

## COVID-19 Update and Recommendations for DDSN FAQs

- **Have any deaths been attributed to any of the COVID-19 vaccines?**
  - There have been no deaths from anaphylaxis (severe allergic reaction), and no deaths from myocarditis. There have been 3 deaths from ~~the~~ thrombosis with thrombocytopenia or TTS (blood clots with low platelet count). Physicians are required to report deaths after COVID-19 vaccination to VAERS, the CDC's Vaccine Adverse Event Reporting System. CDC then reviews medical records, death certificates, and autopsy findings, if available, to determine if death was causally related to vaccine. Other than TTS, CDC has not considered any deaths causally related to the COVID-19 vaccine.
- **Just to compare to other vaccines, are there other potential complications similar to myocarditis with other vaccines?**
  - Myocarditis (inflammation of the heart muscle) has been associated with other immunizations e.g., with DTaP (diphtheria, tetanus, acellular pertussis) and influenza vaccine. The strongest association has been with the smallpox vaccine. Between 2002 and 2018, more than 2 million US armed service members were vaccinated against smallpox, as preparation against possible bioterrorism using this pathogen. The incidence of confirmed myocarditis secondary to smallpox vaccination is estimated to be 16.1 per 100,000 service members, similar to the rate for SARS-CoV-2 mRNA vaccines.
  - Smallpox vaccine-induced myocarditis is a self-limiting entity that requires supportive care (i.e., anti-inflammatory medication, medical therapy for heart failure or anti-arrhythmic therapy, if indicated). Permanent debility and death are rarely reported. The vast majority of cases of smallpox vaccine-associated myocarditis cases were self-limited, resolved completely, and did not lead to long-term cardiac dysfunction. There is no evidence at this time that myocarditis associated with SARS-CoV-2 vaccination will follow a different course.
- **Is Covid-19 endemic now, like the common cold, flu?**
  - Endemic means a pathogen is always around at a certain background rate, which can vary with the season of the year, like the common cold. It is doubtful that SARS-CoV-2 will be eradicated (like smallpox) or eliminated in the US (like polio) and will eventually become endemic. It would not be considered endemic right now – cases are surging not at a stable background rate.
- **Can you break down that 3-7 days again? Those who test positive in a home should then be tested again within 3-7 days?**
  - Per QSO-20-38 (<https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf>):
    - “For outbreak testing, all staff and residents should be tested, regardless of vaccination status, and all staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result.”

- **Is the "DHEC's Recent Activity report" in line with the CMS County Positivity Rate spreadsheet? That is what we have been using since implemented.**
  - Please follow the DHEC [Recent Activity Report per the DHEC Visitation Guidelines](#) and use DHEC's Recent Activity Report for county positivity rates (found on DHEC's [LTCF webpage](#)).
- **For DDSN, is a "consumer" a resident?**
  - Yes.
- **Should the consumers be retested if they have had COVID-19 and have been in quarantine before they resume regular activities?**
  - For consumers that have been in isolation due to being COVID-19 positive, they do not need to be retested to come out of isolation. Follow the [Discontinuation of Transmission based precautions](#) using the symptom-based strategy.
- **Are quarantine and ending transmission-based precautions different?**
  - Yes, quarantine and isolation are different. Quarantine is for close contacts of a positive COVID-19 case. Quarantine lasts 14 days since last exposure. Isolation is for those that test positive for COVID-19, it lasts 10 days past symptom onset or, if asymptomatic, 10 days since first positive test collection date. However, with Isolation, it can vary based on severity of disease and the individual's immunocompromised status. Please review CDC's guidance on [Discontinuation of Transmission Based Precautions](#) and guidance on quarantine for LTCF/Congregate settings in [CDC's Infection Control](#) guidance.
- **Some staff are wearing cloth face masks. Are cloth face masks recommended?**
  - No, staff should only wear medical/surgical facemasks while at work. Cloth face coverings are not personal protective equipment (PPE) for staff members. While staff are out in the community, they can wear cloth face coverings, but not while at work.
- **10 days and 14 days have been mentioned? What is the difference?**
  - The 10 days refers to Isolation for those that are COVID-19 positive; 14 days refers to quarantine of those who are close contacts to a COVID-19 positive case.
- **Is 60% alcohol in hand sanitizer recommended vs a minimum of 70% alcohol?**
  - Please review [CDC's Hand Hygiene Recommendations](#) for alcohol-based hand sanitizer (ABHS) alcohol amounts.
- **For returning to work, does 10 days after symptom onset or first positive test collection pertain to vaccinated or unvaccinated staff?**
  - Both vaccinated and unvaccinated staff members who test positive for COVID-19, should follow the [return-to-work criteria](#).
    - For symptomatic cases, regardless of vaccination status, they can return to work 10 days since positive test collection date or symptom onset, improvement of symptoms, and no fever for 24 hours without fever reducing medications.
    - For asymptomatic cases, regardless of vaccination status, they can return to work 10 days since positive test collection date or symptom onset.
    - For those that are severely ill or immunocompromised, please review the recommendations at CDC's [return-to-work criteria](#) guidance webpage.
- **Do you recommend virtual training whenever possible for the contracted trainers?**
  - Virtual training is a great alternative to face-to-face training in areas with moderate to substantial transmission. The success of the virtual training can be dependent on a

multitude of factors, including the online learning platform. Trainers should perform a systems check prior to training in an effort to preemptively identify any technical issues.

- **If a staff is immunocompromised and their spouse tested positive, how long should she stay out? 10, 14 or 20 days?**
  - If a staff member has a positive spouse (or other person they live with) and cannot have that spouse isolate without contact, then they are considered a household close contact. They need to be out for the spouse's entire isolation period (i.e., 10 days or as per isolation guidance) and then an additional 14 days for their quarantine (a total of the 24 days). Since staff are healthcare workers, it is recommended for them to quarantine if close contacts, unless facility is in a crisis staffing capacity and implementing CDC staffing shortage mitigation strategies.
- **Is it true that vaccinated individuals are more prone to get COVID-19 and become hospitalized versus unvaccinated?**
  - Vaccinated individuals are less likely to get COVID-19 and be hospitalized than those that are not vaccinated.
- **Please explain recommendations on rapid versus PCR.**
  - PCR, also known as polymerase chain reaction, is considered the gold standard for detection of the SARS-CoV-2 virus that causes COVID-19. The PCR was the first available and widely reliable test. Initially, rapid tests to detect SARS-CoV-2 were antigen tests, which were less specific and sensitive than PCR tests. As the need for rapid, reliable testing grew, rapid PCR tests became available. In the congregate setting, both types of tests can play a role in transmission mitigation. The rapid test, whether antigen or PCR, can provide immediate results and is most beneficial upon identification of symptomatic consumers and staff prompting response, such as implementation of transmission-based precautions or exclusion from work. The rapid tests are great when initiating the first wave of outbreak testing, providing timely results which are actionable. The PCR tests is great for either symptomatic individuals, as an alternating test type during outbreak testing, and in expanded (routine) testing of unvaccinated staff when turnaround test times are less critical. Testing for symptomatic and outbreak situations should ideally have results turned around in less than 48 hours. For more information please review CDC's recommendations for [Using Antigen Tests for SARS-CoV-2 in Congregate Living Settings](#) and [Overview of Testing for SARS-CoV-2 \(COVID-19\)](#).
- **Should the COVID-19 vaccine be mandatory for employees, based on our community's percent positivity? Instead of mandatory vaccine requirement, do you think testing all staff based on percent positive level in the county a good approach?**
  - Prevention of COVID-19 in congregate settings is more effective with a layered approach. Source control, physical distancing, vaccination, and expanded testing of staff are all effective means to prevent further transmission in congregate settings in which vulnerable individuals reside. Keep in mind that expanded, or routine testing of staff based upon the county positivity rate should already be occurring in accordance with the [CMS QSO-20-38-NH](#) and DHEC's Updated Guidelines for [Visitation](#).

- **Are you aware of any efforts of health authorities in America to try to find and/or authorize existing medications that may be effective in preventing and/or reducing effects of the virus, for example, Ivermectin? I've seen stats from places like India that tried treatments like Ivermectin with great success.**
  - There need to be randomized controlled studies to demonstrate whether Ivermectin is effective. Severe disease from COVID-19 is from a massive inflammatory reaction. That's why dexamethasone, and anti-inflammatory steroid helps when given to someone severely ill. Researchers are looking at other powerful anti-inflammatory medication (e.g., ones they use in autoimmune diseases) to see if these would help. Remember, all of these drugs, Ivermectin included, have side effects, so more studies are needed to see if benefits outweigh risks.
- **What are your thoughts on arguments from virologists, such as Dr. Robert Malone, that mass vaccination will likely drive new variants as the virus will somehow learn to evade immunity?**
  - It makes sense that the virus will evolve to become more transmissible as we have seen with the Delta variant. It's unlikely that it will evolve to evade immunity completely because that would not necessarily be in the "best interest" of the virus. Speaking anthropomorphically, the virus "wants" to spread quickly, not necessarily to induce severe disease and kill people. Vaccines reduce risk of severe disease, which can lead to worsening outcomes, including death.
- **Can you touch on visitation?**
  - Yes. In terms of outside visitation into the ICFs? Basically, guidelines for such. If that makes sense. Please see the following:
    - [CMS QSO-20-39-NH](#)
    - [DHEC's Updated Guidelines for Visitation](#)
    - [DHEC's Compassionate Care Visits Memo](#)
    - DHEC's [Closed Window Visit FAQs for Nursing Home and Assisted Living Facilities](#)
- **Are there guidelines for residents wearing mask in the facility?**
  - Yes, consumers/residents should wear face coverings (i.e., cloth masks or medical masks) if tolerated while in the facility, especially if they will be indoors in close proximity (6ft) to others.