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PUBLIC HEALTH SERVICES
COMMUNICABLE DISEASE CONTROL

OCHCA Guidance on Prevention and Management of COVID-19 IN RCFEs 4-17-23

The Public Health Emergency due to COVID-19 has expired in California, but COVID-19 continues to circulate in our community. Although our older adult population has a high level of vaccination against COVID, fully vaccinated and boosted individuals may still get infected with COVID -19, and even those with mild, cold-like symptoms, they 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. 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 should be passively screened for COVID-19 signs, symptoms or exposure; visitors who are experiencing symptoms, not feeling well, or who have been recently exposed to COVID-19 should not visit.
b. Staff screening: staff should be educated on and passively screened for COVID-19 signs, symptoms and exposure daily; staff should self-report potential illness for further evaluation.
c. Resident screening: residents should be observed for signs/symptoms of COVID-19, and if symptoms noted, further evaluation performed. 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.

d. 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.
e. Masking:
    i. Residents: masking is not required for residents, however, any resident who has been exposed to COVID should wear a mask when outside of their room.
    ii. Staff: routine masking is no longer routinely required per revised CDPH masking guidelines, but staff still need to use fit-tested N95 respirator, eye protection, gowns, and gloves when caring for suspected or confirmed cases of COVID-19.
f. 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.
g. 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.
h. Testing of staff: Routine testing of asymptomatic staff is no longer required; testing based on symptoms or after an exposure to COVID is covered in section IV
i. Testing and quarantine of new/returning residents: See IV.b, page 4.

II. Testing for COVID

a. Types of COVID Tests:
    i. 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; if negative initially in a symptomatic person, a PCR should be performed or a repeat the rapid antigen in 2 days (48 hours). Rapid antigen tests are not as good at picking up asymptomatic infection (e.g. for screening of staff or visitors without symptoms), and if used for post-exposure testing, should be done at a

minimum between days 3-5 after exposure. For more information in use of these tests, see https://www.aphl.org/programs/preparedness/Crisis-Management/Documents/APHL-SARSCov2-Antigen-Testing-Considerations.pdf

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

b. Testing Residents:

i. Quickly isolate and test any resident with symptoms of COVID; repeat test if initial result is negative (see II.a.i above) and continue isolation if symptoms continue.

ii. In the event that a resident or staff member is diagnosed with COVID, perform contact tracing (identification of those with close exposure to infected individual); a "Close contact" is defined as being within 6 feet for 15 minutes or longer without PPE (cloth face coverings do not count as PPE). Test any resident who has had a close contact at a minimum between days 3 - 5 after the exposure has ended (if no symptoms present; test immediately if symptoms present). If testing negative before Day 3, retest at least a day later at least once, during the 3–5 day window following exposure (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-on-Isolation-and-Quarantine-for-COVID-19-Contact-Tracing.aspx). Post-exposure testing is not recommended for those who had COVID infection in the past 30 days, unless symptoms recur. More broad response testing (testing of all residents and staff in an area or the whole facility) may be indicated if contact tracing is not feasible or if contact tracing fails to control transmission (e.g. outbreak keeps spreading) as directed by local public health. Per CDPH masking guidance, exposed residents should wear a mask when around others for 10 days after the exposure (https://www.cdph.ca.gov/Programs/CID/DCDC/pages/covid-19/guidance-for-face-coverings.aspx). No quarantine required during this time period.

iii. Regular surveillance testing otherwise not recommended for residents.

c. Testing of Staff:

i. For any staff with symptoms of COVID, remove from work and test immediately; repeat test if at 48 hours if initial is negative and symptoms continue (see II.a.i above).

ii. If any COVID-19 case(s) identified in either staff or resident, perform contact investigation as above in II.b.ii, and employers are required to notify all employees and independent contractors who have had a close contact. Staff who have had close contacts to COVID+ in the workplace should be provided testing free of charge during paid time per Cal/OSHA Non-Emergency Regulations (https://www.dir.ca.gov/dosh/coronavirus/Non_Emergency_Regulations/). Per CDPH guidance (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-on-Isolation-and-Quarantine-for-COVID-19-Contact-Tracing.aspx), test exposed staff member at a minimum between days 3 - 5 after the exposure has ended if no symptoms present (test immediately if symptoms present). If testing negative before Day 3, retest at least a day later at least once, during the 3–5 day window following exposure. Post-exposure testing is not recommended for those who had COVID infection in the past 30 days, unless symptoms recur. Per CDPH masking guidance, exposed staff should wear a mask indoors when around others for 10 days after the exposure (https://www.cdph.ca.gov/Programs/CID/DCDC/pages/covid-19/guidance-for-face-coverings.aspx). No work restriction or quarantine required.

iii. Regular surveillance testing otherwise not recommended for staff.

iv. In the event of an outbreak in the worksite, which Cal/OSHA defines as 3 or more employees during 14 day time period, employers must make testing available on a weekly basis, and employees must wear face coverings when indoors, per https://www.dir.ca.gov/dosh/coronavirus/Non_Emergency_Regulations/ . If 20 or more employees infected within a 30 day time period (major outbreak), testing of all exposed is required twice weekly. Cal/OSAH requires that exposed employees who refuse to test should be excluded from work until they have met return to work requirements.

III. 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. Test resident as soon as possible as soon as possible using a rapid antigen test. If rapid antigen is negative, it does not rule out COVID, and 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.
   ii. Any staff member administering tests should 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) until second test is negative.

c. Staff:
   i. Remove from work immediately (or instruct them not to come to work) and test as soon as possible, ideally using rapid antigen or refer to community testing resources (see https://occovid19.ochealthinfo.com/covid-19-testing). If initial rapid antigen test is negative, staff member should remain off of work and the test should be repeated at 48 hours.
   ii. DO NOT let staff member back to work before test result back, even if symptoms improve.

IV. Management of COVID+ 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) several times per day.
   ii. Consider transfer to ER 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 100 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. If multiple infected residents who may not comply with in-room isolation, consider creating a COVID isolation area, or "red" unit (see IV.c. below); can have multiple positive residents in same room if needed.

iv. Ideally, dedicate staff who are up to date with COVID vaccination to care for COVID+ (that is, staff work only with COVID+ during shift. If multiple positive residents on site, consider having licensed clinical staff to help monitor.

v. 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 certain PPE (same respirator and face shield used whole shift), but change gloves and perform hand hygiene between patients. Must remove PPE and perform hand hygiene before breaks. See V for more information.

vi. Release of COVID+ residents from isolation

1. CDC recommends time based clearance from isolation. Isolation can end after Day 5 if: symptoms are not present, or are mild and improving, AND fever-free for 24 hours (without the use of fever-reducing medication). If fever is present, isolation should be continued until 24 hours after fever resolves, and if symptoms, other than fever, are not improving, continue to isolate until symptoms are improving or until after Day 10 per https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-on-Isolation-and-Quarantine-for-COVID-19-Contact-Tracing.aspx. **CDC and CDSS do not recommend retesting COVID+ residents to determine clearance from isolation**.
2. Infected persons should wear a well-fitting mask around others for a total of 10 days, especially in indoor settings.

b. COVID+ Staff:

i. Isolate at home.

ii. Isolation can end after Day 5 if: symptoms are not present, or are mild and improving, AND fever-free for 24 hours (without the use of fever-reducing medication). If fever is present, isolation should be continued until 24 hours after fever resolves, and if symptoms, other than fever, are not improving, continue to isolate until symptoms are improving or until after Day 10 per https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-on-Isolation-and-Quarantine-for-COVID-19-Contact-Tracing.aspx. Licensees can chose to continue to follow more restrictive guidance outlined in table on page 9 of PIN 23-02-ASC https://cdss.ca.gov/Portals/9/CCLD/PINs/2023/ASC/PIN-23-02-ASC.pdf.

iii. Infected staff should wear a well-fitting mask around others for a total of 10 days, especially in indoor settings

c. "Red" Unit/Zone:

i. RCFEs have occasionally created red units by subdividing a wing (e.g., closing fire doors), or by utilizing a vacant wing or vacant apartments. This approach may help if there are a number of residents infected who may not comply with in-room isolation (e.g., cognitive impairment or dementia, or behavioral noncompliance).

ii. Ideally a red unit should be a distinct area separated from the rest of the facility, to prevent interactions between infected and non-infected residents. 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. 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

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

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. Extended use of N-95s may be considered if staff member is caring for residents of same exposure/infection status, but it should be discarded when removed for meal breaks, end of the shift or if damaged, wet or soiled.

b. Gown use:

   i. Long sleeved, washable cloth gowns may be used instead of disposable 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 IV.c. 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.