Public Health Services
Communicable Disease Control

OCHCA Guidance on COVID-19 in SNFs 1-29-21

In Setting of a COVID Case or Outbreak

Red Unit (for COVID+)

1. **Unit set up**:
   a. Red Unit should be a distinct area separated from the rest of the facility, with a separate entrance/exit from the rest of the facility, a break room and bathroom for staff, and nursing station (could be empty room).
   b. Should have closed fire doors or plastic barriers to prevent staff or residents from moving between units; however, if plastic barriers used, need to post signs on the plastic barriers that indicate "Tear Down In Case of Emergency, Emergency Exit" as well as other requirements[1] of the fire marshall.
   c. Staff should not pass through the closed separation doors or plastic to move from one section of the facility to another; zippers, if present, should be closed, preferably taped shut (unless in case of fire, see letter b above).
   d. Place donning/doffing station at entrance to unit and by break room.
2. **PPE: Extended Use Contact and Droplet**
   a. Facemask: N95 respirator or higher level respiratory protection at all times while on unit; may only be removed in designated CLEAN area. N95 should be fit tested and staff should always perform a seal check (see #17) when donning.
   b. Face shield: worn at all times, should be removed and disinfected in clean area before breaks.
   c. Gown: same gown may be used for all patients in the event of a large/extensive outbreak, but for small number of patients, single use is best. Extended use should not be practiced if patient has MDRO (will need to change gown after MDRO care), and always doff gown before breaks or if wet/soiled, and don new gown after. In subacute units, gowns should always be changed between patients, whether or not COVID-19 outbreak is occurring, as these patients are much higher risk to have MDROs.
   d. Gloves changed and hand hygiene between each patient (gel-in and gel-out).
3. **Patient placement**:
   a. Patients can be cohorted multiple per room as long as no highly transmissible pathogen, e.g. *C. difficile*, Norovirus, *C. auris* or Influenza. Patients colonized with *C. auris* may be cohorted together within the COVID-19 unit. Patients with less transmissible and less virulent pathogens, ESBL, VRE and others may be cohorted with other patients to allow for optimal COVID-19 room allocation.
   b. Patients may exit room briefly if desired, but should be masked and must stay on unit.
   c. Patients should stay a minimum of 14 days (from date of positive test) on red unit, but should stay separated from COVID-negative population for full 28 days (can be shortened to 21 if completely asymptomatic the whole time), or until symptoms completely resolved. Full duration of time could be in red zone (to allow patient mobility and to conserve PPE), or after 14 days and symptomatic improvement, could be moved to yellow unit and cohorted with other convalescing COVID+.

[1] When located in a fire-rated corridor, the plastic material shall be flame retardant plastic in accordance with California State Fire Marshal (https://osfm.fire.ca.gov/media/3107/regulations.pdf) and CBC Section 806.7. The plastic barriers shall be placed a minimum (horizontal) distance of 4" from fire sprinklers, similar to a wall. NFPA 8.6.3.3 for pendant and upright spray sprinklers. Staff should be instructed to tear down the barriers in case of a fire or emergency.

4. **Staffing:**
    a. Dedicated staff: staff should not go from red unit to another unit on the same day; may work in different units on different days if needed.
    b. Staff in red unit should utilize separate entrance, break room and bathroom on days working in red unit.

Yellow Zone/Unit: PUIs, Close Contacts of COVID+ and Convalescing COVID+

5. **Unit set up:**
    a. Ideally adjacent to red unit, and located in one section of facility (not interspersed in green unit) for most outbreaks. Having close contacts (roommates of COVID+) and PUIs cohorted in the same area facilitates the dedication of staff to this high risk group. However, for outbreaks that are large and widespread on initial rounds of testing, creating a yellow zone may lead to excessive patient movement, so in these cases, all non-red parts of facility could be considered yellow. Determination should be made on case-by-case basis, with input from OCHCA and consideration of facility set up and number of cases.
    b. Does not require separate entrance/exit from rest of facility, but can utilize one if desired.
    c. Does not require separate break room, bathroom or nursing station, but if space available, can have these.
    d. Ensure proper signage and other visual cues to designate yellow unit space.
6. **PPE: Contact and droplet**
    a. Facemask: Fit-tested N95 or higher level of respiratory protection at all time; perform seal check when donning (see 17).
    b. Face shield: worn in patient rooms, but may be kept on at all times if staff dedicated to yellow zone. Face shield should be removed and disinfected in clean area before breaks.
    c. Gown: donned before entering rooms and doffed when exiting room; must don/doff between each patient (even if in same room). Single use of gowns is best either dispose or launder after use.
    d. Gloves changed and hand hygiene between each patient (gel-in and gel-out).
    e. NO gowns or gloves in hallway of yellow unit!
7. **Patient placement:**
    a. Cohorting:
        i. PUIs must be in single room; if initial test is negative, keep in isolation and repeat test in 24-48 hrs; test for influenza if indicated.
        ii. Close contacts of COVID+ (e.g. roommates) ideally in single room, but can be cohorted two per room with beds at least 6 feet apart, privacy curtain drawn and patients masked, if possible.
        iii. Convalescing COVID patients (beyond 14 days in red) can be cohorted multiple in same room (but NOT with COVID-negative).
        iv. If yellow zone is former observation unit, do not mix observation patients with yellow zone patients; move observation patients to green zone once 14 day test results negative.
    b. Patients may not exit rooms; DOORS CLOSED to rooms! Patients who must smoke should be masked and escorted by a staff member to a designated yellow unit smoking section, maintain social distance from others, then be escorted back to room immediately afterward.
8. **Staffing**: ideally dedicated to yellow unit, but if insufficient number of patients in yellow unit to dedicate staff, then staff should work from green to yellow.

Green Zone/Unit: COVID-negative and non-exposed patients, and for COVID+ who are beyond 28 day isolation period

9. **Unit set up**: no special guidance; rest of the facility that is not yellow or red (do not intermix yellow with green).
10. **PPE**: Enhanced Standard Precautions recommended if large/extensive outbreak; if PPE limited or outbreak small/limited, may follow standard precautions with masking at all times.
    a. Facemask: mask (surgical or N95) at all times while on unit

b. If enhanced standard precautions: single use gowns for significant patient care encounter[2].
c. Face shield: for significant patient care encounter[2], if splashes possible, or when collecting COVID tests. Extended use OK, but should be removed and disinfected in clean area before breaks.
d. Gloves changed and hand hygiene between each patient (gel-in and gel-out).

11. **Patient placement**:
    a. Try to keep patients in room as much as possible; if outside room, should be masked and socially distanced.
    b. Keep green patients from wandering into yellow and red zones.
12. **Staffing**: green staff should not work in red unit on same day (or vice versa), and if needed to work on yellow, work from green (clean) to yellow.

In Setting of No COVID Cases or Outbreak (Or Resolved Outbreak)

13. **Red unit:** if resolved outbreak, should be maintained as above until last patient removed from unit, then it should be thoroughly disinfected before being put back into service.
14. **Yellow unit:** if resolved outbreak, should be maintained as above until last patient removed from unit.
    a. Do not place newly admitted patients into yellow unit with convalescing COVID+.
    b. If no prior outbreak, attempt to maintain one empty room to place PUI if necessary, and locate it where a red or yellow unit might be established in the event of an outbreak.
15. **Observation/new admission unit** (prefer this term to "yellow unit" to avoid confusion with yellow unit in outbreak)
    a. **Unit set up**: no specific guidance, but should be one section of facility, not interspersed with green
    b. **PPE**: Enhanced Standard Precautions[3] at a minimum, ideally droplet and contact if PPE allow.
        i. Facemask: Fit tested N95 at all times; perform seal check after donning.
        ii. Gowns for significant patient care encounter[2].
        iii. Face shield: for significant patient care encounter[2], if splashes possible, or when performing potential cough/sneeze inducing procedures such as obtaining nasal swab. Extended use OK, but should be removed and disinfected in clean area before breaks.
        iv. Gloves changed and hand hygiene between each patient contact.
    c. **Patient placement:**
        i. Single rooms best, but if space not sufficient, cohort new admissions by similar date of admission (i.e., admission dates ideally within 2-3 days of each other, no more than 4 days).
        ii. Ideally keep patients in room as much as possible (in-room therapy and treatments).
        iii. If out-of-room therapy needed, patient should change gown, wear a mask, sanitize hands, socially distance, limit time in therapy room/hallway, and equipment should be sanitized after use.
    d. **Staffing**: dedicated staff if possible; if not, have staff work from green to observation.
16. **Green unit:**
    a. **Unit set up**: no special guidance; consists of rest of the facility that is not red, yellow or observation unit
    b. **PPE**: standard precautions:
        i. Surgical mask at all times.
        ii. Minimum of standard precautions for all; contact precautions as indicated for C. diff or MDROs.
        iii. Consider use of enhanced standard precautions for residents who have one or more risk factors for MDRO; single use of gown.
    c. **Patient placement**: as per usual; patients may leave their rooms, but should wear a mask when in a common area, keep socially distanced from other residents and staff, and stay out of observation area, yellow and red units.

[2] Significant patient care encounter is having significant environmental or body contact, such as bathing, dressing, transfers, toileting, or wound care.

[3] CDPH and CDC advise droplet and contact precautions for new admits.

d. **Staffing**: green staff should not work in observation unit if possible, but if needed to work on observation unit, work from green (clean) to observation.

General Notes on PPE Use

17. Mask use:

a. CDC recommendations state that N95s are preferred over surgical masks for confirmed or suspected COVID, but that surgical masks are acceptable, except when performing AGP (N95s required for AGP). Cal/OSHA requires that NIOSH-certified N95s be used for any occupational exposure to COVID+ if no critical shortage exists. Considering the emergence of new COVID variants that are more highly transmissible, OCHCA agrees with CDC and Cal/OSHA requirements.

b. For all types of mask, fit and consistency and correctness of use are very important. N95 masks come in many different types and sizes, so fit testing should be performed to ensure adequate seal.

   i. Each HCW should be assessed visually by IP/DSD for fit of mask, trained on proper donning and doffing, observed for compliance and need for adjusting mask during work, and educated on the importance of hand hygiene before putting on mask, after doffing mask and after touching mask.

   ii. A quick seal check should be performed with each donning of an N95 mask to ensure effective seal and filtration https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf.

   iii. In areas where a N95 is not required, a surgical mask may be better than an ill-fitting KN95 that the HCW must constantly touch to adjust!

c. Facilities using N95s can follow CDC's guidance for extended use and limited reuse if supplies limited https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/decontamination-reuse-respirators.html However, **Cal/OSHA recommends single use unless facilities have inadequate supplies, and facilities must document their failed attempts to procure more**.

d. Facilities using N95s are required by Cal/OSHA to do fit testing and have a respiratory protection program; therefore, **facilities should pursue qualitative fit testing to ensure adequate fit as soon as possible**.

e. Staff using two masks, or double-masking, should be discouraged. The double-masking strategy provides no additional protection, wastes PPE resources, and increases risk of self-inoculation.

18. Gown use:

a. Due to inconsistent supplies of disposable gowns, facilities are encouraged to purchase long sleeved, washable cloth gowns to ensure an adequate supply.

b. Facilities should bundle care activities to preserve supply of gowns. Ideally, gowns should be single use, being washed or discarded after each use.

   i. In periods of severe shortage, (crisis level) the facility can assign one gown per HCW per patient per shift (unless in SNF red zone, where one gown per HCW for all patients is allowable for large outbreaks), but minimize numbers of times donned and doffed as each reuse can lead to possible contamination.

   ii. Gowns must be doffed and discarded or laundered if soiled or wet, and at end of shift.

   iii. Extended us of gowns on red unit allowed if supplies insufficient or if high numbers of COVID+ patients and whole unit is considered contaminated, but gowns must be doffed and discarded or laundered if soiled or wet, before breaks, and at end of shift .

c. Full body suits/rain jackets not advised; high risk for self-contamination when doffing. Additionally, the blue plastic ("trash bag") gowns have a high risk for self-contamination, so should be utilized only if no other alternative available.

19. Other PPE Practices:

a. Staff should be able to demonstrate proper doffing of PPE to avoid self-contamination.

b. Shoe coverings should be discouraged as they pose a fall hazard and may increase risk of self-contamination.

c. Hair coverings not necessary and may increase risk of self-contamination when doffing. Hair that is long should be secured so it does not contact the patient care area.

d. Shoe decontamination or shoe cleaning stations are not necessary.

Other COVID-Related Recommendations

20. Preventing Staff-to-Staff Transmission

a. Some outbreaks have started when a cluster of staff infections occurred; these clusters may have occurred due to staff-to-staff transmission during breaks.
b. It is critical to ensure that staff maintain social distancing during breaks and meal time. Stagger break and meal times to reduce numbers in break rooms, create new break areas (outside ideal) to increase space, and increase ventilation in break areas.
c. If tables are less than 6 feet in size, allow only one person per table, and ensure tables are 6 feet apart. If tables are 6 feet or greater, mark distancing for seating.
d. Ensure there is a supply of hand sanitizer easily available, sanitizing wipes for face shields and surfaces, as well as bags or paper towels in/on which to store/place masks and face shields.
e. Avoid holiday gatherings for staff.

21. Return to work: OCHCA recommends the following for staff who test COVID+:

a. If asymptomatic, stay out of work for minimum of 10 days. Can return to work sooner if needed, but should provide care only for COVID+ patients, and should maintain social distancing at all times from COVID-negative staff. If symptoms develop at any time, should leave work immediately and isolate at home.
b. If symptomatic, must be off work for a minimum of 10 days after symptom onset, have symptom improvement and be afebrile for one day. Consider extending leave from work to 14 days if symptoms still significant.
c. Test-based strategy for clearance not recommended.

22. Response-driven testing

a. CDPH recommends testing all COVID-negative residents every 7 days until two sequential negative rounds of testing if a single case is identified in either a resident or staff member (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-53.aspx), but allows for more focused testing if testing capacity insufficient to test all serially (see AFL for more details).
b. Previously COVID+ residents and staff should not be retested for at least 3 months; beyond that time, residents and staff members should be included in response-driven testing, if indicated. If resident or staff member tests positive again after 3 months, but has no defined COVID exposure and no symptoms, positive test may be residual of prior infection. Contact PHN Liaison to discuss management and isolate the resident or staff member until results of further testing at PHL are available.
c. OCHCA agrees with testing all residents every 7 days until two negative sequential rounds if a single case is identified in a resident until two sequential negative rounds recommended.
    i. If a new admission tests positive for COVID within the first few days of admission, that is likely infection acquired prior to admission. If new admission tests positive at 14 days, more difficult to tell if infection was acquired in facility or outside. Either way, response testing of all residents is indicated to ensure that there was no transmission to other residents or staff.
    ii. If further transmission documented, then continued testing of whole facility indicated.
d. Performing response-driven testing as recommended by CDPH for a single staff case may necessitate frequent weekly testing of all residents, which may not be feasible in some situations.
    i. According to CDPH, response testing of residents not needed if staff member had no resident contact.
    ii. When a single case is identified in staff member with resident contact, if testing capacity is limited, OCHCA recommends at a minimum to test all close contacts (patients cared for by staff member, or section of facility staff worked in) two sequential rounds 7 days apart.
    iii. If further cases are identified as a result of this contact testing, then testing of all residents indicated.

iv. For a cluster of staff infections, test all residents.

23. Screening testing for residents and staff:

a. CDPH recommends testing of 100% of staff at least weekly, twice a week if county testing positivity rate is > 10%; OCHCA additionally recommends testing of new staff on hire. Previously COVID-positive staff should be added into testing rotation 3 months after their positive test.

b. CDPH recommends testing of admissions from the hospital at baseline (upon admission or within 2 days prior to admission) with quarantine and repeat testing at 14 days; OCHCA also recommends this for admissions from the community or other facilities.

   i. **Consider testing new admissions at 7 days as well as 14 days** to detect potentially incubating infection at an earlier date and to limit potential transmission. In times of high community transmission, test at 5 and 10 days.

   ii. Quarantine and retesting of prior COVID+ patients after hospitalization is not required within 3 months of COVID diagnosis; these patients may be admitted straight to green unit if more than 28 days has elapsed since symptom onset and the patient is asymptomatic.

   iii. Previously positive residents should be quarantined and retested after hospitalization if 3 months have elapsed since their COVID diagnosis.

c. OCHCA also recommends additional screening testing of certain high risk residents:

   i. Test residents who leave the facility on a regular basis (e.g., hemodialysis patients or patients who have radiation therapy or frequent medical visits outside of the facility) every 2-4 weeks.

   ii. Additional consideration should be given to testing highly mobile/social patients (those who interact with a large number of staff or residents) periodically.

24. COVID-19 Testing

a. PCR: preferred testing strategy to detect virus

   i. Sensitivity is about 80%, so if a PUI tests negative initially, keep in isolation or off work and repeat test in 24-48 hours.

   ii. Test-based is clearance not recommended by CDC or OCHCA. People generally become non-infectious 10-20 days after onset of symptoms, but test may remain positive up to and beyond 3 months; prolonged positive tests do not indicate infectious virus.

b. Rapid Antigen tests: current Association of Public Health Laboratories (APHL) and CDPH guidance state:

   i. For use in **symptomatic people in high prevalence population** (e.g. PUI) only.

   ii. Sensitivity is lower than PCR, but specificity very good; do not need to confirm positives in symptomatic cases, especially in a setting of an outbreak. However, since antigen positive cases are considered “probable” instead of “confirmed”, if resources allow, confirm with PCR. Additionally, if not in an outbreak setting or known source of COVID exposure, confirm with PCR. A negative result in a symptomatic person is considered “presumptive”, so any **PUI (patient or staff) who tests negative on rapid antigen must be retested using PCR.**

   iii. Although CDC and CMS guidance on use of antigen tests allows for serial screening of asymptomatic unexposed individuals, given the lower sensitivity of antigen tests, current levels of community transmission, and relatively good availability of PCR testing for staff, OCHCA feels that PCR testing is the better option. However, rapid antigen is a good option for second weekly test if PCR resources limited. However, in the setting of an outbreak, PCR testing must be used, so facilities using rapid antigen testing for staff screening testing should maintain an agreement with a commercial lab for PCR testing. Additionally, false positive rapid antigen tests have recently been seen in staff who are asymptomatic and have no history of COVID exposure; consider retesting with PCR in these situations to confirm result.

   iv. CMS mandates that all rapid antigen test results be reported to Public Health; see https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/CalREDIE_Manual_Laboratory_Reporting_Module.pdf for more information on reporting via CalREDIE.

25. **Environmental Cleaning**:
    a. Facilities with subacute units or with known cases of *C. auris* in their facility should be using K list agents to ensure adequate disinfection.
    b. N list agents for COVID are not sufficient to eradicate *C. auris*.
26. **Visitation Guidelines:** please see separate guidance for visitation and activities at https://occovid19.ochealthinfo.com/guidance-long-term-care-facilities-ltcfs-and-residential-care-facilities-elderly-rcfes