**May 13, 4:30 pm CMS COVID-19 weekly call with nursing homes**

*Note this is a cc transcript with numerous typos, especially when it comes to acronyms and initials. Seema Verma greeting and thanks, including big shout out to AHCA Prez. Very positive and “celebrating successes”. Evan Sholom and the Director of the division of nursing homes and Lauren Ryder of the Northeast division of survey and enforcement talked about in very conciliatory and understanding terms about survey observation. Molly Stone of CDC on safeguards then* [***Larry Slatky and his DON***](#Larry)*on best practices.*

 We are also very happy to be with you during the week where we take the time to celebrate the hard work of nursing home care teams as we care for some of the nation's most vulnerable patients. This is Alina Czekai working on stakeholder engagement on COVID-19 in the office of CMS administrator Seema Verma. Today we are joined by CMS and CDC leaders as well as providers in the field who have offered to share their best practices with you all. I would first like to turn it over to administrator Seema Verma for an update on the agency's latest guidance in response to COVID nineteenth. Administrator firm over to you.

>>Seema Verma:

Thank you very much. And thank you for taking time out of your busy schedules. This week is skilled nursing weekend I wanted to start off by expressing my sincere appreciation and gratitude to everyone of you for your unwavering dedication and commitment to keeping residents safe. These are truly unprecedented times and you all have done an amazing job. This has been an incredibly difficult time for you and your staff. It's been difficult to keep people safe. The number of deaths has been hard on your staff and yet people are there day in and day out not only doing the routine work that you have done in the past but it's also the staff has always been a source of care and comfort but even more so serving as family members and appreciate all the work hacked the stories we hear about nursing home staff on the front lines kept communicating with families, giving them calls, setting up Skype meeting so patients can talk to families that's incredible work and it shows how much you really care for your patience. I also wanted to take a moment to thank Mark Parkinson who is been a great partner. He has been working with us on the administrative level, communicating a lot of the concerns and challenges you all have been going through from testing to supplies. He's been available any time I've called him and I wanted to take this time to tell a story about Mark because we have all been working through this and I think it was a Saturday morning and I called him and said tell me what is going on in what I can do to help. He was talking about testing challenges and talking about PPE challenges into throughout that weekend I must have called him three or four times. He always took my call. He was very prepared and organized. He gave me a list that weekend of all the nursing homes. He had it organized with all the pertinent information the size of the nursing home, the number of staff send it had a PPE calculator in that and I was able to take his spreadsheet and give that to FEMA so as many of you hopefully are receiving some of the packages that FEMA put together to augment supplies, that is kind of how it happened. It was a very simple transfer of information. We are just talking to FEMA about it but a lot of it had to do with the leadership of the association because Mark was organized and had information at his fingertips we could hand it to FEMA and they were really happy to be able to deliver the packages and we are hearing their delivering that all across the country so we help that is just a symbol of our appreciation for the hard work you all have done. I think that story with market really speaks to the partnership that we had had over this enormously difficult time and challenging situations. As part of the FEMA effort we've gotten to deliver the packages and I met a nursing home owner in Virginia and he is telling me about the fact they had had COVID in some of their facilities. They learned a lot. They figured out how to control the spread of the virus in the nursing home and so while it had been a difficult time it was a great example of what nursing homes are doing incredible work across the country and we felt really grateful to be there and listen to their stories and I'm glad that we were able to talk about some of the great work that nursing homes are doing. From our standpoint we hope that the work that we've been doing with the nursing homes represents a partnership. These are challenging times. We are all learning new things about the virus. We hope all the guidance and regulations and information we've been giving is intended to support your efforts. I can tell you the CMS nursing Home team has been working round the clock pretty much every weekend since all of this started and they meet daily with the CDC team and they have been really working hard to make sure that everything is updated based on the latest science and information. We appreciate your great cooperation with the surveys and we really intended those to be problem-solving and an opportunity to identify issues and serve your patients better and just to identify issues and working collaboration to ensure patients are safe so we really appreciate the strong support and your cooperation with all of those surveys that have been going on and the team has used a lot of the information that they have received from that to inform other types of guidance. So we want to continue that partnership with you. We are very excited about the president's commission on the Coronavirus patient -- quality and safety for nursing home patients. We really hope that will be an opportunity for all of us to step back from what's been going on in the day-to-day and try to identify those best practices so we can ensure that not only patients are safe, but they are getting the best quality of life. This is going to be an ongoing battle. We know Coronavirus unfortunately is not going anywhere for a while and we are seeing reductions in cases all across the country you know, it is something we are going to have to continue to be vigilant on. We are hoping the task force or the commission and some of those individuals can kind of give us some awesome outside perspective and we are excited to ensure we have nursing home representation on the commission but it hopefully marks a new way of us trying to figure out what's the best way to increase quality, patient quality of life and ensure all patients are safe so we are excited to begin that process and this week we will be announcing the process for nominations as well. The other thing I wanted to mention the team has worked on as we've put out a toolkit this weekend the toolkit really summarized all of the efforts across states and all the different things they are doing to support nursing home some of them as you know, some of the governors have asked their national guards to help nursing homes with cleaning and disinfection in this week we called for support for states to help nursing homes get their residence tested and to support their efforts to identify patients that may have COVID by risk. We've increased reimbursement and Medicare for testing and we allowed labs to go to patients that are homebound which includes nursing home residents and that is something we will support efforts to identify patients quickly and isolate them. Again I want to make sure, time you can talk about best practices and great work you are doing and I wanted to say a sincere thank you. Really appreciate all the hard work you are doing and look forward to continuing to work with you. Thank you very much and with that I will hand it over to Jean, right. Thank you.

>>Speaker:

Thank you, administrator. And we really appreciate that what you are doing as well and welcome everyone to our weekly call. I would like to add my congratulations and thanks for national skills nursing care week. And it is certainly an observant that we've been recognizing for the entire week so stay tuned for out the rest of this week to do the recognition and provide information so the administrator outlined the things we had in the works on things we've rolled out. As I usually do on this call I like to let you know about some of the flexibilities that we are also rolling out because most of those come from your requests. Your request for waivers or questions you have from this call and so I'm going to name a couple of those and I will not spend too much time because we have a full agenda but one of the things just to mention we did do some changes to the life safety code requirements for skilled nursing facilities and some of the things that we needed to way related to the prescriptive nest of alcohol -based hand rubs and where they are placed, the dispensers. We recognize this time it's more important you be able to get to those alcohol -based hand rubs when you need them versus where they are actually posted. I mean there is a reason whenever we have these kinds of things it is ethyl alcohol, flammable and there is a reason for the regulations that are in place, but we are waving most of those with the exception there is still a restriction on the storage for the large containers because it is flammable so just check that waiver to see what is involved there as well as fire drills. We have waived that. It is still important to include that in your orientation but we recognize now is not the time to be moving massive numbers of patients from place to place and also some of the temporary walls, barriers and the safety codes please note we revised the flexibilities as well to include assisted living facilities. Prior to this time we had done some of the waivers as it relates to long-term care facilities, but now that can be provided and assisted living facilities and similar types of facilities and then the last thing I think I want to note that we will have some relationship to your work is if we placed a waiver out related to swing beds. We have expanded the ability for hospitals to offer long-term care services and swing beds for patients that do not require acute care and do not meet -- do not meet the SNiF requirement level of care and this allows hospitals to establish swing beds to provide additional options when it is not possible to obtain a long-term care bed within their area that they usually work with. We know there has been a few issues with that. So those are the flexibilities that we had put out within the last week or so. Please check our website for additional information but I want to turn to Evan Sholom and the Director of the division of nursing homes within [inaudible] which will provide updates on the survey process and data reporting. Evan.

>>Speaker:

Thank you, Jean and happy skilled nursing week to everyone out there. We appreciate your effort. I'm going to give an overview of some of the updates that we have with some of our programs here. First on surveys I think everyone knows that with the memo we released on March 23 we altered the type of surveys that are being conducted since that time states and federal surveyors have only been conducting surveys that are triaged at the [inaudible] and also the infection control survey that we have released [inaudible] to date states have conducted over 6800 surveys across all of our states. That is hitting approximately 44 percent of our more than 15,000 nursing homes. Of course it will vary by state we have some that have conducted surveys and almost all their nursing homes and some states that have not conducted as many surveys as other states have conducted a very low percentage of surveys. Of course, this could be due to multiple factors the availability of PPE or they need to use surveyors in other capacities for clinical background. But what we are seeing on these surveys is interesting and we are seeing providers do a lot of great work so a big thank you to everyone out there who is doing fantastic work in preventing the spread of COVID-19. They are using the guidance we had put out in conjunction with the CDC CMS and CDC have been putting out guidance well before the COVID-19 pandemic hit and we've been putting out tools and other resources for facilities to use so, thank you for using those and leveraging any other resources you may have access to. We are still seeing some cases where facilities are not doing everything that they should be doing to prevent the transmission of COVID. These are some of the things we have had a long-standing requirement and expectations about, things such as hand hygiene and making sure that hands are disinfected when they should be. Using PPE appropriately and this is not about whether or not a facility has or does not have PPE and is not using it. These are cases where the surveyors are using staff with the appropriate level of PPE, they are just not using it appropriately or down and doffing it appropriately. We are seeing some cases of noncompliance where the facility is not notifying the physician timely related to conditions and then one of the more prominent things we needed to do over the course of this pandemic is cohorting and isolation and I know this can be challenging because of the structure and the makeup of the facilities of how they are structured, but we have seen cases where again the facility has the ability to cohort or isolate residents given the right way they are still not doing it. So I know this is difficult work but, again, a lot of you are most of you are doing a great job at it. The messages don't let your guard down. For those of you that think you've got it and you are doing it right, make sure that, you know, everyone is doing it right so, you know, exactly how every single one of your staff is donning and doffing PPE in every unit of your facility and if not you may want to check on that. Again great work for everyone. We continue to see some erratic noncompliance related to expectations and we are hoping we can sure those up as soon as possible. The other thing again a reminder about the guidance please make yourself as well versed as possible and CMS and CDC have released and this includes the self-assessment that we recently updated on May 6 and update include some information about a new requirement spend some time talking about which is the reporting requirement but the self-assessment is intended for you to be able to conduct your own survey and look exactly at the same thing the surveyors would be looking for and the service and self-assessment are based off of long-standing guidance and regulation, but also the latest information that we know about how to prevent the spread of COVID-19 in nursing facilities. Effective May 8 all facilities are required to do two types of reporting. One is reporting to resident representatives and family members and the other to the CDC. All of, you know, we've had a long-standing requirement for facilities to report cases of communicable diseases in this case COVID-19 to your state or local Health Department and this layers on top of that. So first when a family reporting all facilities are required to report COVID-19 information to residents, resident representatives and families and what we are trying to get at here is answering the questions that family members are asking is what is happening in the environment that my loved one is in and we believe strongly they have a right to know and that's really what that is aiming to do. The second requirement according to the CDC through the MHS and and this is critical for our national surveillance of the trajectory of disease in our country. We know that states have their own type of reporting but there is no national standardized way to collect nursing home COVID-19 information across our country and this is the first ever way to collect this type of information so we as a nursing home community can know how the disease is moving and where we are on the hump as they say of the curve of where this disease so this will give us the ability to see where we are. It is critical that every single one of the nursing homes enroll in \* reporting information as soon as the requirement is to report at least once a week. You can report more than that. But it starts with enrolling thousands of nursing homes already enrolled to submit through the NHS and system but we still need thousands more to enroll. Thousands have also started to report and we still need thousands more to report. CMS will be making this information public. We will also be enforcing noncompliance of nonreporting so, again, I urge all of you to look at the CDC website. There is very easy to follow instructions on there if you have questions they have a Help Desk that can help but based on what we are seeing with thousands of facilities being able to enroll the enrollment should not be a barrier. So with that thank you again for all of your hard work out there. We as a nursing home community are all in this together and so we really appreciate your collaboration and, again, in your hard work particularly during this week the skilled nursing week. Gene, I will turn it back to you.

>>Speaker:

Thanks much Evan appreciate all the information. And I want to move to observations from the field. First from the federal perspective but then we will quickly move as well into hearing from our guest speaker today. But Lauren Ryan I'm going to turn it over to her is the division Director for our Northeast survey and enforcement division and in her role she provides supervision, direct supervision to the federal surveyors as well she works really closely with the state surveyors and the state survey agencies and so I have asked her to kind of give us an overview of some of the things they have been finding in the field over the past several weeks and then when she completes her statements she will turn it to Dr. Stone who has been with us on a couple of occasions, the medical epidemiologist for long-term care from the Centers for Disease Control and prevention to talk about some practices, promising practices she has seen as well. So Lauren and then to Dr. Stone.

>>Speaker:

Okay, very good. Hello, everybody. I'm Lauren Ryder 10 and I represent the Northeast division of survey and enforcement and it actually represents 14 states activities in 14 states and includes Puerto Rico and the U.S. Virgin Islands. So in our area, we have had COVID-19 hospitals as I'm sure all of you are aware. We also have had several high media cases from outbreaks that have garnished a lot of attention and we also have from our work as federal surveyors and also with these state agencies, we have information from the CMS focus infection control survey. So we all know that we have a commitment, all of us here on the call have a commitment to take care of the residents in this COVID-19 emergency and it is one of our highest priorities and we all know how foundational strong infection control practices are. From our experience, we have seen nursing homes meeting infection control requirements and doing a marvelous job under some very challenging experiences and conditions. But I did want to share today a few areas in which perhaps more attention or oversight might be applied to improve some outcomes. And as Evan Shulman had mentioned and I am sure that you all also are cognizant of, there seem to be three major areas that we see repeating opportunities that are available to reduce infection spread. One of the first areas is hand hygiene. And we are all only as good as our weakest link and we really need to make sure that we pay attention. We educate our staff and observe them and remind them and make a hand hygiene a readily accessible type of activity and keeping an eye on them and I know everybody is working hard and trying to work fast to get the job done, but we have seen quite a bit of problems with hand hygiene. The other area is actually donning and doffing of PPE. You know, when you have the PPE, we have seen -- I'll go into a little more detail in a minute, but we have seen people taking off PPE incorrectly. Not really donning it properly. Masks that are not on their nose is exposed in various other things. So that is one of the areas that donning and doffing PPE that we all can use the reminders on to make it easy, hopefully you will have etiquette supplies available to educate your staff -- adequate and make sure they are doing the donning and doffing appropriately. They're also is the concept of that separation and cohorting and signage and making sure that there is an overall awareness of your staff for these infection control actions that we are all working so hard to make sure are available to the residents. So the big three are hand hygiene, donning and doffing of PPE and the signage and the cohorting and that separation and making sure that everybody is aware of it and following those actions. So specific opportunities that you may be doing this already, but I'm going to be mentioning some of the things we have seen in various surveys and experiences in the skilled nursing facilities. So in terms of surveillance there's an opportunity to have more robust resident monitoring which goes beyond taking temperatures, but also taking other vital signs on a routine schedule. We have seen some facilities. The only documented monthly notes unless the resident starts to complain or has a temperature and there seems to be little documentation in the clinical records often of stomach issues, headaches, other vital signs and the types of signs and symptoms of COVID-19 that the CDC has issued expanded guidance on. We also have seen cases where staff screening was not adequate and we have seen social distancing not present in the main entrance of the facility. So in the area of infection control, we need to have nursing homes consider having backups to key roles in infection control. We have seen several cases where the infection control nurse might be absent with illness or COVID-19 and we have seen issues where the infection control nurse was assigned to staff nurse duties instead and that role of infection control and that oversight is held vacant. So we also have seen situations where first line staff are not informed of a possible COVID infection. A lack of signage in the areas where COVID-19 residents are. We have seen the cohorting of COVID negative residents or uninfected residents with the COVID positive or the P UI are expected COVID positive residents and then we also have seen staff who provide services in a COVID room then go into a COVID negative room without washing hands or changing PPE, gloves and that. We have also seen that not only in the nursing staff, but also in housekeeping and support services. So that's another area that is an opportunity to keep an eye on. The hand hygiene the housekeeper we have seen going from one resident room to the other without washing hands and we have had during interview staff expressed that they don't understand that if they touch residents -- touch items and a resident room that they also need to perform adequate hand hygiene. And we have seen circumstances where hand sanitizers not readily available that soap was not available so these things really can be solved with observation and vigilance and management. We have seen facilities that do provide and 95 masks, but they have not been tested there staff for the appropriate use of the appropriate size. We have seen one mask issued for the entire day and that is a difficult one. The staff are working with COVID-19 with acute symptoms. As I mentioned before we have had staff not wearing masks not appropriately covering their mouth and their nose, not changing gloves appropriately. Single use gowns that were being reused, but not washed correctly. And then gowns with holes and tears and one guy owned a day and the individual will be walking through the entire facility in and out of COVID-19 positive and negative rooms and then only issued a new gown if it gets soiled. And there are issues also that staff have not been instructed on how to handle PPE when they go on lunch breaks or to the restrooms. And we did have a couple of facilities where there was not adequate cleaning of resident care equipment between COVID positive in COVID negative residents and that equipment included thermometers, blood pressure cuffs et cetera and we had an instance also where the staff didn't know how to use the temporal thermometer according to the manufacturer's directions so the calibration was a concern. The environment we have seen the lack of wiping down surfaces frequently, trash sometimes was not removed and floors were dirty. And just, you know, basically we have also seen that education is extremely important that the staff at times were needing additional understanding of how COVID-19 would be spread and we have had circumstances where they were really not aware that their own practice of not changing gloves or gowns appropriately could be spreading the disease to other residents so these are some of the weaknesses that we saw, but we are sharing those with you so that you will be able to find opportunities within your own facilities in order to increase the control of infection spread. And then finally on a more macro level, it is an opportunity for management and the facilities to really reevaluate the risk assessments for your skilled nursing facility to reevaluate your power levels, staffing plans, capacity, capabilities and with all of these opportunities that you might be able to consider we really feel that paying attention to your staff and the way infection is handled creates a very good opportunity to really control and protect the residents there and the care. We really think all of you for the jobs you are doing. It's not easy to do these important tasks, but we do hope that some of the items that I mentioned might be taken into consideration as you continue your good work in infection control. So I would like to now turn it over to Dr. Stone of the CDC. And thank you for the time here today.

>>Speaker:

Thank you, Lauren and this is Molly Stone and I'm grateful for my colleagues at CMS for the opportunity to spend a few minutes with you and hear your feedback and learn from you and all of them so that we as a community of partners can work together to make our residents and our staff in long-term care safe. I want to just say a couple of things about what Lauren just shared because it's so important. Some of the key actions that she raised. I'm going to point out three. The first is her comment about and 95 respirator use in testing. Something people don't always know about and 95 respirator's is there is a whole medical evaluation that goes into the fit testing and respiratory protection program and that is because they are some of our healthcare team members who may not be comfortable or safe using an N95 especially for prolonged period of time. So I think that is really a critical piece of the safety of our personal protective equipment and one reason why it's been raised often about having a fit testing program and the second thing on respiratory is to emphasize her comment about the importance of doing regular vital sign and symptom screening and documenting those findings so that you can go back and build the picture of how a resident clinical course has been and in particular being able to trend some of those vital signs to see patterns that might be early warning signals that a resident may need to be moved to a higher level of care or receive additional closer follow up. So in addition to the typical vital signs we are used to doing I also hope you are all adding pulse optometry, which is a measure of the oxygen level in people's blood. This is a very important piece of detection of the early respiratory distress that can come with COVID-19 infection. And the third thing I want to say it is put a plug-in to comment about having a backup person to support infection control in your buildings and I'm going to go one step further because I can as a public health advocate and say I would consider making your infection prevention a full-time role right now during your COVID response activities. If you think about the incredible amount of work that somebody has to do surveillance, screening, staff and residents, there is reviewing those screenings to make sure that they detect early any new cases, reinforcing the infection prevention practices that Lauren pointed out through observation on the units and doing coaching and just in time training for frontline staff and environmental and housekeeping staff because we know a lot of the equipment is new, unfamiliar. We know there's a lot of stress going on in the building and just the heightened vigilance. Everybody is on add and some centers are short staffed so there's a hard shift in terms of people getting fatigued after working long hours or double shifts so having somebody is dedicated to the safety in your buildings is a really important part of this response. So thank you, Lauren for those points in the opportunity to sort of build a little bit on what you said. The other thing I want to bill on is some comments from Administrator Verma about celebrating successes of our provider community across the country. We are immensely grateful for the work you are all doing in your front line staff and residents and family sent everything you're doing to support them and I want to share with you that CDC is starting to compile a list of success stories, different tiny intake notes that illustrate how centers have been able to implement some of the key COVID prevention strategies that we have been promoting throughout the response. Things like keeping COVID out from entering the facility through staff screening and reinforcing things like social distancing among staff even when they are on breaks or hanging out after hours to just remind people that we want to be mindful of not sharing germs with our colleagues. The identification of infections early and the rapid implementation of those infection prevention precautions to stop the spread as well as managing and optimizing our supplies and helping do the monitoring to prevent severe illness those strategies are sort of the scaffolding, if you will that we are going to use to bill some of our success stories and I'm just going to share one that illustrates an example of early detection and early action. There was a center that shared with us that they learned to trust their gut and really advocate for testing when it's your initial exposure, your first case and there may be some skepticism about whether you should be considering COVID. This center noticed that one of their residence had a constellation of symptoms that seem to vary concerning and with COVID infection even though they had not had any known cases and so they hadn't already kind of had a lot of COVID circulating in the community. Because of there high suspicion they placed that resident in precautions quickly and started advocating to get testing which at the time that they experienced this was not very critical back in early and mid March we know a lot of facilities couldn't get their hands on testing so they had to go through the public health program and really push the request multiple times to convince the public health program that yes, it was a legitimate COVID and we should test for it. In the interim they minimize the number of caregivers interacting with that resident. They were using all the PPE they had on hand but, again, as a lot of us realized early in the response most of our facilities did not have all the full PPE, for example, this center did not have a high protection either goggles or face shields that they were using masks gowns and gloves and they were being as cautious as possible for the staff that were working with the residents but there was still risk. And after they finally got testing for that resident confirmed that this was a diagnosis of COVID-19, they then identified the staff that were the most exposed, had them go on furlough or voluntary sick leave for the recommended 14 days following their exposure with the time caring for that resident and they immediately reached out and contacted all of the residents families and other team members and staff in the building to make everybody aware either a phone call or through a personal communication. And bottom line, because of their early identification, trusting their gut what this resident might have been really creating that case appropriately they did not have any other residents or team members diagnosed with COVID or become infected so a lot of good lessons buried in that story and we are looking forward to hearing your stories as well as we build up our website and the platform for sharing we will be letting, you know, how we can hear more from you and share your experiences and lessons. Thank you so much.

>>Speaker:

**Thank you so much Dr. Stone that's a perfect lead into our last speaker of the day Larry who is the Executive Director of Shaker Place rehabilitation and nursing Center in Albany, New York so I will turn it right to you.**

>>Speaker:

Thank you very much I'm joined by our Director of nursing and William Redman who ascended infection control specialist and thank you for having us. We will talk a little bit about best practices but first, I want to talk which I think is very important and it goes to some of what the speakers have been saying about cohorting and the structure of nursing home, which is very important. We are going through and I will quickly go over this where we are adding on to our existing nursing home units and three are done and three are not done and three units in the high-rise approximately 120 beds and three units are downstairs, 120 beds. Whatever the downstairs units, which have been renovated and goes to social distancing and I can really emphasize how important that is. Downstairs with 120 residents we had three residents test positive since January. Upstairs where we have the same hundred 20 residents on the same three units we've had over 50 residents test positive. So it shows that the social distancing which we are capable of doing downstairs versus the traditional nursing home basically a 40 bed corridor is virtually impossible and then we have also learned how difficult cohorting us because we do cohort but you have residents within scores who are wandering around and will not stay in their room or have the door shut and they opened the door and they are walking around the units. So it becomes extremely difficult to take care of 40 residents or 35 residents on a 40 bed unit and at the same time try to keep everyone in line with infection control who is a resident living here in a restraint free environment. It becomes very, very cumbersome for this staff to deal with. We have developed some protocols to follow, but it was and still is difficult to cohort on a traditional nursing home units. And the last thing, which I will state before I turn it over to Rebecca is that we started everything early on meaning we did not wait for any guidelines. We didn't wait for any releases from CMS or CDC because I believed and I think most nursing homes have all of these procedures for infections whether it be a flu in place already and we started early on with screening of all new employees coming into our nursing homes, taking temperatures, monitoring sick calls, looking at people's symptoms and starting even when we started to do testing we started testing at yes but if someone had symptoms we immediately started treatment we didn't wait for the result. The assumption was they are going to test positive so we used what we had and then when we got the guidelines that assisted us in furthering what we had in developing what needed to be in place to better supervise the COVID-19 virus. And make sure our residents are properly protected. So I'm going to turn it over to Rebecca now and go over some more specifics.

>>Speaker:

I am Rebecca the Director of nursing. I want to say early on the New York State Department of Health came in and tested and educated us on testing ourselves. We initiated a assessment to include symptoms and monitor the residents temperature every shift. Of her resident had any symptom or temperature of 99 or above we added pulse ox to them and tested them. We monitor our COVID residents and we started oxygen therapy early and we also do IV and crisis therapy early. We tested all of the residents in our building and happy to say we have 19 that are in recovered phase of the COVID virus. So I think what that was for us as we were able to test and tested quickly and get our results quickly and have access to the results which usually takes less than 24 hours and then we start treating their symptoms.

>>Speaker:

We are also testing our staff. We do our screening before the guidance was given and we monitor symptoms, temperatures and if they have symptoms of a Medical Director here and our infectious prevention nest and we send the staff home and they come back and they are tested during our testing so we meet them at the door and don't let them come in and we get access to them very quickly.

>>Speaker:

And another thing, which I think is important and I think this was also mentioned, we have -- and I don't believe that every nursing home has the type of staff members that are part of our administrative and nursing team, which really truly helped us get ready and just jump into this not only do we have a Director of nursing, Assistant Director of nursing, they are an infection control specialist even though we don't have a ventilator unit we have a full-time respiratory therapist on our staff and we have a full-time MD Medical Director all of which work in concert with our three RNs who are in the education department and quality assurance so that team was able to immediately create the type of protocols that needed to be followed by our staff and then education education education. Follow-through follow-through, constantly and even as we speak today four or five months and we still do this almost every single day. Thank you.

>>Speaker:

Thank you. That is really truly amazing all the things that you did and especially as you said you didn't need guidance to know to do those things so we truly appreciate that.

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

>>Speaker:

Yes, we have one question from the line of Terry Harmon and. Your line is now open.

>>Speaker:

Thank you.

>>Speaker:

My question is relative to the labor waivers and some clarity around when that expires. I think that I know that an extension of the emergency situation and there is no clarity and I've looked everywhere to see when they expired.

>>Speaker:

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

>>Speaker:

That would be great and if we could get something in writing that would be even better.

>>Speaker:

Thank you for that question.

>>Speaker:

Thank you so much.

>>Speaker:

Okay, well, Alina let me turn it back to you to close us out.

>>Speaker:

Great. Thanks Jean and thanks, everyone for joining our call today. We hope that you will join us for our CMS COVID-19 office hours tomorrow, Thursday May 14 at 5:00 p.m. Eastern for a technical Q&A with our CMS subject matter experts. Please continue to direct your questions to our e-mail box which is covid-19@cms.hhs.gov again we appreciate all that you are doing for nursing home residents and their families around the country as we address COVID-19 as a nation. This concludes today's call. Thank you.

>>Speaker:

This concludes today's conference call. Thank you for your participation.