloth face coverings are not considered PPE and should not be worn when a situation calls for full PPE. The purpose of this recommendation is for facilities to be prepared at all times for a possible outbreak of COVID-19. Each facility should be completing two PPE surveys (IRTS and Survey123 - links to these can be found on our website). IRTS should be completed daily. Survey123 should be completed daily</p>

<p>for every staff to wear at all times and change between residents?</p>	<p>unless the facility has plenty of supply and is not currently utilizing any PPE. Even when an outbreak has occurred, some facilities have been denied PPE, as they were not current on completing the 1-2-3 surveys. This is a crucial step. Please review the CDC's website for recommendations to optimize the supply of PPE during times of shortage at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html. Adequate supplies of hand sanitizer (alcohol-based hand sanitizer with 60–95% alcohol), hand soap and paper towels should also be available at each facility. Also, it continues to be recommended that ALL personnel should wear a facemask while they are in the facility.</p>
<p>When is full PPE required to be used?</p>	<p>Full PPE should be worn by all staff for interactions with all residents when there is a suspected case in the facility.</p>
<p>Do we need to have documented evidence of the training of all staff in PPE use?</p>	<p>Yes. According to IDAPA 16.03.22.625.03.1, all staff must be trained in infection control. The Stage 4 guidance states there should be a written plan for several protocols; including, but not limited to, infection prevention and control, which includes training of staff on PPE donning and doffing procedures. Please refer to the Stage 4 guidance for further details on all policies that require a written plan.</p>

Visitors

<p>Can we wait to re-allow visitors until (2) incubation cycles (or 28 days) beyond the start of Stage? Can we remain closed to visitors if we feel nervous about letting them back in even if the facility meets the minimum criteria?</p>	<p>The facility can choose to test all HCP and all residents if they are in an area with community spread before opening to visitors. The facility can also determine how they will allow visits to take place. Consider limited, outdoor-only visits as a starting place. Currently, the rule requiring residents to be allowed to have visitors is waived. Technically, you do not have to open to visitors. However, there may be detrimental effects of residents not having interactions with their families and visitors. It is something that should be worked towards but is not required as soon as the minimum criteria is met.</p>
<p>Can we require visitors to be tested?</p>	<p>Facilities can do this, although it may be difficult to implement. A test tells you if someone is shedding virus at the time of the test. If someone has a negative test Friday (for example) it would not tell you anything about them visiting on Sunday. Urging precautions (hand hygiene, social distancing, face coverings) and asking about symptoms can be more beneficial and realistic for facilities.</p>
<p>If a facility has positive COVID cases, would we need to stop visits?</p>	<p>Yes. If you have a positive case, go back to previous restrictions (no visitors, minimize communal activities, etc.) until the outbreak is resolved. Notification of families and employees is important. Restrictions can be relaxed when the minimum criteria is again met.</p>

<p>Can you deny visitors if they refuse to comply with your protocols or policy?</p>	<p>Yes. If because of a health reason, try to work with them – disposable surgical masks are much easier to breathe through than some cloth face coverings. Page 2 of the Stage 4: Protocols for Long-Term Care Facilities states, “Deny entry to the facility for any visitors unable or unwilling to comply with visitor screening, hygiene, and source control measures...” Alternative methods for visitation, such as electronic visits, should be offered.</p>
<p>What category are outside service employees such as home health, hospice and CBRS workers (i.e. HCP, visitors or vendors)? When should they be allowed back into facilities?</p>	<p>Outside service employees are considered HCP. The administrator should determine which outside service HCP are essential, and ensure they meet the same requirements for written protocols and testing as facility staff to ensure the health and safety of everyone before entering the building(s). As much as possible, visits from outside service agencies should still be carried out via Telehealth. However, if Telehealth is not a feasible option for the resident’s situation, the facility should have protocols in place, providing the residents with safe access to those providers. These could include protocols used for all visitors, as listed in Stage 4: Protocols for Long-Term Care Facilities, such as limiting the number of outside providers allowed in the facility at any given time, scheduling ahead, etc.</p>
<p>When can the hair stylist come back to the facility?</p>	<p>It is up to each administrator to determine which services are essential. Consider whether the hair stylist works at other salons or just the facility. Train any outside vendor/personnel determined to be essential in precautions, monitor to make certain they are using safe practices and ensure they have appropriate PPE.</p>
<p>Would facility tours be appropriate?</p>	<p>No. These are neither visitors of residents nor essential services. Facilities should conduct tours using social media – consider recording a tour for prospective residents or conducting live tours using a tablet or smartphone so they can stay outside yet see everything through a device.</p>
<p>Residents Leaving the Facility</p>	
<p>Should a resident returning from a medically-necessary appointment be isolated?</p>	<p>Up to this point, there has not been a recommendation to isolate individuals when they return from the community for medically-necessary appointments; unless they are returning from the hospital, where a greater risk of exposure can occur. Residents who must regularly leave the facility for medical appointments (e.g. hemodialysis patients) should wear facemasks, if available, or at a minimum, a cloth face covering. These residents should also be prioritized for testing.</p>

<p>What about residents who go into the community regularly? Should they be quarantined continuously? Should residents who go into the community regularly be regularly tested? What interval would you suggest? Regarding testing residents that choose to leave the facility for non-medical reasons, does this mean if they left for any time period? For example, if a resident wants to go to one store and buy an item or two, do we test them for COVID upon return?</p>	<p>The recommendation continues for residents of Residential Assisted Living Facilities to avoid going out into the community as much as possible, to limit their exposure to the virus. Those residents who choose to go into the community regularly, must be educated as to the facility's policy that will be followed when they return. Each facility must decide how to construct their own policy, based on their facility's situation, the spread of COVID-19 in the surrounding community, etc. The policy should be clear and should be provided to all residents and their families/guardians for review and consideration before they make a decision about whether or not to leave the facility. It is recommended that individuals be tested after they return to the facility following an outing into the community (if this is an infrequent occurrence). For those residents who choose to go out into the community on a regular basis for non-medically necessary outings, the recommendation is that the facility test the resident on a regular basis, for example, every 7-14 days. The Stage 4: Protocols has measures you can consider, such as providing a separate room, providing a face mask, enhanced sanitation, etc. See that document for what is reasonable for your facility. Say someone goes to the bank wearing a face mask, goes with someone wearing a face mask, lower-risk. Going to a family reunion, higher-risk. Make decisions on a case-by-case basis, assess exposure and minimize risk.</p>
<p>What do we do for residents who are intellectually disabled and are pushing to return to their DDA? What if the DDA is not following proper protocols? One DDA has a confirmed case of COVID-19.</p>	<p>Residents in RALFs are still recommended to not go into the community. In determining if residents should return to DDA, consider how much risk of exposure they will have there. Is the DDA following safe protocols? How many other residents attend the DDA? Is everyone at the DDA wearing face coverings, maintaining physical distancing, using proper handwashing? If your DDA is not providing a safe situation, it is ok to not allow participation. If residents do return to DDA, consider testing on a regular interval.</p>
<p>We have a resident that really wants to go to church every Sunday. What do we do?</p>	<p>Are church teleservices possible? What about outdoor church service from the car? Find ways to minimize risk. Encourage face covering and social distancing. Consider testing this person on a regular interval if they are leaving weekly.</p>
<p>What about transportation companies that may not be following protocols?</p>	<p>Monitor any transportation company your residents use to make sure they are following protocols. If not, you can report to Medicaid (if applicable) or utilize a different company. Those who are not sanitizing would be putting residents at high-risk.</p>

<p>We are not allowed to forbid residents from leaving the facility for non-medical reasons, but the protocol is that they should not be leaving for non-medical reasons. Can we include in our facility policy that if the resident is being reckless, they could be evicted?</p>	<p>Yes. The facility policy should be clear and state what measures will be put in place for residents who choose to leave the facility, how residents should maintain safety on when they leave and the consequences for engaging in behavior that would have a high probability of placing others at risk. You must provide a written notice of discharge to the resident/responsible party for both 30-day notices and immediate discharges.</p>
<p>Can we schedule non-essential medical appointments (such as annual physicals and dental care)?</p>	<p>Yes. However, continue to use telehealth when it is an option. Determine on a case-by-case basis which appointments are necessary for the resident's health and which can safely be deferred for longer. Make sure residents wear masks and follow hand hygiene and physical distancing when they go on appointments.</p>
<p>Stage 4: Protocols and Additional Guidance</p>	
<p>Are there any changes to which rules are waived?</p>	<p>No, the same rules continue to be waived. See the document titled Temporarily-Waived RALF Rules on our website.</p>
<p>In the Stage 4 guidance, both "protocol" and "consideration" are mentioned. Can you explain the difference between the two?</p>	<p>The "protocol" is the written plan or policy that the facility is expected to develop for each topic (i.e. safe environment for visits, protecting HCP, etc.) The "considerations" listed under each subject are recommendations that each facility may wish to think about when developing their protocols.</p>
<p>How long will this stage last? Is there a plan for when we will be able to go back to regular dining and activities?</p>	<p>We will continue to look to the Governor, as he consults with various agencies, for guidance on when facilities may discontinue recommendations found in the Stage 4: Protocols. Because the COVID-19 pandemic continues to affect Idaho, we must remain vigilant, using the guidance to keep the vulnerable facility residents safe for as long as needed.</p>
<p>We heard we must meet "minimum criteria" to re-allow visitors, group dining and activities. Can you clarify what that means?</p>	<p>See page 1 of the Stage 4: Protocols for Long-Term Care Facilities for the list of "minimum criteria [that] should be met before a facility opens to visitors or relaxes other restrictions."</p>

<p>Should isolation of new admissions and re-admissions to the facility continue?</p>	<p>New and re-admissions should be presumed to have been exposed to COVID-19 in the community and should isolate in their room for 14 days. This is necessary for ALL admissions, including those into a memory care unit and those returning from the hospital. All recommended PPE should be worn during the care of residents during the 14-day isolation/observation. Per the Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Residential Assisted Living Facilities (revised April 10, 2020) "Facilities that have no known COVID-19+ [positive] residents should not accept any new residents who are known to be COVID-19+ and are still on transmission-based precautions. Such individuals can be considered for admission once transmission-based precautions are lifted."</p>
<p>What cleaning products kill COVID-19?</p>	<p>A list of products which effectively eliminate COVID-19 can be found on the FDA website (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2). Note: unexpired household bleach is effective against SARS-CoV-2 when properly diluted at 5 tablespoons (1/3rd cup) bleach per gallon of water or 4 teaspoons bleach per quart of water. Alcohol-based cleaning products (such as wipes) are also effective if they contain at least 70% alcohol.</p>
<p>Can we create guidelines for staff when they are not at work?</p>	<p>The facility should provide education and encourage staff to follow all safety protocols when not at work, and avoid places of likely transmission, such as places where physical distancing cannot be maintained, large crowds or places where there is a high percentage of people not wearing masks. Include in your guidelines considerations for staff traveling. Discourage travel to areas with high disease activity.</p>
<p>Will surveyors need a separate room/space? Would you be willing to consider surveying remotely? Our records are electronic and are can be accessed remotely with a sign-in.</p>	<p>Yes, if possible, having a separate space or room for surveyors when they are in your building is greatly appreciated. We will still need to conduct a tour and observations, but will do as many record reviews and interviews as possible off-site. This may increase the number of copies needed. If you have electronic records that can be accessed remotely, this would be ideal.</p>
<p>What are the rules that go into effect on July 1?</p>	<p>See the summary of the proposed rule changes: https://healthandwelfare.idaho.gov/Portals/0/Medical/LicensingCertification/RALFDraftRulesSummary.pdf</p> <p>The full rule set was published in the administrative bulletin: https://adminrules.idaho.gov/bulletin/2020/04SE.pdf#page=860</p>

Twin Falls Manor is not listed on the public portal. Is there another name for this facility?

It is currently an extension of Heritage of Twin Falls. Once it is licensed separately, it will show up as Twin Falls Manor on the public portal.