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# PUBLIC HEALTH SERVICES
## COMMUNICABLE DISEASE CONTROL

## OCHCA Guidance on Prevention and Management of COVID-19 IN RCFEs 3-14-22

The availability of COVID-19 vaccines greatly reduced the impact of COVID on older adult facilities for a period of several months. However, the recent emergence of the highly transmissible omicron variant has been causing infection in fully vaccinated individuals and has led to outbreaks in facilities again. Although most fully vaccinated individuals who get infected with COVID -19 do not have severe symptoms, many have mild, cold-like symptoms and can transmit the virus to others. Therefore, continued vigilance for signs and symptoms of COVID-19 among both residents and staff, regardless of vaccination status, is very important, and licensees must be able to isolate suspects and test quickly. COVID-19-related mortality rate in older adults in residential care facilities for the elderly (RCFEs) prior to the availability of vaccine was about 20%; the mortality with omicron has been lower, but is still substantial. Many RCFEs did not have to deal with COVID during the first two waves, so it is important to remember that the disease can manifest with a variety of symptoms, often leading to delayed recognition, and to continue to educate staff (especially new staff) on recognition of symptoms and appropriate infection prevention practices.

The following guidance from the Orange County Health Care Agency (OCHCA), which provides public health services to the County of Orange, is based on experience from hundreds of outbreaks in skilled nursing facilities (SNFs) and RCFEs, as well as recommendations from state and national authorities. This guidance should be considered as recommendations as local public health does not have regulatory authority over RCFEs; however, we work closely with the Community Care Licensing Division (CCLD) regional office and they often defer to OCHCA's recommendations on disease control. Please contact your LPA if any clarification needed, or visit the COVID Landing Page, which has the COVID-related PINs separated by topic: https://www.cdss.ca.gov/inforesources/cdss-programs/community-care-licensing/covid-19-information-and-resources/covid-19-asc-pins . Many RCFEs have been able to adequately care for their COVID+ residents onsite following this guidance.

### I. Prevention and Mitigation of COVID Spread

a. Visitors: All visitors (essential or nonessential) should be pre-screened with temperature and review of COVID symptoms and should not be allowed in if fever or symptoms present. Recommendations about visitation have been changing frequently; please refer to latest PIN on visitation (21-17.2).

b. Symptom screening: temperature check and review of symptoms should be performed for all staff prior to start of shift, and for residents as indicated (e.g. 3 times per day if recent COVID exposure, or at least daily if facility experiencing an outbreak). Remember that **older adults may not have the classic symptoms of COVID** (fever and cough), but can present with more mild or less common symptoms, such as the following:

i. Cold/flu symptoms: lower grade fever (99.2 – 99.3), sore throat, runny nose, headache and/or muscle aches; these symptoms, and dry cough, are common symptoms seen in vaccination-breakthrough infections
ii. Gastrointestinal symptoms: nausea, vomiting or diarrhea, diminished appetite
iii. Weakness or falls
iv. Loss of sense of taste or smell
v. Confusion, altered mental status
vi. Neurologic symptoms (stroke)
vii. Behavioral changes: increased agitation, sudden sadness, reduced activity
viii. Be vigilant for any change in status, and if change noted, test right away. If test negative, but suspicion for COVID-19 is high, repeat test in 1-2 days.

c. Cancellation or modification of group activities/communal meals: activities and communal meals should be canceled or at least modified if there is a large cluster of residents infected with COVID in the facility, because other residents may be incubating COVID and spread the virus further, even without symptoms. Dining and activities may be resumed once transmission has decreased.
d. Social distancing and masking:
   i. Residents: regardless of vaccination status, should wear masks and avoid crowds and poorly ventilated indoor spaces (per PIN 21-49, https://www.cdss.ca.gov/Portals/9/CCLD/PINs/2021/ASC/PIN-21-49-ASC.pdf )
   ii. Staff: surgical mask must be worn at all times in the facility (per PIN 21-32-ASC, https://www.cdss.ca.gov/Portals/9/CCLD/PINs/2021/ASC/PIN-21-32-ASC.pdf ), and maintain 6 feet distance as much as possible.
e. Hand hygiene: encourage frequent hand hygiene, either hand washing or alcohol-based hand sanitizer (non-alcohol-based hand sanitizer, such as benzalkonium chloride, not recommended for COVID) for both staff and residents.
f. Environmental cleaning/disinfection: regularly scheduled cleaning and disinfection with EPA-listed disinfectant of frequently touched surfaces in common areas. Be sure to follow the product label and maintain the proper contact time. Dirty surfaces should be cleaned with soap and water or other cleaning agent before disinfection.
g. Testing of staff: see IV.c, page 4.
h. Testing and quarantine of new/returning residents: See IV.b, page 4.

## II. Management of COVID-19 Suspects (called "Persons Under Investigation", or "PUIs")

a. A PUI is somebody who is exhibiting symptoms possibly consistent with COVID. Licensees should be aware that even fully vaccinated staff and residents can develop COVID infection, and that symptoms of breakthrough infection may be mild, such as sore throat, runny nose, headache or dry cough. Such symptoms should not be considered as "a cold" without having testing done for COVID-19 first.
b. Resident:
   i. Isolate PUI in a single room (ideally) and test as soon as possible. Many facilities have rapid antigen testing available, but the sensitivity is not as good as PCR, so if rapid antigen is negative, it does not rule out COVID. The resident should remain in isolation and have a specimen for PCR sent, or repeat rapid antigen in 48 hours. If repeat specimen(s) also negative, for the health and safety of other residents, it is best to keep the resident away

from others until symptoms improve, as other viruses may be causing the symptoms. Call OC Public Health at 714-834-8180 to facilitate PCR testing, if needed, or send to commercial lab if turnaround time is good (72 hours or less).

ii. Use full personal protective equipment (PPE) including gown, gloves, face shield and N95 respirator, when dealing with PUI; remove gown and gloves after contact and perform hand hygiene.

iii. Doors closed to room; DO NOT let resident out of room to mingle with other residents (even if symptoms resolve) before test result back.

c. Staff:

i. Remove from work immediately (or instruct them not to come to work) and test as soon as possible. Call OC Public Health at 714-834-8180 to arrange testing, if desired, or test with commercial lab with quick turnaround time (< 72 hours), or refer to community testing resources (see https://occovid19.ochealthinfo.com/covid-19-testing).

ii. DO NOT let staff member back to work before test result back, even if symptoms improve.

iii. If initial test negative, but high suspicion for COVID, keep off of work and retest days (see II.b.i. above).

## III. Management of COVID+ or COVID-Exposed Residents or Staff

a. COVID+ Resident:

i. Isolate in room and monitor by doing vitals, pulse oximetry and review of symptoms (see I.b. above) 3-4 times per day.

ii. Consider transfer to ER (if not on comfort care) for following changes:

1. Fast breathing/shortness of breath or oxygen saturation below 95%
2. Fast pulse rate (>100-110), or systolic blood pressure that is below 110 or is much lower than their normal
3. Significantly decreased oral intake (skipped multiple meals or not drinking sufficient fluids), vomiting, or diarrhea that is moderate to severe
4. Change in mental status/confusion, neurologic symptoms
5. Prolonged high fevers
6. Moderate to severe weakness or a fall
7. Chest pain

iii. Review end-of-life wishes to determine further actions if resident decompensates; COVID is hospice-qualifying condition and mortality of COVID in unvaccinated older adults is >10%.

iv. If multiple residents infected, consider creating a COVID or "red" unit (see III.d. below); can have multiple positive residents in same room if needed.

v. Ideally, dedicate staff who are up to date with COVID vaccination to care for COVID+ (that is, staff work only with COVID+ each shift; may work with COVID-negative on other days, but do not float between COVID+ and COVID-negative on same day). If multiple positive residents on site, consider having licensed medical staff to help monitor.

vi. Use full PPE (N95, gown, gloves, and face shield; see V below) when giving care to COVID+ residents; if staff only caring for COVID+ residents, may practice extended use of PPE (same respirator, gown and face shield used whole shift), but change gloves and perform hand hygiene between patients. Must remove PPE and perform hand hygiene before breaks, and must discard gown if soiled or wet. See V for more information.

vii. Release of COVID+ residents from isolation

1. CDC recommends time or symptom based clearance from isolation; 10 days from symptoms onset or positive test for mild to moderate illness, 20 days from symptoms onset if severe disease or if immune system compromised. Resident should have no fever for at least 24 hours and symptoms improved before release from isolation. For more information, see https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html. **CDC and CDSS do not recommend retesting COVID+ residents to determine clearance from isolation**.
2. Shortened isolation periods recommended by CDC for general community do not apply to the high risk setting of a congregate older adult living facility.

b. Roommates or close contacts of COVID+ residents
   i. "Close contact" means being within 6 feet for 15 minutes or longer without PPE (cloth face coverings do not count as PPE).
   ii. Unvaccinated roommates of a person with COVID have a 50-75% chance of becoming COVID+; more difficult to estimate risk for non-roommate close contacts or roommates who are up to date with COVID vaccination.
   iii. Roommates (regardless of vaccination status) of COVID+ need to be **quarantined in a single room and tested via PCR at day 5-7 days after last contact with COVID+**; **do not let them leave room** and roam about the facility! If result of test at day 5-7 after last contact is negative, and no symptoms have developed, resident can be released from quarantine.
   iv. Exposed residents should be monitored 2-3 times per day with vitals and symptom check; test immediately if symptoms develop.
   v. Staff should use full PPE when dealing with these close contacts.

c. COVID+ Staff:
   i. Isolate at home.
   ii. Return to work: based on vaccination status and staffing needs; please see table on pages 3-4 in PIN 22-09-ASC https://www.cdss.ca.gov/Portals/9/CCLD/PINs/2022/ASC/PIN-22-09-ASC.pdf

d. COVID-Exposed Staff
   i. High risk exposure is defined as being within 6 feet for 15 minutes or longer without appropriate PPE (N-95 and face shield).
   ii. Any exposed staff member who develops symptoms (even mild), regardless of vaccination status, should be removed from work immediately and tested.
   iii. Quarantine and work restrictions based on vaccination status and staffing levels; please see table on page 5 of PIN 22-09-ASC https://www.cdss.ca.gov/Portals/9/CCLD/PINs/2022/ASC/PIN-22-09-ASC.pdf

e. "Red" Unit/Zone:
   i. RCFEs have created red units by subdividing a wing (e.g., closing fire doors or putting in a temporary wall or barrier to separate positive residents), or by utilizing a vacant wing or vacant apartments.
   ii. Ideally 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, if possible. Also, a separate break room and bathroom for staff (could be an empty room or part of an apartment) is advisable. Staff should not use resident restrooms in a COVID unit and should be encouraged to take breaks outside to avoid having to take off mask while in unit. .

iii. COVID+ residents should not be allowed to have contact with COVID-negative residents; if plastic barriers used to contain them, need to post signs on the plastic barriers that indicate "Tear Down In Case of Emergency".

iv. Residents may leave their rooms in a COVID unit (ideally, they should be masked); HCW should use N95, gown and face shield at all times, and gloves for any contact with body fluids. Staff should perform frequent hand hygiene, and remove all PPE in a "clean area" (e.g. break room) or change PPE if caring for non-COVID residents, sanitize face shield and perform hand hygiene after doffing

v. Creating a red unit allows residents to get more exercise and social interaction, which helps prevent social isolation and may assist in recovery.

## IV. Testing for COVID

a. Types of COVID Tests:

i. PCR tests are the preferred type of test, ideally from a nasal specimen; throat specimens are less sensitive (not as good at picking up infection) and saliva or oral-based specimens are now available, but data on these is mixed and experience is limited. Additionally, older adults may suffer from dry mouth and not be able to produce enough saliva for test, or may not be able to comply with specimen collection if cognitively impaired.

ii. Rapid antigen tests are now being used in many facilities; these tests can detect a part of the virus and result in 15 minutes. These tests are not as sensitive as PCR (may only detect 15-30% of early infections), but perform reasonably well in people who have had COVID symptoms for several days (about 90% sensitive at 48 hours), and if positive in a symptomatic person, likely indicate active COVID infection. However, if a rapid antigen is negative, it does not rule out COVID infection; ideally, a PCR should be performed, or at least repeat the rapid antigen in 2 days. They are not as good at picking up asymptomatic infection (e.g. for screening of staff or visitors without symptoms). For more information in use of these tests, see https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/APHL-SARSCov2-Antigen-Testing-Considerations.pdf

iii. Blood tests should not be used to test for active COVID infection.

b. Testing Residents:

i. At a minimum, test new residents, any resident who has been cared for by a COVID+ staff member, was a close contact of a COVID+ person, or who has symptoms suggestive of COVID.

ii. In the event that a resident or staff member is diagnosed with COVID, perform response testing of COVID-negative residents every 5-7 days until two negative sequential rounds of testing in both residents and staff over 14 days as per PIN 21-32-ASC https://www.cdss.ca.gov/Portals/9/CCLD/PINs/2021/ASC/PIN-21-32-1-ASC.pdf; may need to test more frequently in a high risk setting (e.g. memory care unit, or MCU). A negative test only means negative that day (and time); if symptoms develop, test again, even if not due for testing -- do not wait for next scheduled round of testing!

iii. Testing of new residents (see iv. below for new residents admitted from hospital/SNF): ensure that any new resident has tested negative for COVID prior to move in (ideally within 48-72 hours prior to move-in day). Although quarantine of new admissions is no longer recommended per PIN 21-17.2, in higher-risk settings (e.g. memory care unit, or all areas

when transmission in community is widespread), consider quarantine of newly admitted residents and repeat the test at 5 days; do not allow resident to socialize with others until repeat test is back. If symptoms develop anytime during the quarantine period, test immediately.

1. A COVID+ resident who has fully recovered from the illness, passed the time or symptom-based clearance period, and who is within 3 months of COVID diagnosis can move in directly without quarantine or testing. PIN 21-17.2 states all new admissions "should" be tested prior to moving in, but such recently infected individuals may continue to test positive via PCR for up to 3 months after initial infection, and such residual positive tests do not indicate infectiousness. Rapid antigen is much less likely to be persistently positive.
2. A resident who was diagnosed with COVID-19 more than 3 months ago should be considered for testing, although some may continue to have residual positive test from their initial infection even up to 4-5 months after diagnosis.

iv. Testing of residents returning from hospitals/SNFs: although not specifically required in the PINs, during surges, there is unrecognized transmission in hospitals, so some hospitalized patients are returning to facilities with incubating COVID. At a minimum, residents returning from the hospitals should be monitored closely for development of any COVID-related symptoms, and consider testing at 5 days for residents who return from hospitals and SNFs during times when COVID transmission is high in the community. Unvaccinated residents are at highest risk for getting and transmitting COVID, so could consider quarantine until 5 day test result back.

v. Regular surveillance testing otherwise not recommended for all residents, but consider testing those who leave facility to go to high risk medical settings (e.g. dialysis) on a regular basis.

c. Testing of Staff:

i. Test those who have cared for a COVID+ resident and close contacts to COVID+ and anybody who has symptoms suggestive of COVID. Also consider testing new staff prior to hire.

ii. In, the event that a resident or staff member is diagnosed with COVID, test all COVID-negative staff every 5- 7 days until two sequential negative rounds of testing in both residents and staff over 14 days; if symptoms develop, test again, even if not due for testing -- do not wait for next scheduled round of testing!

iii. In non-outbreak setting, testing of all staff who are unvaccinated must be done weekly per PIN 22-05-ASC https://www.cdss.ca.gov/Portals/9/CCLD/PINs/2022/ASC/PIN-22-05-ASC.pdf. Staff who were previously COVID+ should not be tested for 3 months after their diagnosis, but after that time should be returned to the regular surveillance testing.

## V. Personal Protective Equipment (PPE)

a. Mask use: Cal/OSHA now mandates that any staff member caring for known or suspected COVID patient must use a N95 respirator, per the Emergency Temporary Standards issued on November 30, 2020 (https://www.dir.ca.gov/title8/3205.html). These Emergency Temporary Standards require a written COVID-19 Prevention Plan, including free COVID testing for employees during

their work hours, and respiratory protection according to the California Code of Regulations Title 8, Section 5144 (https://www.dir.ca.gov/title8/5144.html)

i. The most important factors in considering which type of mask to use is fit, consistency and correctness of use. Note that OSHA does not consider KN95s as equivalent to N95s; any N95 used should be NIOSH-certified.
    1. Each HCW should be assessed visually 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/adjusting mask.
    2. 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.
    3. Fit testing of staff who will need to care for COVID+ residents should be pursued as soon as possible.
    4. N95 respirators should never be altered including alteration of straps.

ii. N-95s may be reused during shift if staff member is caring for residents of same exposure/infection status, but it should be discarded at end of shift or if damaged, wet or soiled.

b. Gown use:
    i. Due to previous shortages of disposable gowns, facilities are encouraged to purchase long sleeved, washable cloth gowns.
    ii. Gowns should be single use, being washed or discarded after each use.
    iii. If staff is working only with COVID+ residents, gowns may be used for extended periods (for several patients) in a red zone (see III.d. above) as long as patients do not have any drug-resistant bacteria. However, gowns must be doffed and discarded or laundered if soiled or wet, before breaks, and at end of shift. If COVID+ resident rooms are scattered throughout facility, it is best to doff gown upon exiting a resident's room to avoid contaminating the rest of the facility.
    iv. Use of full body jump suits or rain jackets are not advised; these pose a high risk for self-contamination when doffing.

c. Other PPE Practices:
    i. Staff should be able to demonstrate proper doffing of PPE to avoid self-contamination; CDC videos on proper technique can be found at:
        1. Donning: https://www.youtube.com/watch?v=H4jQUBAlBrI
        2. Doffing: https://www.youtube.com/watch?v=PQxOc13DxvQ
        3. Don't forget to sanitize hands before putting on and after taking off gloves, and after touching/adjusting mask or face shield.
    ii. All PPE should be removed during breaks, with masks (if to be reused) stored in open-to-air baggy and face shield disinfected and hung to dry. Break rooms should have hand sanitizer and sanitizing wipes available for staff to use, and appropriate area for storage of PPE.
    iii. Shoe coverings should be discouraged as they pose a fall hazard and may increase risk of self-contamination.
    iv. 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.