Question	Answer
SARS-CoV-2 Testing	
Do all staff and residents need to be regularly tested for COVID-19?	According to the *Protocols for Long-Term Care Facilities* (https://rebound.idaho.gov/wp-content/uploads/Protocols_LTCFD1026-03.pdf) and the 6/3/20 *Testing Strategy for Long-Term Care Facilities in Idaho* (https://coronavirus.idaho.gov/wp-content/uploads/2020/06/LTCF-Testing-Strategy-FINAL-2020_6_3.pdf), baseline SARS-CoV-2 (the virus that causes COVID-19) testing of all Healthcare Personnel (HCP), regardless of any symptoms, is recommended, with regular testing every 7-14 days thereafter. However, as the virus surges in various areas around the state, your local health district may recommend facility staff be tested more frequently; contact your local health district office for their recommendation. Surveillance testing for staff is being offered through Crush the Curve (https://coronavirus.idaho.gov/wp-content/uploads/2020/10/RALF_CTCITestingProgramFlyer.pdf). For more information and to sign up for Crush the Curve testing, visit: https://crushthecurveidaho.com/self-administered. A list of other laboratories can be found in: https://coronavirus.idaho.gov/wp-content/uploads/2020/09/Testing-Implementation-Guidance-2020_7_8-FINAL.pdf. Surveillance testing of residents is not currently recommended unless the resident leaves the facility routinely. It is still recommended that all new admissions and readmissions be tested as well. Both residents and staff should be tested during an outbreak (outbreak = even 1 positive staff member or resident); contact your local health district for guidance during an outbreak.
If we have not had an active COVID case, and if we do not have anyone that has symptoms, are we currently required to test all of our team members?	A person can be asymptomatic and still shed the virus. If possible, we recommend the baseline testing. Then, the staff should be tested at some regular interval as part of the facility's infection control and prevention surveillance. See previous FAQ for details on surveillance testing.

Do staff or residents who have contracted COVID still need to be regularly tested for COVID-19?	No. Those who been diagnosed with COVID do not need to participate in surveillance testing within 3 months of symptom onset or of positive PCR test (if they did not have symptoms). **<u>Role of Viral Diagnostic Testing (PCR or Antigen) After Discontinuation of Isolation or Precautions</u>** • For persons previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, retesting is not recommended within 3 months after the date of symptom onset for the initial COVID-19 infection. • For persons who develop new symptoms consistent with COVID-19 during the 3 months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant retesting. Consultation with infectious disease or infection control experts is recommended, especially in the event symptoms develop within 14 days after close contact with an infected person. Persons being evaluated for reinfection with SARS-CoV-2 or for other infectious diseases should be isolated under recommended precautions before and during evaluation. If infection or reinfection is confirmed or remains suspected they should remain under the recommended isolation until they meet the criteria for discontinuation of precautions. • For persons who never developed symptoms, the date of first positive viral diagnostic test (PCR or antigen) for SARS-CoV-2 RNA should be used in place of the date of symptom onset. For more information and guidance visit https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html and contact your local health district.
What should we do at the first sign of COVID-19 in our facility?	In the *Protocols for Long-Term Care Facilities* guidance (see link on first page), facilities have been asked to prepare policies and procedures for their response to COVID-19. As soon as a case is suspected, facilities should immediately implement the protocols outlined in that policy. These protocols should include, but not be limited to: • Immediately isolate symptomatic resident(s) in their room with the door closed • Notify the local public health district immediately and follow their recommendations, including testing • Notify the resident's primary care physician

	• Notify residents, families and staff members of COVID-19 cases occurring in the facility • Discontinue communal dining and serve all meals in the residents' rooms • Discontinue group activities • Utilize full PPE for all staff during cares (for ALL residents, not just those symptomatic) and practice proper donning/doffing. Staff should be assigned to work either with all COVID-positive residents or all COVID-negative residents. • Monitor residents closely, at least 3 times daily per CDC, including a symptom check with vital signs taken, to watch for worsening symptoms which may require a higher level of care. All protocols should remain in place until your local health district directs you to do otherwise.
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?	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, "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 restriction, 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." (https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html). 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. A resident who refuses testing must be made aware of the 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 POA or guardian written consent to do continued resident COVID-19 testing? I have had some family pushback after our first round of testing when a staff became positive, and the health department did blanket testing.	It is best practice to obtain written consent for any testing. Again, residents do have the right to refuse testing. 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.
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. Are there financial resources for testing costs?	As previously stated, regular testing of staff is recommended. The staff member's insurance will be billed for testing; if the staff member is uninsured, the Crush the Curve contract pays for staff surveillance (every 7-14 days). Crush the Curve will also perform staff and resident testing during an outbreak. If the person being tested (staff or resident) has another means of payment (insurance, Medicaid, Medicare, etc.), and the facility does not provide that information, then the facility would be responsible for the cost of the testing. 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. Contact your local health district for guidance on staffing issues; other guidance can be found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html and https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html.
Should all new employees be tested?	This would be good practice. Be sure to check with whoever advises you on occupational health when developing policies for testing of staff.

If we test a new admit upon entrance and then approximately 24-48 hours and receive negative results for both tests, can we discontinue quarantine/isolation?	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. On 6/25/20, the CDC stated, "Residents can be transferred out of the observation area* to the main facility if they remain afebrile and without symptoms for 14 days after their admission. Testing at the end of this period can be considered to increase certainty that the resident is not infected." (*If the facility does not have a separate observation area, isolate new admissions in their room for 14 days.) https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html.
Who can administer a test? Are some RALFs doing the testing themselves?	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, health district or manufacturer of the test for training requirements. Some RALFs do have staff who have been trained to administer tests. Work with your health district, lab or Crush the Curve to identify who will conduct testing for your facility. Please be aware that many tests require a CLIA (Clinical Laboratory Improvement Amendment) waiver to be able to perform these tests. For more information about obtaining a CLIA waiver in Idaho, visit https://healthandwelfare.idaho.gov/providers/idaho-laboratories-and-testing/clinical-lab-certification. Remember, PCR testing remains the gold standard, and serum antibody tests are not to be used for testing for current COVID-19 infections. For information on the use of rapid antigen tests in long-term care facilities, review: https://coronavirus.idaho.gov/wp-content/uploads/2020/10/Use-of-RATs-in-Idaho-LTCFs-FINAL-2020_Oct_20.pdf.
Where is everyone getting their COVID testing supplies? I'm thinking it would be good to have a stock of testing supplies so if and when an outbreak occurs, we can be prepared. Any advice?	If you have someone in-house who can administer the tests, talk with the public health district about getting supplies. They get regular shipments of testing supplies from the state lab. Independent laboratories often provide the testing supplies, as does Crush the Curve (CTC).
Are facilities expected to have a "written agreement" with a lab and the health	It is recommended the facility have an agreement in place with a lab in advance (as recommended in the reopening protocol), and registration/agreement with Crush the Curve would satisfy this recommendation. Some labs may require a written

department for testing protocols?	agreement – keep documentation of your communication/agreement on file to demonstrate you have an agreement with a lab.
Do you have to have a doctor's order to test?	You likely will for a private lab. Work with your facility physician 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. Crush the Curve will inform you if an order is required, if your facility utilizes this organization for testing.
COVID-19 Symptoms and Positive Cases	
What does "subjective fever" mean?	"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.
We have residents whose baseline is low oxygen saturation – is it acceptable to use a "decrease from baseline" as the criteria instead?	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. The facility should have a system in place in which all residents are screened at least daily for symptoms of COVID-19. As always, the facility nurse should regularly monitor the health of each resident, including vital signs such as oxygen saturation levels. Because the condition of a resident ill with COVID-19 can change quickly, the facility nurse should train staff on what to watch for and provide clear parameters (if not already outlined by the resident's medical provider), so caregivers know which readings are out of normal range for each resident and should be reported to the nurse. While the rules do not require a nurse be present in the facility 24/7, ideally, only those facilities which have a regular facility nurse on site would retain residents with COVID-19. There are many small facilities which only have nurses who come in periodically. This would not be safe for overseeing their COVID-19 protocols to make sure they do not end up spreading it to others, nor for monitoring the health and condition of the resident with COVID-19, and being there to assess as the resident's condition changes.
Should we discharge residents who test positive?	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 *Protocols for Long-Term Care Facilities*, facilities should inform residents and their families of the facility policy **in advance**, regarding the need to relocate a resident with suspected or COVID-19+ status to alternative facilities. The facility still needs to provide a written discharge notice.

	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."
When there is a positive case, does the 14 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?	The criteria are 14 days from the last symptom onset at the facility, and the facility is not currently conducting outbreak testing. If a confirmed case was asymptomatic or pre-symptomatic, the date used is the date their test was collected. Facilities should work with their local public health district to determine when the outbreak is resolved.
The 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 for every staff to wear at all times and change between residents?	Yes; a facemask (a surgical mask or N95), 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. The purpose of the PPE recommendation is for facilities to be prepared at all times for a possible outbreak of COVID-19. Each facility should be completing Survey123 (https://coronavirus.idaho.gov/wp-content/uploads/2020/09/RALFSurvey123.pdf). This is a crucial step. Even when an outbreak has occurred, some facilities have been denied PPE, as they were not current on completing the surveys. 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. The CDC also has a "burn rate calculator" (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html) to help you determine how long your PPE stock will last. Be sure that adequate supplies of hand sanitizer (alcohol-based hand sanitizer with 60–95% alcohol), hand soap and paper towels are available at each facility. Governor Little's order, dated 10/27/20, "requires the universal use of face coverings in long-term care facilities in Idaho. This order applies to anyone who is not a resident of that facility" (with certain exceptions; review the order at: https://coronavirus.idaho.gov/wp-content/uploads/2020/10/Mandatory-Use-of-Face-Coverings-in-Long-term-Care-Facilities-2020_10_28.pdf). Remember, staff should be

	wearing a facemask (surgical mask or N95) in the facility at all times; cloth face coverings are not acceptable for staff to use in the facility.
When is full PPE required to be used?	Full PPE should be worn by all staff for interactions with all residents when there is a suspected case in the facility.
Do we need to have documented evidence of the training of all staff in PPE use?	Yes. According to IDAPA 16.03.22.625.03.l, all staff must be trained in infection control. The *Protocols for Long-Term Care Facilities* 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 *Protocols for Long-Term Care Facilities* guidance for further details on all policies that require a written plan.
Visitors	
Can we remain closed to visitors if we feel nervous about letting them back in even if the facility meets the minimum criteria?	Currently, the rule requiring residents to be allowed to have visitors is waived. Technically, you do not have to open to visitors. That being said, we encourage you to do everything in your power to allow residents to visit with their families, as the lack of visitation is being shown to have detrimental effects on the residents. Video and window visits are still the safest; search the internet, as there are some very creative ways these visits can be done, even with memory care residents, so that the visits are interactive and meaningful. Some facilities have had great success with outdoor visits as well, as long as all participants wear a facemask and stay six feet apart during the visit. Please review the *Guidelines for Safe Visitation in Long-term Care Facilities*, dated 10/23/20 (https://coronavirus.idaho.gov/wp-content/uploads/2020/10/Visitation-Guidelines-for-Long-term-Care-Facilities-FINAL.pdf), as there are specific guidelines for facilities to follow in order to protect the residents' health and safety during visitation. Also, please check with your local health district for additional recommendations and requirements for visitation in your area (example: Central District Health's 10/20/20 order).
Can we require visitors to be tested?	According to the *Guidelines for Safe Visitation in Long-term Care Facilities*, dated 10/23/20, while not required, we encourage facilities in counties with medium or high-positivity rates to test visitors, if feasible. If doing so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2–3 days) with proof of negative test results and date of test. However, even with a recent negative test result, all visitors must strictly adhere to the protocols for infection prevention outlined above.

If a facility has even one positive COVID-19 case, would we need to stop visits?	Yes. If you have a positive case, go back to previous restrictions (no visitors, communal dining, etc.) until the outbreak is resolved. Notification of families and employees is important. Restrictions can be relaxed again to the level outlined in the *Protocols* (as referenced above) when the minimum criteria are again met, unless otherwise directed by the local health district.
Can you deny visitors if they refuse to comply with your protocols or with the Governor's mask mandate?	Yes. If visitors refuse to wear a mask because of a health reason or other reason listed in the Governor's Stay Healthy Order, try to work with them. Page two of the *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.
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?	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 *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.
What about the hair stylist?	It is up to each administrator to determine which services are essential. Consider whether the 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.
Would facility tours be appropriate?	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 smart phone so they can stay outside yet see everything through a device.
Residents Leaving the Facility	
Should a resident returning from a medically-necessary appointment be isolated?	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.

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?	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 *Protocols for Long-Term Care Facilities* have measures you can consider, such as providing a separate room, providing a face mask, enhanced sanitation, etc. See the measures suggested in the *Protocols* and determine what is reasonable for your facility. When residents leave the facility, assess exposure on a case-by-case basis and minimize risk. If someone goes to the bank wearing a face mask with someone wearing a face mask, this would be considered lower-risk, where someone going to a family reunion would be a higher-risk situation.
What about intellectually disabled residents who are pushing to return to their DDA that may not be following proper protocols? At least one DDA has had a confirmed case of COVID-19.	Residents in RALFs are still recommended to not go into the community. In determining if residents should return to a 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, etc.? If your DDA is not providing a safe situation, it is ok to not allow participation. If residents do return to a DDA, consider testing on a regular interval.
We have a resident that really wants to go to church every Sunday. What do we do?	Are there teleservices? An outdoor church service from the car? Find ways to minimize risk. Encourage a face covering and social distancing. Consider testing this person on a regular interval if they are leaving weekly, as outlined in the *Testing Strategy for Long-Term Care Facilities in Idaho* (6/3/20).
What about transportation companies that may not be following protocols?	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.

We are not allowed to forbid residents from leaving the facility for non-medical reasons, but the protocol is that they should not being leaving for non-medical reasons. Can we include in our facility policy that if the resident is being reckless, they could be evicted?	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 both for 30-day notices and immediate discharges.
Can we schedule non-essential medical appointments such as annual physicals, dental care, etc.?	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 a mask and follow handwashing and physical distancing recommendations when they attend appointments.
Protocols and Additional Guidance	
Can we discontinue COVID-19 precautions after we begin vaccinations?	No. Vaccination does not provide 100% immunity. Continue to implement all COVID protocols and follow the CDC and state guidance for COVID-19. If the CDC issues new guidance specific to those who have been vaccinated, we will immediately inform you via FLARES.
Have there been any changes to which rules are waived?	No, the same rules continue to be waived. See https://coronavirus.idaho.gov/wp-content/uploads/2020/09/RALFCOVID19WaivedRules.pdf.
In the guidance, both "protocol" and "consideration" are mentioned. Can you explain the difference between the two?	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.
How long will this current stage last? Is there a plan for when we will be able to go back to regular dining and activities?	Other than the Governor's orders as outlined at https://coronavirus.idaho.gov/ and https://rebound.idaho.gov/, each local health district will make decisions for their area. Please visit your local health department's website or contact them directly regarding guidelines for your specific region. You can also find current city/county local health orders at https://dhr.idaho.gov/covid-19-workforce-guidance/.

We heard we must meet "minimum criteria" to re-allow visitors, group dining and activities. Can you clarify what that means?	See page one of the *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." Again, please contact your local health district for any additional recommendations or restrictions.
Should isolation of new admissions and re-admissions to the facility continue?	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."
What cleaning products kill COVID-19?	A list of products which effectively eliminate COVID-19 can be found on the EPA 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.
What about guidelines for staff when they are not at work?	The facility should provide education, 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.
Will surveyors need a separate room/space for survey? Our records are electronic - and are accessible remotely with sign-in. Would you be willing to consider surveying remotely?	Yes, if at all 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 much record review 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.

What are the rules that went into effect on July 1, 2020?	https://publicdocuments.dhw.idaho.gov/WebLink/DocView.aspx?id=5834&dbid=0&repo=PUBLIC-DOCUMENTS. These rules and other resources can be found at our website: https://healthandwelfare.idaho.gov/providers/residential-assisted-living/resources.
What assisted living facilities are taking COVID+ residents?	Twin Falls Manor (an extension of Heritage of Twin Falls): https://coronavirus.idaho.gov/wp-content/uploads/2020/09/RALFCOVIDTwinFallsManor.pdf Veranda Senior Living: https://coronavirus.idaho.gov/wp-content/uploads/2020/09/RALFCOVIDVeranda.pdf Hope Springs; and Guardian Angel Homes If a COVID+ resident requires skilled nursing, a list of facilities can be found at: https://coronavirus.idaho.gov/wp-content/uploads/2021/01/List-of-COVID-Exclusive-Facilities-Updated-Jan-72021.pdf

REFERENCES

Clinical Questions About COVID-19: https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html

Crush the Curve: https://coronavirus.idaho.gov/wp-content/uploads/2020/10/RALF_CTCITestingProgramFlyer.pdf. To sign up for Crush the Curve testing, visit: https://crushthecurveidaho.com/self-administered

Guidelines for Safe Visitation in Long-term Care Facilities: https://coronavirus.idaho.gov/wp-content/uploads/2020/10/Visitation-Guidelines-for-Long-term-Care-Facilities-FINAL.pdf

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Protocols for Long-Term Care Facilities: https://rebound.idaho.gov/wp-content/uploads/Protocols_LTCFD1026-03.pdf

Resources for Long-Term Care facilities in Idaho: https://coronavirus.idaho.gov/ltc/

Staffing: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html and https://www.cdc.gov/coronavirus/2019-ncov/community/critical-workers/implementing-safety-practices.html

Survey123: https://coronavirus.idaho.gov/wp-content/uploads/2020/09/RALFSurvey123.pdf

Testing Strategy for Long-Term Care Facilities in Idaho: https://coronavirus.idaho.gov/wp-content/uploads/2020/06/LTCF-Testing-Strategy-FINAL-2020_6_3.pdf

Use of Rapid Antigen Tests in Long-term Care Facilities (10/20/20) https://coronavirus.idaho.gov/wp-content/uploads/2020/10/Use-of-RATs-in-Idaho-LTCFs-FINAL-2020_Oct_20.pdf