OCHCA Guidance on COVID-19 in SNFs 2-27-23

In Setting of a COVID Case or Outbreak

COVID Isolation Area: formerly "Red Zone" (for COVID+)

1. **Unit set up**:
   a. Per CDPH AFL 23-12 (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-12.aspx), facilities must maintain a designated COVID Isolation Area (will still use the term "red zone") in a distinct area separated from the rest of the facility, and any COVID+ resident should be moved to this area for the duration of their isolation period. There is no need for a separate entrance/exit from the rest of the facility, or for a separate break room or bathroom for red zone staff, but the red zone should be demarcated by some visual indicator (e.g., fire doors, stanchion, privacy stand or other barrier; floor-to-ceiling sealed plastic barriers no longer allowed) to prevent entry of residents or unauthorized staff. If using fire doors to demarcate COVID unit, keep these closed. Unnecessary movement between red zone and other areas should be avoided. Staff leaving the red zone should doff any PPE and perform careful hand hygiene upon exiting.
   b. 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 closed door, and if the smoke or tissue is pulled toward/under the door, the room is negatively pressurized. If negative air pressure cannot be obtained, consider using portable HEPA filters. Additionally, consider installation of MERV-13 level filters in the HVAC system if possible.
   c. 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. **Transmission Based Precautions (TBP): Contact and droplet**[1]
   a. Facemask: N95 respirator or higher-level respiratory protection **at all times while on unit**; may only be removed in designated CLEAN area (outside of COVID unit. N95 should be fit tested at least annually and staff should always perform a seal check (see #17) when donning.
   b. Face shield: worn at all times while on unit, should be removed and disinfected in clean area before breaks, before moving between zones, or if splashed/soiled.
   c. Gown: no extended gown use; single use of gowns only (dispose or launder after each resident care episode; remove before exiting room).
   d. Gloves changed and hand hygiene between each resident (gel-in and gel-out).
   e. **No gowns and gloves in hallway**, unless used by a staff transporting or ambulating a COVID+ resident!
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

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

treating each bed as a separate room. 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 be isolated for a minimum of 10 days (from date of positive test or symptom onset) on COVID unit. If resident highly immunocompromised or very ill, should consider extending isolation until 20 days, or until symptoms significantly improved. Rebound of symptoms may occur in any COVID-infected resident after an initial improvement; this rebound may be more common in residents who receive Paxlovid, and is most likely to occur within 5 days of completion of Paxlovid. Rebound requires another 10 days of isolation. Facilities should consider keeping residents who recently completed Paxlovid separated from COVID-negative residents until 5 days have passed since completion of the course to avoid exposure to others; this can be done by extending time in red zone, or by cohorting recently recovered (past 10 days) COVID+ residents together.

4. **Staffing:**
   a. Dedicated staff: There is no longer need to have dedicated staff on the red unit, but if the outbreak is large, it makes sense to dedicate staff who have the most direct patient contact, e.g. CNAs. Staff leaving the red unit should fully change PPE (discard respirator, remove and sanitize face shield, remove gown) and perform careful hand hygiene.
   b. Vaccination status: ideally, staff working here should be up to date with COVID vaccination; if not fully vaccinated, utilize recently COVID-recovered staff.

Quarantine/Isolation: Close Contacts of COVID+, and Persons Under Investigation ("PUIs", or persons displaying respiratory symptoms, or other symptoms of COVID),

5. **Quarantine Placement:**
   a. Close contacts of COVID no longer need to be in a distinct area (former yellow zone), or to routinely have transmission-based precautions (which includes quarantine) applied (see 7.b. below for when to consider using TBP and quarantine for exposed). However, if any resident becomes symptomatic, he/she is then a PUI and should be moved to a separate isolation room (not in red unit) and transmission-based precautions applied, including N95 and face shield, pending test results. Outbreaks may spread throughout one area of a facility, and in that case, the facility may choose to turn a whole unit or area "yellow" (quarantine and apply transmission-based precautions) if numerous COVID cases have been identified, and standard control measures have not helped. Avoid excessive and/or unnecessary movement of exposed residents.
   b. If possible, modify airflow to create slight negative pressure (air flows from hallway into room) and for quarantine rooms, keep doors closed with residents in the room as much as possible.
   c. Ensure proper signage and other visual cues to designate quarantine and precautions indicated.
6. **Transmission Based Precautions (TBP): Contact and droplet[2] (required when caring for PUIs or persons demonstrating respiratory symptoms; encouraged for care of asymptomatic residents who have had close contact to COVID+)**
   a. Facemask: Fit-tested N95 or higher level of respiratory protection at all times; 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 care of exposed residents. 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 only; 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!
7. **Resident placement:**

[2] 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 (symptomatic residents) must be in single room; **if initial test is negative, keep in isolation and repeat test in 48 hrs; test for influenza or other respiratory viruses as indicated.**
    ii. Close contacts of COVID+ (e.g. roommates) best left in their own room when COVID+ roommate moved out; for remaining exposed roommates, move beds at least 6 feet apart, draw privacy curtain drawn and encourage residents to mask to reduce potential exposure, if possible.
    iii. Do not move exposed resident into a room with non-exposed residents or admit new resident to a room with exposed residents.

b. Testing and quarantine of asymptomatic exposed residents: testing is required as soon as possible after exposure (but not sooner than 24 hours), with repeat tests 48 hours and 96 hours later (exposure = day 0, so test on days 1, 3, and 5). However, quarantine is no longer required by CDC or CDPH. Whereas routine implementation of quarantine for asymptomatic exposed residents is not required, facilities could request exposed residents to voluntarily quarantine for 7 days, or until result of day 5 test is available. Additionally, **per the CDC guidance, use of TBP (including quarantine) may be considered in the following circumstances**: patient is not able (or refuses) to be tested or to wear source control, patient has moderate to severe immunocompromise, patient resides in a unit with moderately or severely immunocompromised individuals, or patient resides in a unit that is experiencing uncontrolled transmission of COVID. If quarantine used, patients should remain in room with doors closed (as much as possible) until quarantine over. Exposed residents are supposed to wear source control for a full 10 days after exposure, and ideally (per CDPH) all residents are supposed to wear facemasks in common areas at all times.

8. **Staffing**: if staff not dedicated to quarantine area or quarantine rooms, then should attempt to work from unexposed to exposed (“clean to dirty”). Avoid using unvaccinated staff for exposed or symptomatic PUIs if possible. Staff should change respirator, remove and sanitize face shield, and perform careful hand hygiene between care for exposed and non-exposed residents.

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 quarantine or isolation. In facilities with large outbreaks, there may not be a green zone; could consider everything that is not red as quarantine.
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 higher level) 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[3].
    c. Face shield: for significant resident care encounter[3], 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 high according to CDC COVID Data Tracker https://covid.cdc.gov/covid-data-tracker/#county-view (check “community transmission: on dropdown)
    d. Gloves changed and hand hygiene between each resident (gel-in and gel-out).
11. **Resident placement**: Keep non-exposed residents from wandering into quarantine or isolation areas.
12. **Staffing**: if staff need to work with unexposed residents and COVID-exposed (quarantine), PUIs or COVID-infected residents (isolation) during the same shift, attempt to bundle duties and work from “clean to dirty” (unexposed to exposed to infected) as much as possible. PPE must be changed, and careful hand hygiene performed between care for exposed or infected residents and care for unexposed/uninfected.

[3] Significant resident care encounter is having significant contact with resident or resident environment, such as bathing, dressing, transfers, toileting, wound care or room cleaning. (“6 moments")

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

13. **Isolation (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. **Quarantine/exposed area: see (#5-8 above)**
    a. Most facilities will not have formal "yellow zone" anymore; if an area is in quarantine, maintain it in quarantine until residents have completed recommended testing.
    b. Attempt to maintain one empty room to place PUI if needed.
15. **New admission/observation unit**:
    a. Previously, new admissions required quarantine and testing, so most facilities cohorted such patients into a new admission/observation area. Currently, testing is still required on days 1 (day of admission), as well as on days 3 and 5, but quarantine is no longer required, nor is it required to use droplet or contact precautions for these patients. Lacking such requirements, a formal new admission area is no longer necessary. Many facilities, however, are uncomfortable with the relaxation of these requirements, as many outbreaks have arisen from new admissions who were asymptomatically incubating COVID on admission. Facilities may still choose to maintain a new admission area to keep new admissions separate from longer term population, and/or could follow some of the suggestions below to minimize risk of introduction of virus by new admissions.
    b. **Transmission Based Precautions (TBP): Contact and droplet[4]**: although COVID transmission-based precautions are no longer required during care of new admission; facilities may choose to continue to use these precautions to care for newly admitted patients.
        i. Respirator: 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. **Quarantine**: whereas routine implementation of quarantine not required, facilities could request newly admitted residents to voluntarily quarantine for 7 days, or until result of day 5 test is available. If newly admitted resident meets criteria described in section 7.b. above, TBP and quarantine may be implemented. If in quarantine, residents should remain in room with doors closed (as much as possible) until quarantine over. Newly admitted residents are supposed to wear source control for a full 10 days after admission, and ideally (per CDPH) all residents are supposed to wear facemasks in common areas at all times.
    d. **Resident placement and movement:**
        i. Single rooms best, but if space not sufficient, cohort new admissions by similar date of admission if possible.
        ii. If new admission voluntarily agrees to quarantine, keep residents in room as much as possible (in-room therapy and treatments).
        iii. For any out-of-room movement or activity, resident should wear clean gown or clothes, wear a mask at all times, sanitize hands, socially distance, limit time in therapy room/hallway, and equipment should be sanitized after use.
    e. **Staffing**:
        i. Ideally utilize staff who are up to date with vaccinations.
16. **Green (unexposed, uninfected) area:**

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

a. **Area set up**: no special guidance; consists of rest of the facility that is not isolation, quarantine or observation unit.
b. **PPE**: standard precautions:
    i. Surgical mask at all times; N-95s for aerosol-generating procedures if community transmission 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 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, quarantine and isolation areas. Residents should wear source control (mask) when in common areas.
d. **Staffing**: no restrictions, but best to dedicate staff with most patient contact to avoid changing of respiratory protection.

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 masks, 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, ideally 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.c).
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. Whereas CDC guidance state that source control is only necessary when community transmission is high, CDPH continues to require source control to be worn at all times in facilities (Guidance for Face Coverings (ca.gov)). Staff can only remove facemasks during breaks and should socially distance from fellow staff.
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-date recommendations: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx

23. Response testing (for any positive staff or resident)

a. CDC and CMS advise testing if a single case of COVID is identified. Testing can be either via contact tracing (if possible), unit-focused, or broad testing, depending on the number and location of positives; discuss with your Public Health Nurse liasion. Testing should be done as soon as possible, but not less than 24 hours after exposure, and repeated at 48 and 96 hours (exposure is day 0, so test on days 1, 3 and 5).
b. Previously COVID+ residents and staff should not be retested for at least 30 days; between 31-90 days after recovery, testing can be considered (and should be performed if symptoms present), but should be done via rapid antigen, not PCR.

24. Diagnostic screening testing of staff:

a. Routine diagnostic screening testing of staff who are not up to date with vaccines is no longer required per AFL 22-13.1. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-13.aspx. However, facilities may consider continuing some type of routine staff testing as a requirement of employment; facilities should discuss with their internal leadership, human resources and/or corporate leaders if such a policy would be advisable.

b. Any employee that develops symptoms should be tested and restricted from work if positive or symptomatic as per AFL 22-13.

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 48 hours. May consider testing for other respiratory disease (influenza, rhinovirus, RSV, etc.)
   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