# OCHCA Guidance on COVID-19 in SNFs 3-8-22

## In Setting of a COVID Case or Outbreak

### Red Unit (for COVID+)

1. **Unit set up**:
   a. If small number of COVID cases, do not necessarily need to set up COVID unit; can cohort in one or two rooms.
   b. If large numbers of cases, or potential for large outbreak, set up a Red Unit in 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).
   c. Should have some kind of separation to keep residents and other staff from moving between units (e.g. closed fire doors or plastic barriers). 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. Plastic barriers are controversial (according to CDPH); ideally, assess to ensure that it does not affect airflow in a negative way.
   d. Staff should not pass through the closed separation doors or plastic barrier 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).
   e. Recommend negative air pressure gradient for rooms in Red Unit, if possible; this can be facilitated with creating air flow from hall into rooms by damping down air register in room, or turning on bathroom exhaust fans. Negative pressure can be verified by using smoke tube or tissue test: a capsule of smoke or a tissue is placed near the bottom of the door; if the smoke or tissue is pulled toward/under the door, the area is negatively pressurized. Alternatively, if a plastic barrier is used, billowing of the plastic barrier into the red unit would also indicate a negative pressure gradient. If negative air pressure cannot be obtained, consider using portable HEPA filters.
   f. Doors to rooms should be kept closed as much as possible to prevent infectious aerosols from entering hallway; try to keep residents in rooms.
2. **PPE: Contact and droplet**[2]
   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 or if splashed/soiled.
   c. Gown: no extended gown use; single use of gowns only (dispose or launder after each resident care episode.
   d. Gloves changed and hand hygiene between each resident (gel-in and gel-out).

[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.

[2] Respiratory protection must be for airborne (i.e., particulate respirator or higher level of protection), but airborne infection isolation room (AIIR) not required.

e. No gowns and gloves in hallway!

3. **Resident placement**:
   a. Residents can be cohorted multiple per room as long as resident does not have other highly transmissible pathogen, e.g. *C. difficile*, Norovirus, *C. auris* or Influenza. Residents colonized with *C. auris* may be cohorted together within the COVID-19 unit. Residents with less transmissible and less virulent pathogens, ESBL, VRE and others may be cohorted with other residents to allow for optimal COVID-19 room allocation. COVID+ residents should not be left in a room with a COVID negative resident, even if the COVID+ resident is asymptomatic or if it has been several days since test was obtained.
   b. Residents should stay a minimum of 10 days (from date of positive test or symptom onset) on red unit. If resident unvaccinated or very ill, should stay separated from COVID-negative population for 14-20 days, or until symptoms significantly improved.
4. **Staffing:**
   a. Dedicated staff: ideally, staff should not go from red unit to another unit on the same day; may work in different units on different days if needed. If outbreak small and insufficient staff to have dedicated staff for red zone, can possibly have staff care for both red and yellow patients, but should fully change PPE and do careful hand hygiene between.
   b. Vaccination status: ideally, staff working here should be up to date with COVID vaccination; if not fully vaccinated, utilize COVID-recovered staff.
   c. Staff in red unit should utilize separate entrance, break room and bathroom on days working in red unit. Consider having outdoor break area, or if indoor only, increase ventilation and/or utilize portable HEPA filter.

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

5. **Unit set up:**
   a. No longer needs to be a distinct area to which exposed residents are moved. However, if residents are symptomatic, they should be moved to a separate area pending test results. Having close contacts (roommates of COVID+) and PUIs cohorted in the same area facilitates the dedication of staff to this high risk group, so many facilities will turn a whole unit or area yellow if a case has been identified or if a positive staff member exposed many residents in one area. Avoid excessive and/or unnecessary movement of exposed residents.
   b. Does not require separate entrance/exit from rest of facility, but can utilize one if desired.
   c. If possible, modify airflow to create slight negative pressure (air flows from hallway into room) and keep doors closed with residents in the room as much as possible.
   d. Does not require separate break room, bathroom or nursing station.
   e. Ensure proper signage and other visual cues to designate yellow unit space.
6. **PPE: Contact and droplet[3]**
   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 resident rooms, or whenever interacting with resident but may be kept on at all times if staff dedicated to yellow zone. Face shield should be removed and disinfected if splashed or soiled, and before breaks.
   c. Gown: donned before entering rooms and doffed when exiting room; must don/doff between each resident (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 resident (gel-in and gel-out).
   e. NO gowns or gloves in hallway of yellow unit!
7. **Resident placement:**

[3] Respiratory protection must be for airborne (i.e., particulate respirator or higher level of protection), but airborne infection isolation room (AIIR) not required.

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 or more per room with beds at least 6 feet apart, privacy curtain drawn and residents masked to reduce potential exposure to roommates, if possible.
    iii. Do not mix newly admitted residents with yellow zone residents in same room; move observation residents to green zone per current CDPH recommendations.
b. Residents should not exit rooms; DOORS CLOSED to rooms! Residents who must smoke or wish to spend time outdoors should perform hand hygiene, be masked and escorted by a staff member to a designated yellow unit smoking/outdoor section, maintain social distance from others, and be escorted back to room immediately afterward.

8. **Staffing**: ideally dedicated to yellow unit, but if insufficient number of residents in yellow unit to dedicate staff, then staff should work from green to yellow. Avoid using unvaccinated staff in yellow area if possible.

### Green Zone/Unit: COVID-negative and non-exposed residents, and for COVID+ who are beyond isolation period

9. **Unit set up**: no special guidance; rest of the facility that is not yellow or red. In facilities with large outbreaks, there is no green zone; consider everything that is not red as yellow.
10. **PPE**: Enhanced Standard Precautions recommended if large/extensive outbreak; at a minimum, follow standard precautions with masking at all times.
    a. Facemask: mask (surgical or N95) at all times while on unit; current guidance recommends using N95s if an outbreak has occurred.
    b. If enhanced standard precautions: single use gowns for significant resident care encounter[4].
    c. Face shield: for significant resident care encounter[4], if splashes possible, or when collecting COVID tests. Extended use OK, but should be removed and disinfected in clean area before breaks. **Note**: CDPH recommends face shield for all resident care if community transmission is substantial or high according to CDC COVID Data Tracker https://covid.cdc.gov/covid-data-tracker/#county-view
    d. Gloves changed and hand hygiene between each resident (gel-in and gel-out).
11. **Resident placement**: Keep green residents 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 if possible.

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

13. **Red unit:** if resolved outbreak, should be maintained as above until last resident removed from unit, then it should be thoroughly disinfected before being put back into service. Do not need to maintain a red unit, but must be able to stand it up quickly if needed.
14. **Yellow/exposed area:**
    a. Maintain as yellow until residents have completed recommended testing and quarantine period, then turn back to green.
    b. Attempt to maintain one empty room to place PUI if needed.
15. **Yellow/observation unit**: this is for new admissions who require quarantine and testing as per current recommendations.
    a. **Unit set up**: no specific guidance, but should be one section of facility, not interspersed with green
    b. **PPE**: droplet and contact; CDPH and Cal-OSHA require use of respirators.

[4] Significant resident care encounter is having significant contact with resident or resident environment, such as bathing, dressing, transfers, toileting, wound care or room cleaning.

i. Facemask: Fit-tested N95 at all times; perform seal check after donning.
ii. Gowns for significant resident care encounter (not necessary if no contact with resident or resident environment)
iii. Face shield: worn in resident rooms, but may be kept on at all times if staff dedicated to this zone. Face shield should be removed and disinfected if splashed or soiled, and before breaks.
iv. Gloves changed and hand hygiene between each resident contact.

c. **Resident 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 residents in room as much as possible (in-room therapy and treatments).
   iii. If out-of-room therapy needed, resident 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**:
   i. Ideally utilize fully vaccinated staff.
   ii. 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; N-95s for aerosol-generating procedures if community transmission substantial or high (could also consider using N-95s for all resident contact if transmission is at this level).
      ii. Minimum of standard precautions for all; enhanced standard or contact precautions as indicated for C. diff or other MDROs.
      iii. Face shield: if splashes possible, or when performing potential cough/sneeze inducing procedures such as obtaining nasal swab. **Note**: CDPH recommends face shield for all resident care if community transmission is substantial or high according to CDC COVID Data Tracker https://covid.cdc.gov/covid-data-tracker/#county-view . Consider use of enhanced standard precautions for residents who have one or more risk factors for MDRO; single use of gown.
   c. **Resident placement**: as per usual; residents may leave their rooms, but should perform hand hygiene and follow current COVID prevention guidance, and stay out of observation area, yellow and red units.
   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 recommends and Cal/OSHA requires that NIOSH-certified N95s be used for PPE when caring for confirmed or suspected COVID.
   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.
   c. Cal/OSHA recommends single use of N95s unless facilities have inadequate supplies, and facilities must document their failed attempts to procure more. However, staff who are working with residents of similar exposure status (e.g. all COVID+ or all COVID-exposed) may practice extended use of mask if allowed by manufacturer. However, respirators should not be reused day to day, and must be discarded at end of shift, or sooner if it becomes soiled, wet or otherwise damaged.

d. All facilities are required by Cal/OSHA to do fit testing and have a respiratory protection program.
e. Practice of double masking, that is, using a tight fitting cloth mask over a surgical mask, is allowable in the green zone. However, no mask should be placed over or under a N95, and double masking with two surgical masks is not advised.

18. **Gown use**:
    a. Facilities may utilize long sleeved, washable cloth gowns to care for any resident, regardless of infection or exposure status.
    b. Facilities should bundle care activities to preserve supply of gowns. Gowns should be single use, being washed or discarded after each use.
    c. Full body suits/rain jackets or double gowning 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 resident care area.
    d. Shoe decontamination or shoe cleaning stations are not necessary.

## Other COVID-Related Recommendations

20. **Air Flow in Facility**
    a. Considering the size of outbreaks and the rapidity of spread seen during several surges, as well as concern about increased transmissibility of new variants, facilities should review their air handling systems. Consult your building engineer or a HVAC specialist, if possible.
    b. Ensure HVAC system is well maintained and filters are current (best to use the highest rated filter compatible with the system, minimum of MERV 13).
    c. In the event of an outbreak, increase outdoor air and minimize return air in the HVAC system. Leave the system running to maximize air changes per hour and avoid stagnant air. Keep doors to isolation and quarantine rooms/areas closed, etc.
    d. Attempts should be made to create a negative pressure in red zone (see page 1, 1.e).
    e. See CDC guidance https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html for more information on low cost ways to improve ventilation.
21. **Preventing Staff-to-Staff Transmission**
    a. In the pre-vaccination era, some outbreaks started when a cluster of staff infections occurred; these clusters may have occurred due to staff-to-staff transmission during breaks.
    b. According to recent CDC and CDPH guidance, staff who are fully vaccinated do not have to mask or socially distance in areas where residents are not present (e.g. break rooms or conference rooms) if all present are fully vaccinated. However, if any unvaccinated staff member if present, then all have to mask (if not eating or drinking) and the unvaccinated staff member must socially distance.
    c. Outdoor break areas are still encouraged, as many facilities do not have 100% vaccination rate for staff and the recent omicron surge has led to increasing vaccine breakthrough cases. If indoor spaces are utilized, attempt to increase ventilation as much as possible.
    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,
22. **Quarantine and isolation of COVID-exposed or infected staff**: recommendations for quarantine and isolation change often based on the variant circulating, vaccination status of staff and staffing situation; please refer to

latest CDPH guidance on this issue for most up –to-dare recommendations: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx

23. **Response testing** (for any positive staff or resident)
    a. CDPH currently recommends testing all COVID-negative residents and staff (regardless of vaccination status) every 3-7 days until two sequential negative rounds of testing in all residents and staff over 14 days if a single case is identified in either a resident or staff member. However, guidance changes often, so please refer to latest AFL on the topic for most up to date recommendations: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-53.aspx .
    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 testing, if indicated.
24. **Diagnostic screening testing of staff and testing of new admissions:**
    a. CDPH currently recommends testing of staff who are not up to date with COVID vaccination twice a week; please see latest version of AFL 20-53 for more information: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-53.aspx
    b. CDPH recommends testing of admissions who are not up to date on COVID vaccination; although AFL 20-53 has not been updated to reflect new guidance at the time of this revision, it should be forthcoming.
        i. Consider short quarantine and testing all admissions from the hospital (regardless of vaccination status) during COVID surges when unrecognized exposures are occurring in the hospital setting**.**
        ii. Quarantine and retesting of prior COVID+ residents after hospitalization is not required within 3 months of COVID diagnosis; these residents may be admitted straight to green unit once released from isolation.
    c. Consider additional screening testing of certain high risk residents:
        i. Routine testing of all residents is not necessary, and may lead to false positive tests.
        ii. Consider (not a firm recommendation) testing residents who are not up to date with COVID vaccination who leave the facility on often (e.g., hemodialysis residents or residents who have radiation therapy or frequent medical visits outside of the facility) on a periodic basis (e.g. weekly).
25. **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. May detect noninfectious virus for up to (and sometimes beyond) 3 months after acute infection; therefore, repeat PCR testing should only be done during this time period if COVID-specific symptoms occur (but preferable to use rapid antigen in this case, which may be more reflective of infectiousness). Consult your PHN liaison to help determine the significance of repeat positive PCR results during this time period.
    b. Rapid Antigen tests: current Association of Public Health Laboratories (APHL) and CDPH guidance state:
        i. Best use is in **symptomatic people in high prevalence population** (e.g. PUI).
        ii. Sensitivity is lower than PCR, but specificity 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 (resident or staff) or exposed individual who tests negative on rapid antigen should be retested using PCR.** Therefore, rapid antigen testing is not ideal for response testing, because PCR confirmation should be done on all negative results**.**
        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 and relatively good availability of PCR testing for staff, OCHCA feels that PCR testing is the better option.

However, rapid antigen is an option if PCR resources limited or turn-around times are prolonged, but must be performed twice a week due to lower sensitivity.

iv. Reporting regulations state that all positive 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.

**26. Environmental Cleaning**:

a. Facilities with subacute units or with known cases of *C. auris* in their facility should be using list P agents https://www.epa.gov/pesticide-registration/list-p-antimicrobial-products-registered-epa-claims-against-candida-auris to ensure adequate disinfection. If list P agents are not available, then can use List K (C diff)

b. N list agents for COVID are not sufficient to eradicate *C. auris*.

**27. Visitation and Resident Activity Guidelines:** please see AFL 22-07 for guidance in these areas: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-07.aspx