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Division of Communicable Disease Control and Prevention

COVID-19 Outbreak Control Recommendations for Skilled Nursing Facilities
Updated 5/30/2024

This guidance was created by the Alameda County Public Health Department (ACPHD) and is intended for use by Skilled Nursing Facilities (SNFs) for the management and containment of COVID-19 outbreaks. More detailed guidance that includes recommendations about prevention and planning for influenza, COVID-19 and other respiratory outbreaks is available on the California Department of Public Health (CDPH) website These recommendations supplement the California Department of Public Health (CDPH) All Facilities Letters (ca.gov), CDC and CMS Guidance.

Long Term Care Facilities experiencing influenza-like illness (ILI) outbreaks and other non-COVID-19 acute respiratory illness (ARI) outbreaks should refer to COVID-19-Influenza Like Illness (acgov.org)

Note: Changes to this document as of **05/30/24 are in red.**

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Public Health Department
Alameda County Health

Definitions

Reportable Events:

- ≥2 cases of COVID-19 among residents identified within 7 days detected via rapid antigen/molecular testing
  OR
- ≥2 cases of COVID-19 among HCP AND COVID-19 among residents, with epi-linkage detected via rapid antigen/molecular testing
  OR
- ≥3 cases of acute illness compatible with COVID-19 among residents with onset within a 72h period
  https://www.corha.org/wp-content/uploads/2024/01/COVID-19-HC-Outbreak-Definition-Guidance_January-2024.pdf

Signs and Symptoms potentially consistent with COVID-19: at least one of the following symptoms: new or worsening cough, shortness of breath or difficulty breathing, new olfactory/taste (loss of taste or smell) disorder(s); **OR** at least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, nausea, vomiting, diarrhea, fatigue, congestion, or runny nose.

Epidemiologic linkage among HCP: having the potential to have been within 6 ft for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms; for example, worked on the same unit during the same shift, and no more likely sources of exposure identified outside the facility.

HCP with Higher Risk Close Contact: HCP with prolonged close contact (e.g., 15 minutes or more) with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection and

- HCP was **not wearing a respirator** (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or face mask); OR
- HCP was **not wearing eye protection** if the person with SARS-CoV-2 infection was not wearing a cloth mask or face mask; OR
- HCP was not wearing all recommended PPE during an aerosol-generating procedure.
  CDC Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2

Close Contact: A close contact is someone sharing the same indoor airspace (examples: home, clinic waiting room, airplane, office, bathroom, break rooms) for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5-minute exposures for a total of 15 minutes) with someone infected with COVID-19.

Reporting Requirements

- ❑ Report a **confirmed outbreak or reportable event** to the Alameda County Public Health Department
  - Alameda County utilizes the Shared/School Portal for Outbreak Tracing (SPOT) to gather information about congregate setting COVID-19 cases. How to Report an Outbreak
  - The LTCF-SPOT User Guide is available with detailed instructions. For any questions or concerns regarding SPOT, please contact LTCFdata@acgov.org.
  - For any other questions or concerns contact ACPHD at (510) 267-3250, option 2 or email COVIDOB@acgov.org Mon-Fri 8:30 am to 5:00 pm. Always begin isolation of any confirmed/probable/suspected cases immediately.
  - On weekends, if there are urgent issues, call Alameda County Fire Dispatch at (925) 422-7595 and ask to speak to the Public Health Duty Officer on call.

- ❑ Submit a map/floor plan of your facility to ACPHD upon request.
- ❑ **Skilled Nursing Facilities** (SNFs) should report cases and outbreaks to Licensing and Certification East Bay District Office: (510) 620-3900.
- ❑ Providers (physicians) or facilities on behalf of providers, complete a Confidential Morbidity Report (CMR) within 24 hours for COVID-19 cases that result in hospitalization or death. CMRs should be submitted by encrypted email to the assigned outbreak investigator to COVIDOB@acgov.org or Fax 510-273-3944. Order of the State Public Health Officer: Revision of Mandatory Reporting of Covid-19 Results by Health Care Providers
- ❑ For **other reportable diseases and contact information**, see Disease Reporting and Control

Outbreak Control Recommendations

Communication

- ❑ In addition to notifying ACPHD and Licensing & Certification, the following should be aware of a new outbreak:
  - Infection Preventionist and Director of Nursing
  - Facility Administrator
  - Medical Director
  - HCP and caregivers who work at the facility.
  - Primary Care Provider of:
    - Residents who reside on a unit where an outbreak is occurring **or**,
    - Residents who are a close contact of a resident, staff, or visitor who tested positive for COVID-19
- ❑ Facilities should notify HCP, residents, and families promptly about identification of COVID-19 infections in the facility and maintain ongoing, weekly communication with HCP, residents, and families with updates on the situation and facility actions.
- ❑ Post instructions for visitors, information on COVID-19 signs and symptoms, infection control precautions and other facility practices at entries/exits and other routes. Provide visual alerts instructing residents and staff to report symptoms of COVID-19 to a designated person. Utilize the CDC latest versions of instructional signage throughout the facility. CDC print resources Cover Your Cough

HCP Surveillance

- ❑ Institute active symptom screening during outbreaks. See Sample Employee COVID-19 Health Questionnaire
- Exclude from entrance any HCP presenting with the following symptoms: new or worsening cough, shortness of breath or difficulty breathing, fever (measured or subjective), chills, rigors, myalgias, headache, sore throat, new or worsening congestion & runny nose, new olfactory and taste disorder(s), nausea, vomiting or diarrhea.
- Instruct HCP to report symptoms of COVID-19, a positive COVID-19 or Flu test, and close contact with someone with COVID-19 infection to a point of contact designated by the facility.

See "Managing HCP Illness & Exposure" section for details on handling ill HCP.

Testing

- ❑ Maintain plans to conduct testing at your facility.
- ❑ **Implement Antigen testing for fast results to Isolate effectively and evaluate for timely COVID-19 treatments. Antigen testing should be conducted 2-3 times per week.**
- ❑ See guidelines and resources for Antigen Testing:
  - CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

- ❑ Residents or HCP with signs or symptoms potentially consistent with COVID-19 should be isolated and tested for immediately to identify current infection, **regardless of their vaccination status.** Do not delay testing of symptomatic individuals until scheduled screening or response testing.
- ❑ Test symptomatic residents or HCP for COVID-19 and Influenza during respiratory illness season, especially when there is a cluster of symptomatic individuals. Consider additional respiratory viruses, such as RSV. See ACPHD Influenza-Like Illness and non-COVID-19 Acute Respiratory Illness Outbreak Recommendations for Long-Term Care Facilities
  - **Symptomatic individuals who test negative for COVID-19** should be isolated and receive a PCR test or repeat the antigen test 48 hours after the first negative test, even if symptoms have resolved. **While awaiting test results, move only if the resident can go into a private room**.
  - For residents or HCP who develop new symptoms consistent with COVID-19 between 31-90 days after the date of initial symptom onset, if an alternative etiology cannot be identified, then retesting using antigen test can be considered in consultation with the medical director, infectious disease, or infection control experts.
  - Immediately isolate residents and HCP who test positive for COVID-19.
  - All testing must be ordered by a clinician who will be responsible for informing the patient and arranging for appropriate clinical follow-up or testing should comply with Alameda County Health Officer Order No. 20-19

- ❑ Follow infection control precautions when collecting nasopharyngeal (NP) and other swabs:
  - Patient should be in a single room with door closed.
  - Minimum number of HCP should be in room.
  - Perform hand hygiene immediately before donning and immediately after doffing.
    PPE Donning and Doffing Sequence and Signs
  - Wear N-95 respirator (or equivalent), eye protection (face shield or goggles), disposable gown and gloves.
  - For further guidance on proper specimen collection, see CDC guidelines for methods of specimen collection.
    Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19)
- ❑ Please check with your testing laboratory to confirm the most appropriate specimen, transport medium, etc. for collection.

- ❑ Maintain the ability to ramp up testing by having available supplies or testing vendor in place in the event of outbreaks. See COVID-19 Surge Readiness: Best Practices for SNFs

Outbreak Testing
❑ Screening testing (i.e. response testing) is serial testing which can be performed following an exposure or potential outbreak in high risk environments. Screening testing has been used to identify asymptomatic infections to prevent further spread of COVID-19. When implemented, testing should be initiated as soon as possible when a potential outbreak may be occurring. CDC Overview of Testing for SARS-CoV-2, the virus that causes COVID-19
❑ There are two testing approaches to consider for preventing further spread in a facility, Contact Tracing or Facility Wide or Group Level Testing. See "Choosing an Outbreak Response" Algorithm
Testing: Using Contact Tracing Approach
Consider using the contact-tracing approach if: • You have the expertise, resources, and ability to identify all close contacts (two days before symptom onset or two days before positive test result if no symptoms) immediately, including communal dining, break rooms, activity rooms, therapy rooms. • The initial positive case is staff. A resident case may be an indicator of facility spread and inability to identify all potential contacts, consider using **facility wide** testing. • The initial positive case has a clear link to exposure outside of the facility (e.g., family, friends). • If the HCP that tested positive does not have resident contact or have contact with other facility HCP who provide care or have contact with residents. See Contact Tracing Approach Algorithm
❑ **Testing Guidance for Exposed Residents identified during Contact Tracing:** • All residents and HCP who have been identified as close contacts, regardless of vaccination status, should be tested promptly and, if negative, again at intervals of 3 days and at 5 days after the exposure**. If unable to test on days 1, 3 and 5, proceed to Facility Wide or Group Level Testing** • Residents do not need to quarantine but should wear a well-fitted mask or surgical mask (recommended) for 10 days. They should not participate in communal dining. • Exposed **symptomatic** SNF residents or those **unable to wear masks**, should be placed on transmission-based precautions until the diagnosis of current SARS-CoV-2 infection or other respiratory illness is excluded. • Post-exposure testing is not generally recommended for HCP or residents who have had SARS-CoV-2 infection in the last 30 days if they remain asymptomatic. • Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a nucleic acid amplification test (NAAT) is recommended. CDC
❑ If testing of close contacts reveals additional HCP or residents with COVID-19 infection, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with COVID-19 infection for further testing.
❑ **A facility-wide or group-level** (e.g., unit, floor, or other specific area(s) of the facility) **approach should be performed if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.** If the nurse investigator determines that the outbreak has not been controlled effectively with the contact tracing approach, you may be asked to begin facility-wide testing.

Response/Screening Testing: Facility Wide or Group Level Approach

As soon as possible after one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility, perform testing on the affected unit(s) or facility-wide immediately and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be on day 1 (where day of exposure is day 0), day 3, and day 5. If no additional cases are identified, no further testing is indicated. Masks should be worn as source control for 10 days after exposure for both residents and staff.

See Facility-wide or Broad-based Testing Approach Algorithm

- ❑ If additional cases are identified, testing should continue on affected unit(s) or facility-wide twice a week until there are no new cases for 14 days.
  - Once a resident or HCP tests positive, no additional testing is needed for that individual for 30 days if they remain asymptomatic.
  - If HCP or resident test positive, identify contacts during the infectious period (two days before symptom onset or two days before positive test result if no symptoms) to identify close contacts and determine exposure to residents.
- ❑ Antigen tests provide timely results for purposes of immediately cohorting residents, providing treatment and isolating healthcare personnel (HCP). It is the preferred testing method

Resident Placement, Movement Restrictions & Transferring Residents

Plan for and create a distinct Isolation Area to be ready as soon as you have a positive case.

- ❑ **Isolation Area (dedicated area):** COVID-19 Positive – Use Transmission Based Precautions
  - Isolate COVID-19 positive residents for the duration of the Isolation period, regardless of their vaccination status
  - MDRO colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
  - Consider a designated floor, unit, wing, or group of rooms at the end of a hallway that is physically separate and includes ventilation measures to prevent transmission to other residents outside of the Isolation Area. Provide signage to remind individuals that they are entering the Isolation Area. Assess airflow in the Isolation area and resident rooms. Strategically place portable air cleaners throughout the Isolation area and in resident rooms.
  - Dedicated staffing who do not provide care for residents in other areas (e.g., HCP are assigned to only care for COVID-19 patients during their shift) may be preferred during a large outbreak. If unable to dedicate HCP, educate and encourage a workflow process that allows HCP to perform routine care working from non-isolated to COVID-19 isolated residents (e.g., resident assessments, med pass, etc.).
  - All HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to CDC Standard Precautions for All Patient Care and use a NIOSH-approved particulate respirator with N95 filter or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) and perform hand hygiene and change PPE between residents. CDC
- ❑ **Symptomatic residents - Isolate in Single room,** if possible, otherwise Isolate in current room - Use Transmission-based Precautions for duration of testing **(**including N95 respirator, gown, gloves, and eye protection) – **Do not move to Isolation Area unless COVID-19 positive.**

- Additionally, it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory infections based on symptoms alone. Consider testing for pathogens other than COVID-19 and initiating appropriate infection prevention precautions for symptomatic older adults.
  - COVID-19-Influenza Like Illness (acgov.org)
  - Recommendations for Prevention and Control of COVID-19, Influenza, and Other Respiratory Viral Infections in California Skilled Nursing Facilities – 2023-24

❑ **Avoid movement of residents that could lead to new exposures** (e.g., roommates of symptomatic residents, who have already been potentially exposed, should not be placed with new roommates, if possible).

❑ DO NOT MOVE suspected cases to the Isolation Area unless they are COVID-19 positive. While awaiting test results, move only if the resident can go to a private room; otherwise, leave in current room with as much space as possible between beds and curtains drawn.
Contact COVIDOB@acgov.org if you have questions or concerns regarding patient placement

❑ **Consider empiric use of transmission-based precautions for exposed residents (close contacts) if:**

- Resident is on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions or if there is widespread outbreak (e.g., positive cases after 2nd round of testing.
- Resident is unable to be tested or wear source control as recommended for the 10 days following their exposure.
- Resident is moderately to severely immunocompromised.
- Resident is residing on a unit with others who are moderately to severely immunocompromised.
- New admissions with a known exposure in the last 2 weeks.
  CDC AFL 23-12

❑ **Discontinuation of empiric use of transmission-based precautions for asymptomatic exposed (close contacts) residents**

- on Day 7 if exposed residents do not develop symptoms and testing is negative.
- on Day 10 for Residents who are not tested if they do not develop symptoms.
- When discontinuing quarantine or isolation, residents should remain on Enhanced Barrier Precautions if they have another indication (e.g., colonized with multidrug resistant organism, has indwelling devices, has unhealed wounds or pressure ulcers). CDC

❑ Facilities should consider, in consultation with their assigned nurse investigator, implementing limitations on communal activities and dining based on the status of COVID-19 infections in the facility (e.g., if the outbreak has not been controlled effectively).

❑ Regardless of vaccination status, residents on Transmission-based precautions/Isolation should stay in their rooms with doors closed (if possible), should not participate in communal dining, nor group activities, nor access shared facility amenities, equipment, or non-essential services (e.g., salon and barber services) until they meet the conditions to discontinue Transmission based precautions.

❑ Before transferring ANY resident outside of the facility, such as to outpatient appointments, dialysis centers, acute care hospitals, and other facilities, you **must** use the ACPHD Infection Control Transfer Form **to communicate to transport personnel and other HCP accepting the resident that your facility is experiencing a suspected or confirmed COVID-19 outbreak**. If the resident is a

probable or confirmed COVID-19 case, you must also include symptoms, signs, date of illness onset, laboratory test results, and infection control precautions.

Transmission-Based Precautions and Other Infection Control Measures

❑ COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category

Recommendation for Transmission Based Precautions During Outbreak Response	COVID Positive Residents (Isolation Area)	Exposed (if using facility-wide or group-level testing), Symptomatic, Suspected COVID, Awaiting Test Results	No known exposure, COVID recovered, exposed asymptomatic
N95 Respirator	Yes	Yes	No (optional)
Facemask	No; N95 respirator required	No; N95 respirator required	Yes, for source control
Eye Protection During direct patient care	Yes	Yes	No, except for aerosol generating procedure
Gowns Maintain clean areas where gowns are not worn, such as a main workstation. Extended use NOT permitted	Yes	Yes	As needed per Enhanced Barrier Precautions (e.g., likely exposure to blood and body fluids)
Gloves with hand hygiene before donning and after donning gloves	Yes, upon room entry and between providing care for residents	Yes, upon room entry and between providing care for residents (if more than one resident in a room).	As needed per Enhanced Barrier Precautions (e.g., likely exposure to blood and body fluids)

❑ For Standard Precautions – Please see CDC Isolation Precautions

❑ Educate HCP on hand hygiene, respiratory hygiene, cough etiquette, and document training activities.

❑ HCP should perform hand hygiene before and after donning and doffing personal protective equipment (PPE). HCP must understand the need to change gloves and gowns and perform hand hygiene between all residents, regardless of known COVID-19 or other infectious disease status. AFL 23-12

❑ Post clear and visible signage for PPE donning and doffing and appropriate infection prevention precautions where Isolation/Transmission-based precautions are in use. CDC PPE Donning and Doffing Sequence and Signs

❑ Conduct weekly monitoring of compliance with hand hygiene and PPE procedures and provide on-the-spot correction as needed.

- Monitoring Adherence to Health Care Practices that Prevent Infection
- YouTube Donning and Doffing PPE for Staff Wearing an N95 Respirator

- ❑ Use a fit-tested N-95 respirator or equivalent when performing Aerosol Generating Procedures. Healthcare workers should also wear appropriate PPE, including gloves, gown, and eye protection. CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- ❑ Ensure HCP that care for residents with COVID-19 are fit-tested for an N-95 respirator. Fit-testing of N-95 respirators must be performed at least annually or when there is a change in the type of mask used. Cal/OSHA enforces CCR, Title 8, Section 5144 includes a requirement for an employer to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use, including, but not limited to, respirator Fit Testing.
  N95 Respiratory Resources
- ❑ Healthcare facilities should make N95 respirators available to any HCP who wishes to wear one when not otherwise required for the care of patients or residents with suspected or confirmed COVID-19. Respiratory Protection Standard AFL 21-08 CDC
- ❑ Source Control Masking
  - HCP use of masks or respirators for source control of respiratory infections in healthcare settings prevents HCP from infecting residents and other HCP with respiratory viruses. Implement source control masking in the event of a facility outbreak. Consider source control masking for residents while in common areas.
    CDPH Guidance for Face Coverings as Source Control in Healthcare Settings
  - When N95's are used as source control (i.e., not used as Personal Protective Equipment (PPE), they can be used for the entire shift. A seal check should be performed. The mask should be discarded whenever damaged or soiled and whenever it's removed (e.g., lunch break).
    How do I test the seal on my N95 - CDC Project First Line video
- ❑ When using eye protection during Outbreak Response, ensure appropriate cleaning and disinfection after each use if reusable face shields or goggles are used. APIC Eye Protection Fact Sheet - Guidance
- ❑ Ensure an adequate supply of test kits, facemasks, N-95 respirators (in size and model for fit-tested HCP), face shields/goggles, gowns, and gloves. Place supplies in all areas where patient care is provided. **Ensure a 2-week supply of PPE at minimum, preferably 30-day supply**. CDC Burn Rate Calculator is a spreadsheet-based model that will help healthcare facilities plan and optimize the use of PPE for response to COVID-19.
- ❑ **Do not re-use PPE.** Please contact ACPHD at COVIDOB@acgov.org if you are running low on supplies.
- ❑ Ensure an adequate supply of **alcohol-based hand rub** (at least 60% ethanol or 70% isopropanol) and that it is easily accessible both **inside and outside every patient room, common areas and break rooms**. Ensure that hand-washing stations are easily accessible and equipped with soap and paper towels.
- ❑ Whenever possible, bundle care & treatment activities to minimize entries into isolation rooms (e.g., having clinical HCP clean and disinfect high-touch surfaces when in the room), and minimize the overall number of HCP assigned to the COVID-19 positive cohort. Staff should work with asymptomatic residents before caring for symptomatic residents.
- ❑ Use single-use equipment for residents with COVID-19 infection whenever possible; otherwise, dedicate reusable medical equipment to residents with COVID-19 infection (e.g., thermometers, stethoscopes, Hoyer lifts, medication carts, wheelchairs) and clean/disinfect between each use.

Discontinuation of Transmission-Based Precautions for COVID-19 Recovered Residents (Transferring Out of Isolation)

- ❑ Discontinuation of transmission-based precautions should be determined by using a time and symptom-based strategy for patients with lab-confirmed or suspected COVID-19 as follows:
  - For residents who have never been symptomatic, transmission-based precautions may be discontinued 10 days from date of COVID-19 (+) test.
  - For residents who were symptomatic and **NOT** severely immunocompromised, discontinue Transmission-based precautions after at least 24 hours have passed since last fever (without fever-reducing medications), **and** improvement in symptoms (e.g., cough, shortness of breath); **and** at least 10 days have passed since symptoms first appeared.
  - For residents with severe or **critical illness,** transmission-based precautions may be discontinued after at least 24 hours have passed since last fever (without fever-reducing medications), **and** improvement in symptoms (e.g., cough, shortness of breath); **and at least 10 days and up to 20 days** since symptoms first appeared. CDC Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure.
  - Persons who are **moderately or severely immunocompromised** may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. Consultation with infectious diseases specialists is recommended. Use of a test-based strategy for determining when Transmission-Based Precautions may be discontinued could be considered in these rare situations. The **moderately or severely immunocompromised** category includes patients under cancer treatment, bone marrow or organ transplant recipients, immune deficiencies, poorly controlled HIV or AIDS, on immunosuppressant medications such as prolonged use of corticosteroids and other immune weakening medications, and patients who were critically ill with COVID-19 (intubated and/or in ICU). People with Certain Medical Conditions | CDC

    Important! After recovering from COVID-19, a resident may have a residual cough, which can last days or weeks after any virus. Residents with a cough should wear a face mask when outside their room until resolution of cough and physically distance if in communal settings. If residents with a cough cannot tolerate or remember to keep on the mask, or physical distancing is not possible, please contact the resident's health care provider or the local health department for direction, including if additional isolation is necessary.

Surveillance of Residents

- ❑ **Consult medical director or clinical team for best practice for monitoring residents in isolation.**
  - Consider checking residents in Isolation every 4 hours at minimum
    - Check for subtle changes in mental status, somnolence, hydration status, and respiratory rate. A change in baseline temperature (up or down) and/or a drop in oxygen saturation should trigger a more thorough assessment.
    - Residents over 60 may present with atypical signs and symptoms such as loss of appetite, confusion, weakness, falls new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell.
    - Residents living with dementia may not be able to verbalize their COVID symptoms.

- ❑ Conduct active daily monitoring of all residents to identify signs or symptoms of respiratory illness and quickly manage any ill residents.
  - Identification of these symptoms should prompt isolation and testing for COVID-19

Treatments

- ❑ **Effective treatment** for residents with mild to moderate COVID-19 is available and **should be offered**. CDPH HEALTH ADVISORY: Reminder to Lower Barriers to Prescribing COVID-19 Therapeutics
- ❑ Older age ≥ 50 is one of the many reasons a person is at higher risk. For other higher risk conditions: https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html
- ❑ During an outbreak, LTCF's should assess residents who may be eligible for treatment (high risk with symptoms) **daily** and ensure providers are notified immediately. Treatments often have a short timeline to initiate **(5 days for oral anti-virals and 7 days for IV treatment**). Facilities should actively engage providers with information on COVID treatment. **If you need any assistance with accessing treatment, contact ACPHD at COVIDOB@acgov.org**
- ❑ Resources for more information on treatment:
  - ACPHD Treatment for COVID-19?
  - AFL-23-29 COVID-19 Treatment Resources for Skilled Nursing Facilities (SNFs)
  - CDPH COVID-19 Treatment Resources for Healthcare Providers
  - Therapeutics Myths and Facts (ca.gov)
  - IDSA Guidelines on the Treatment and Management of Patients with COVID-19 (idsociety.org)
- ❑ **Remdesivir Patient Access Program - Manufacturer Provides Payment Assistance**
  Gilead Sciences, the manufacturer of remdesivir (Veklury), has an Advancing Access Program for assisting patients who are prescribed remdesivir and cannot afford the co-pay or cost. Eligible commercially insured patients can access the co-pay coupon program, and un- or underinsured patients may be able to get free product through the patient assistance program. You can call the Advancing Access program at 1-800-226-20576 for details of eligibility and how to use the programs. https://www.vekluryhcp.com/access/
- ❑ The U.S. Government Patient Assistance Program (USG PAP) is operated by Pfizer to help people without commercial insurance get PAXLOVID for free. To qualify for free PAXLOVID through the program until December 31, 2024, patients must be:
  - Medicare beneficiaries
  - Medicaid beneficiaries
  - Uninsured and do not have a prescription drug benefit at the time they fill their prescription
    PAXCESS™ | PAXLOVID™ (nirmatrelvir tablets; ritonavir tablets)
    Commercial COVID-19 Oral Antivirals Memo (cms.gov)

Managing HCP Illness & Exposure

- ❑ Skilled Nursing Facilities should use the CDC Risk Assessment Framework to determine exposure risk for HCP with potential exposure to patients, residents, visitors, or other HCPs with COVID-19.
  AFL 21-08 CDC's updated risk assessment framework
- ❑ HCP who has had close contact with someone with SARS-CoV-2 in the **community** (e.g., household contacts) should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the

first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. See below for work restrictions. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

- ❑ For HCP with an ongoing household exposure who are unable to isolate from the COVID-19 positive case, testing should begin during the exposure and extend for 5 days after the COVID-19 positive case isolation time frame ends.
- ❑ Monitor and investigate HCP absenteeism due to any suspected COVID-19 symptoms.
- ❑ Instruct HCP who develop any symptoms suspicious for COVID-19 while at work to immediately stop work, alert their supervisor, leave the facility, and self-isolate at home. These HCP should be tested immediately for COVID-19 regardless of vaccination status.
- ❑ Plan for worker absences. Do not require a healthcare provider's note for employees who are sick to validate their illness. Have a transparent, non-punitive sick leave policy to allow them to stay home when they are sick.
- ❑ Please provide Isolation information to healthcare personnel (HCP) who test COVID-19 positive. Instructions are also available for HCP who were exposed to someone with COVID-19. See ACPHD Isolation Guidance. https://covid-19.acgov.org/isolation
- ❑ **Instructions for HCP who test positive for COVID-19**:

Work Restrictions for HCP with SARS-CoV-2 *INFECTION*

Vaccination Status	Routine work restriction	Critical staffing shortage
All HCP, regardless of vaccination status	5 days* with negative diagnostic test† same day or within 24 hours of return-to-work **OR** 10 days without a viral test	<5 days with most recent diagnostic test† result to prioritize staff placement

*Asymptomatic or mildly symptomatic with improving symptoms, and meeting negative test criteria; facilities should refer to CDC guidance for HCP with severe to critical illness or moderately to severely immunocompromised.

† Antigen testing is preferred for discontinuation of isolation and return-to-work for SARS-CoV-2 infected HCP and for HCP who have recovered from SARS-CoV-2 infection in the prior 90 days; NAAT is also acceptable if done and negative within 48 hours of return.

- HCP returning to work between days 5-9 after meeting routine criteria should wear a fit-tested N95 for source control through at least day 10 from symptoms onset or positive test (for HCP who remain asymptomatic throughout their infection).
- HCP whose most recent test is positive and are working before meeting routine return-to-work criteria due to critical staffing shortage should**:**
    - provide direct care only for patients/residents with confirmed SARS-CoV-2 infection, preferably in Isolation.
    - maintain separation from other HCP as much as possible (for example, use a separate restroom and breakroom, take meal breaks outdoors or in a well-ventilated area, away from other HCP or residents when removing their N95)
    - If breakrooms are shared, N95 should not be removed.
    - Always wear a N95 respirator for source control while in the facility until at least 10 days from symptoms onset or positive test.
- These HCP are restricted from contact with severely immunocompromised patients. AFL 21-08 CDC HCP High Risk Exposure Guidance

❑ **Instructions for HCP who were exposed for COVID-19**

Work Restrictions for asymptomatic HCP with *EXPOSURE* to SARS-CoV-2

Vaccination status	Routine work restriction	Critical staffing shortage
All HCP, regardless of vaccination status	No work restrictions with negative diagnostic test† upon identification, (but not earlier than 24 hours after exposure) and if negative, test at days 3 and 5	No work restrictions with negative diagnostic test† upon identification (but not earlier than 24 hours after exposure) and if negative, test at days 3 and 5

- Exposed HCP who are working during their post-exposure testing period should also always wear a N95 respirator for source control while in the facility until they have a negative test result on day 5. If they test negative on day 5, continue to wear a surgical mask for source control.
  AFL 21-08 CDC HCP Risk Assessment Guidance

Facility Admissions, Re-admissions and Residents Who Temporarily Leave the Facility

❑ **Covid-19 Positive Admissions and Re-admissions**:

- Facilities must develop plans for managing new admissions and providing care for residents with COVID-19 who require transmission-based precautions in Isolation, while still maintaining the capacity to provide care safely for other residents. A negative test result is not required for admission.
- Hospitalized patients with COVID-19 should be discharged when they no longer require the level of care provided in an acute care setting. Hospital discharge and admission or re-admission to a facility should not be delayed or prevented due to the COVID-19 status of the patient. Facilities should be prepared to accept and care for COVID-19 (+) patients and provide care safely **without putting existing residents at risk**.
- For new or returning residents who were hospitalized for COVID-19 and are clinically ready for discharge from the hospital, implement transmission-based precautions and place resident in a single room in the Isolation area until they qualify for discontinuation of precautions. If a single room is not available, residents with laboratory-confirmed COVID-19 may be cohorted in the same room.

❑ Consult with facility medical director and ACPHD to determine if the facility should be closed to new admissions during a COVID-19 outbreak.

- The duration of closures or limiting admissions should be determined for each situation individually.
- Facility-wide and prolonged closures are not necessary if transmission is controlled and there is an unaffected location available where new admissions can be placed

❑ **New Admissions:** Testing newly admitted residents upon arrival is an effective strategy for identifying COVID-19 cases. Test on day 1, and, if negative, test again at 3 days and 5 days after their admission to inform the type of infection control precautions used (e.g., room assignment/cohorting, or PPE used) and prevent unprotected exposures. Use empiric transmission-based precautions pending initial test result. **Do not require testing before accepting admission** CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

- Quarantine is not required for newly admitted and readmitted residents, regardless of vaccination status.
- If a new admission tests positive and was not in empiric transmission-based precautions during the infectious period, initiate outbreak response (Contact Tracing or Broad-based testing)

- If any resident begins showing **symptoms** of COVID-19 upon their return to the facility regardless of their vaccination status, place in a single room (if available) and test the resident.
- Testing and Isolation are **not required** for hospitalized residents who tested positive for COVID-19 and met criteria for discontinuation of isolation and precautions prior to SNF admission or readmission and are within 30 days of their infection.

❑ Residents who leave the facility

- 24 hours should be treated as a new admission. CDC
- < 24hours:
  - If they are visiting friends or family in their homes, they should follow the masking and physical distancing recommendations for visiting with others in private settings as described How to Protect Yourself & Others | CDC
  - Upon return to the facility, screen residents for signs and symptoms of COVID-19.
  - Asymptomatic residents **with close contact** with someone with COVID-19, **regardless of vaccination status**, should be tested promptly (day 1) and, if negative, again at 3 days and at 5 days after the exposure. (Consider transmission-based precautions if transmission is high in the community)
  - If any resident begins showing **symptoms** of COVID-19 upon their return to the facility regardless of their vaccination status, place in a single room (if available) and test the resident.

Managing Family, Visitors, and Volunteers

While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention.

If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the resident's room. The visit should occur in a manner that does not place other residents at risk. If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.

Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.

While not required, we encourage facilities in counties with high levels of community transmission to offer testing to visitors, if feasible.

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❑ **Any visitor entering the facility, regardless of their vaccination status, should adhere to the following**:

- All visitors must be educated to screen themselves prior to entry and be made aware of recommended actions to prevent transmission to others if they have COVID-19 symptoms and/or exposure within the prior 14 days to another person with COVID-19. They must also be made aware of recommended actions to prevent transmission to others.
- **During an outbreak, designate a facility staff member to conduct active screening**; if a visitor had COVID-19 symptoms in the last 24 hours or has been in close contact with a confirmed positive case or someone with symptoms, they should reschedule their visit, regardless of their vaccination status.
- All visitors should wear a well-fitting face mask with good filtration (N95, KF94, KN95, or surgical masks are preferred over cloth face coverings) and perform hand hygiene upon entry and in all

common areas in the facility. Facilities may **choose to require** visitors to wear masks while in the facility during an outbreak.

- If personal protective equipment (PPE) is required for contact with the resident due to transmission-based precautions or COVID-19 positive isolation status (including fully vaccinated visitors), it should be donned and doffed by the visitor according to instruction by HCP. The resident should wear a well-fitting mask, if tolerated.
- Facilities should limit visitor movement in the facility, regardless of the visitor's vaccination status; for example, visitors should not walk around the hallways of the facility and should go directly to and from the resident's room or designated visitation area.
- Visitors who are unable to adhere to these core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave.

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❑ **Outdoor visitation is preferred** and should be allowed because it poses a lower risk of transmission due to increased space and airflow. Masks outside can be encouraged. When providing outdoor visitation, facilities should facilitate visits on the facility premises (e.g., visits on lawns, patios, and other outdoor areas)

Recommendations for Visitors with Confirmed COVID-19, Compatible Symptoms, or Recent Exposure

Criteria	Actions*
Confirmed COVID-19 or compatible symptoms	• Defer non-urgent, in-person visitation until the healthcare criteria to end isolation is met (10 days from test date or onset date which is known to be day 0). This time period is longer than what is recommended in the community.
Close contact with someone with COVID-19 or were in another situation that put them at higher risk for transmission	• Defer non-urgent, in-person visitation until 10 days after their close contact if they are unable to wear source control. No delay if source control is worn unless symptoms develop, in which case the resident should be placed in isolation.

* Visits that occur in Skilled Nursing Facilities (SNFs) specifically, must align with the guidance and core principles of COVID-19 infection prevention outlined in QSO-20-39.

Vaccination

❑ Vaccines are the most effective tools for preventing infection, hospitalization, serious complications, and deaths from respiratory infections.

❑ Obtain standing COVID-19 vaccination orders from providers for residents and staff and vaccinate residents and staff for COVID-19 at the beginning of respiratory season as well as for any newly admitted residents who are unvaccinated. Offer COVID-19 vaccine to residents and staff who previously declined vaccination throughout the year.

- To schedule a vaccine clinic with HSAG: https://www.hsag.com/en/medicare-providers/nursing-homes/infection-prevention/vaccine-assistance/

❑ Provide easy access, education, and outreach to residents, their families, and the staff on the value and importance of being up-to-date with vaccinations.

- ❑ Encourage all workers to be up-to-date with vaccinations. See CDC Stay Up to Date with COVID-19 Vaccines
- ❑ The facility must report COVID-19 vaccine status of residents and staff, each dose of vaccine received, COVID-19 vaccination adverse events and therapeutics administered to residents for treatment of COVID-19. As already required at §483.80(g)(2), this data also must be reported to CDC's NHSN.
  COVID-19 Nursing Home Data COVID-19 Health Care Staff Vaccination Requirements - Final Rule
- ❑ Resources:
  - #GETVACCINATED AHCA Toolkit
  - HSAG- The Roadmap to Success - Improving Vaccination Rates in Long-Term Care
- ❑ **Flu Vaccines:** LTCF's should vaccinate residents with the influenza vaccine at the beginning of every influenza season. Mild illness is not a contraindication to flu vaccinations, and residents may receive vaccination regardless of COVID status. Flu vaccines and COVID-19 vaccines can be given at the same time if both vaccines are due. Egg allergy necessitates no additional safety measures for influenza vaccination beyond those recommended for any recipient of any vaccine, regardless of severity of previous reaction to egg.
- ❑ **Resources:**
  - HCP Influenza Vaccination Summary Reporting in NHSN | NHSN | CDC
  - Prevention and Control of Seasonal Influenza with Vaccines: Recommendations ACIP
- ❑ Keep residents up to date with all vaccines they may be eligible for:
- RSV
- Pneumococcal
- COVID-19
- Flu
- Shingrix

  CDC Recommended Adult Immunization Schedule

Ventilation

- ❑ When weather and air quality conditions allow, increase fresh outdoor air by opening windows and doors. Do not open windows and doors if doing so poses a safety or health risk to anyone using the facility.
- ❑ Use fans to increase the effectiveness of open windows.
  - Position fans securely and carefully in or near windows. The fan should be turned around to pull the air from the rooms to the outside (exhaust mode) if possible. Window fans placed in exhaust mode can help draw fresh air into a room via other open windows and doors without generating strong room air currents.
  - Take care with electrical cords; look out for tripping or wet conditions, which can create electrocution hazards.
  - Position fans so that air does not blow from one person to another.
- ❑ In the Isolation area/rooms, review, and address ventilation to ensure air flow is adequate. Observe ceiling vents, the use and position of fans, and if air can travel from the Isolation Area to other areas of the facility.
  - **A portable air cleaner with a HEPA filter should be placed in Isolation rooms/areas**.

- A room window should be open with a small fan turned around and pulling the air from the rooms to the outside if possible.
- Bathroom fans should remain on.
- Ceiling fans in the Isolation Area should be turned off and portable fans circulating "dirty air" should not be used.
- See illustration

❑ If there are two ceiling vents in the Isolation Area rooms, one vent is likely pushing air into the room and the other is pulling air out of the room and potentially recirculating the "dirty" and potentially contaminated air to other resident rooms. If this is the case, completely cover the vent pulling "dirty" air out of the Isolation Area rooms when they are occupied with positive or PUI residents.

❑ Place portable air cleaners in areas with poor air flow such as poorly ventilated dining rooms, therapy rooms, activity rooms and staff breakrooms. Portable air cleaners are designed to take in "dirty air," filter contaminants, and release fresh air back into the room. HEPA filtration is proven; ozone and "ionizers" are not recommended.

❑ Resources:

- Interim Guidance for Ventilation, Filtration, and Air Quality in Indoor Environments (ca.gov)
- Ventilation in Buildings | CDC
- Best Practices for Ventilation of Isolation Areas to Reduce COVID-19 Transmission Risk in Skilled Nursing Facilities, Long-Term Care Facilities
- Temporary airborne infection isolation for airborne infectious diseases (AirIDs)

Environmental Cleaning

❑ Increase frequency of environmental cleaning to **at least twice per shift** and whenever surfaces or equipment are soiled or contaminated with body fluids or respiratory secretions. Greater frequency of cleaning will also be needed for any areas where someone must take off their mask to eat or drink. Ensure staff have access to EPA-registered disinfectant wipes in break rooms.

❑ Educate Environmental Services staff on proper hand hygiene, PPE donning & doffing procedures & appropriate cleaning and disinfectant contact times. Document training.

❑ Regular monitoring of and feedback of results to staff can maintain or improve adherence to environmental cleaning practices. Use these tools weekly during outbreaks to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

- CDPH EVS Adherence Monitoring Fluorescent Marker Assessment Tool
- CDPH Adherence Monitoring Environmental Cleaning and Disinfection Tool

❑ Perform **Terminal Cleaning** when an infected patient (COVID, other infectious agent and/or MDRO) is moved out of one room to another or discharged from the facility. EVS staff should refrain from entering a newly vacated room without all the recommended PPE.

- Environmental Cleaning in Resource-Limited Settings (Spanish translation available)
- Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency

❑ **Terminal Cleaning Recommendations for Residents who were in Transmission-Based Precautions**

- Prior to entering the room, determine if the vacated resident was on transmission-based precautions to determine appropriate PPE usage and amount of time required to wait before

entering room. Once the recommended time has passed, individuals may enter the room and clean as described below:

- HCP, including environmental services personnel, should refrain from entering the vacated room of a SARS-CoV-2 (or other airborne pathogen) positive resident until sufficient time has elapsed for enough air changes to remove potentially infectious particles. Refer to CDC's Air Contaminant Removal Table. After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before returning to routine use.
- Remove soiled/used personal care items (e.g., cups, dishes) for reprocessing or disposal.
- Remove facility-provided linens for reprocessing or disposal. See CDC's linen and laundry management
- Inspect window treatments and if soiled, clean blinds on-site, and remove curtains for laundering.
- Clean and disinfect all reusable (noncritical) resident care equipment.
- Using the general best practices, clean and disinfect the room systematically from clean to dirty, top to bottom, including all low-touch and high-touch surfaces, other surfaces that may not be accessible when the room/area was occupied (e.g., patient mattress, bedframe, tops of shelves, vents), and floors.
- All non-dedicated, non-disposable medical equipment used for that resident should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another resident.

Resources:

- CDC Core Components of environmental cleaning and disinfection
- EPA List N
- CDPH HAI Effective Cleaning Strategies

Best Practices for Cleaning in Healthcare Facilities	Additional Guidance for Ongoing Success
Use disinfectants that kill SARS-CoV-2	• Use EPA List N for a complete list of disinfectants
Clean reusable items between use	• Dispose of single-use items after use
Work from clean to dirty to avoid spreading dirt and microorganisms	• Clean low-touch surfaces before high-touch surfaces • Clean resident zones (beds, sitting areas) before resident toilets • Clean high-touch surfaces outside the resident zone before the high-touch surfaces inside the resident zone
Clean general resident areas not under transmission-based precautions before those areas under transmission-based precautions.	• Ensure appropriate PPE is worn
Proceed from high surfaces to low surfaces to prevent dirt and microorganisms from dripping or falling and contaminating already cleaned areas	• Clean bed rails before bed legs • Clean environmental surfaces before cleaning floors • Clean floors last to allow collection of dirt and microorganisms that may have fallen
Proceed in a systematic manner to avoid missing surfaces	• Clean clockwise, or left to right, etc.
Perform management of laundry, food service utensils, and medical waste in accordance with state law and regulations and facility policy.	• Ensure policies in place for staff to reference

Assess Outbreak Control Measures

- ❑ If new cases are identified, facility leadership should review practices, obstacles to fully implementing control measures, and additional actions.
- ❑ **If using the Contact Tracing** approach to testing, ACPHD LTCF Outbreak surveillance for new cases will continue until there are no new positives when testing close contacts on day 1, 3 and 5 plus 5 additional days of surveillance.
- ❑ **If using the Facility-wide or Unit based** approach to testing, ACPHD LTCF Outbreak surveillance for new cases will continue until
  - There are no new cases when testing on day 1, 3, and 5 plus 5 additional days of surveillance.
    or
  - Two consecutive weeks (14 days) of testing every 3-4 days reveal no positive test results for residents.

Additional Resources:

ACPHD

- Influenza-Like Illness and non-COVID-19 Acute Respiratory Illness Outbreak Recommendations for Long-Term Care Facilities
- Respiratory Resources (fit-testing)
- COVID-19 Long Term Care Facility Webpage
- https://covid-19.acgov.org/isolation-quarantine

CMS

- QSO 20-39 Nursing Home Visitation - COVID-19

CDC

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- Infection Prevention Training
- CDC Burn Rate Calculator
- PPE Donning and Doffing Sequence and Signs

CAHF

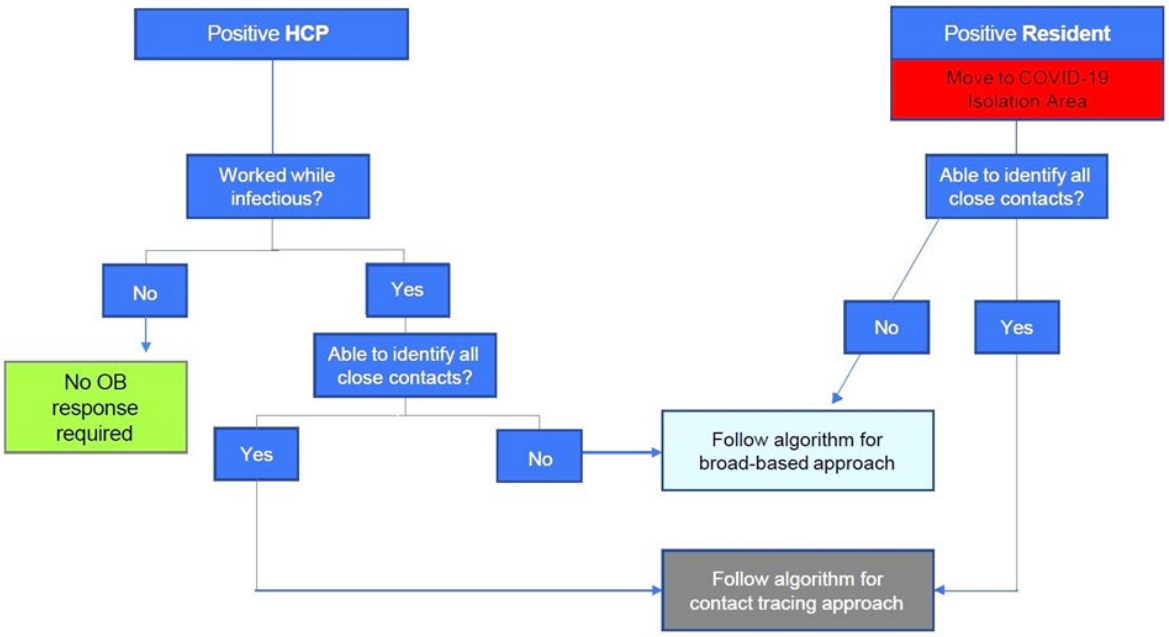
- YouTube-Creating Airborne Infection Isolation Rooms (AIIR) for Long-Term Care 6-21-21
- YouTube-Understanding the Effects of Wildfire Smoke in the Long-Term Care setting 6-21-21

CDPH

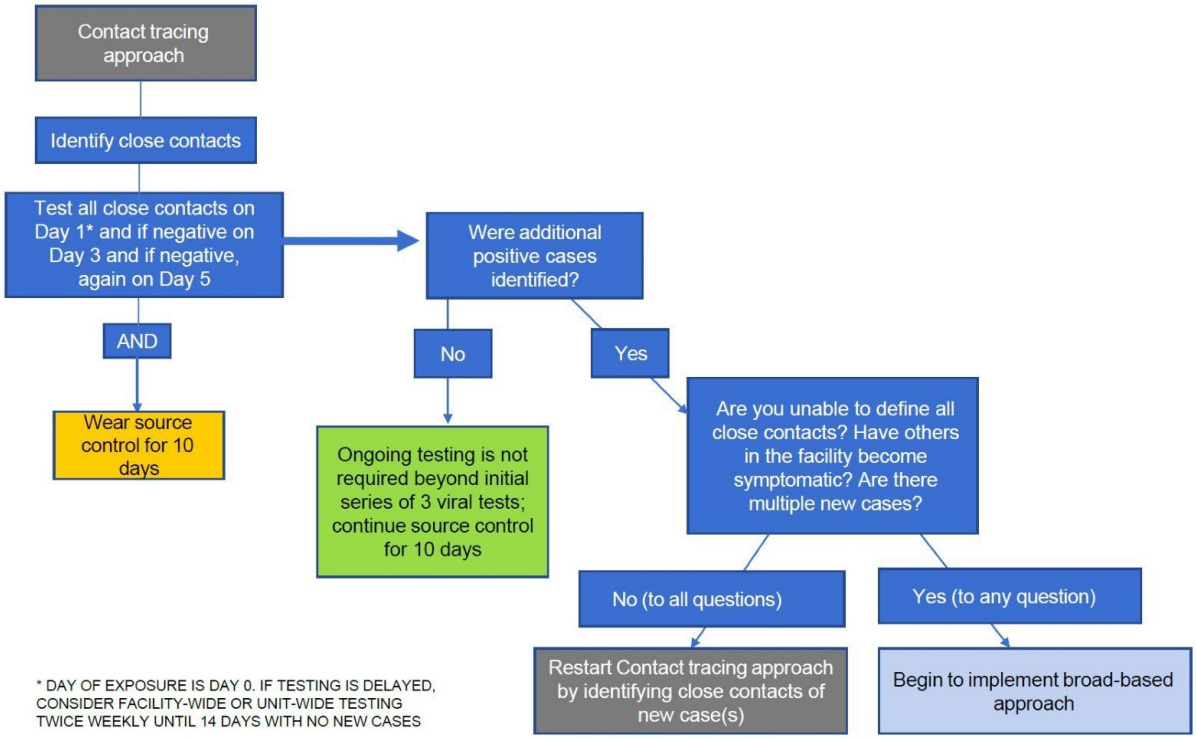
- COVID-19 Surge Readiness: Best Practices for Skilled Nursing Facilities
- CDPH Guidance by Topic
- AFL 23-12 Recommendations PPE, Resident Placement/Movement, and Staffing in SNF's
- AFL 21-08 Guidance on Quarantine and Isolation for Health Care Personnel (HCP) and Return to Work for HCP with COVID-19
- Recommendations for Prevention and Control of COVID-19, Influenza, and Other Respiratory Viral Infections in California Skilled Nursing Facilities – 2023-24

APPENDIX:

CHOOSING AN OUTBREAK RESPONSE METHOD FOR LONG-TERM CARE FACILITIES

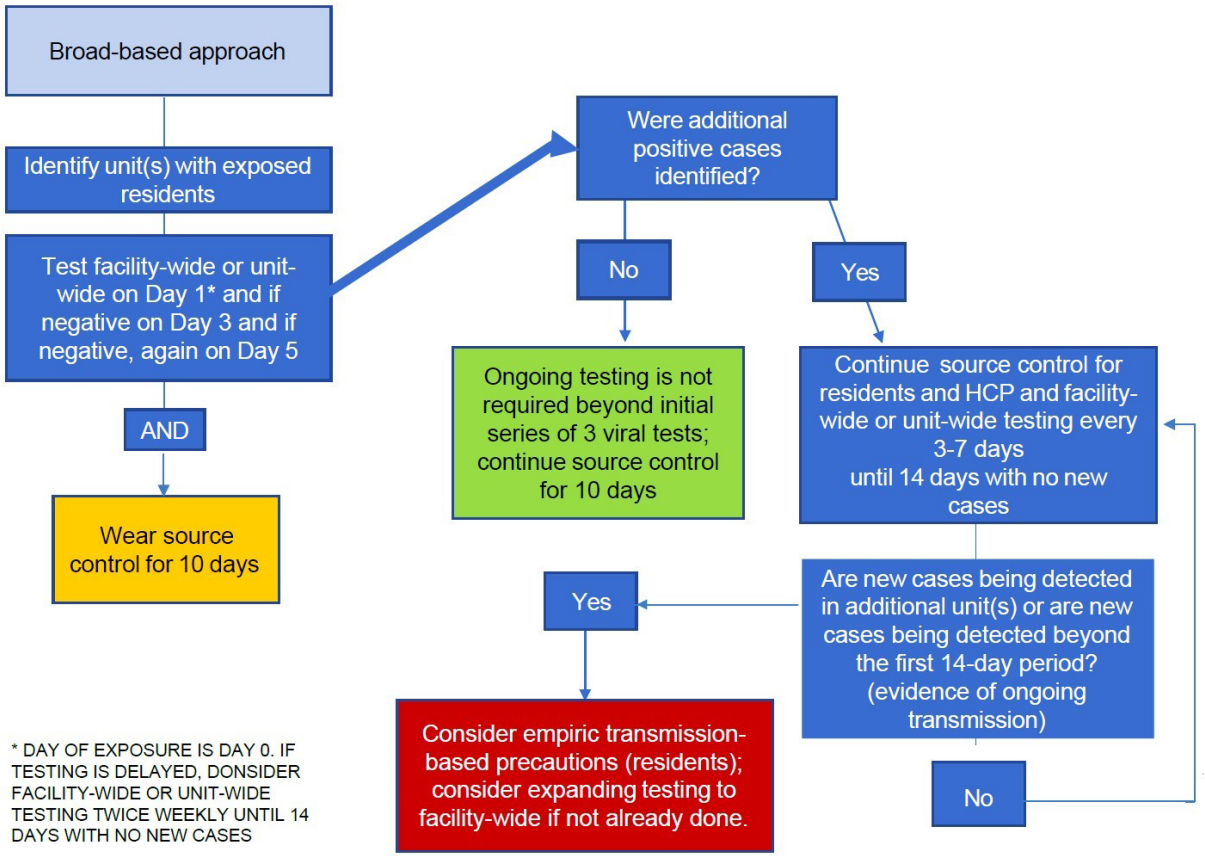


IMPLEMENTING A CONTACT-TRACING-BASED APPROACH TO OUTBREAK RESPONSE FOR LONG-TERM CARE FACILITIES

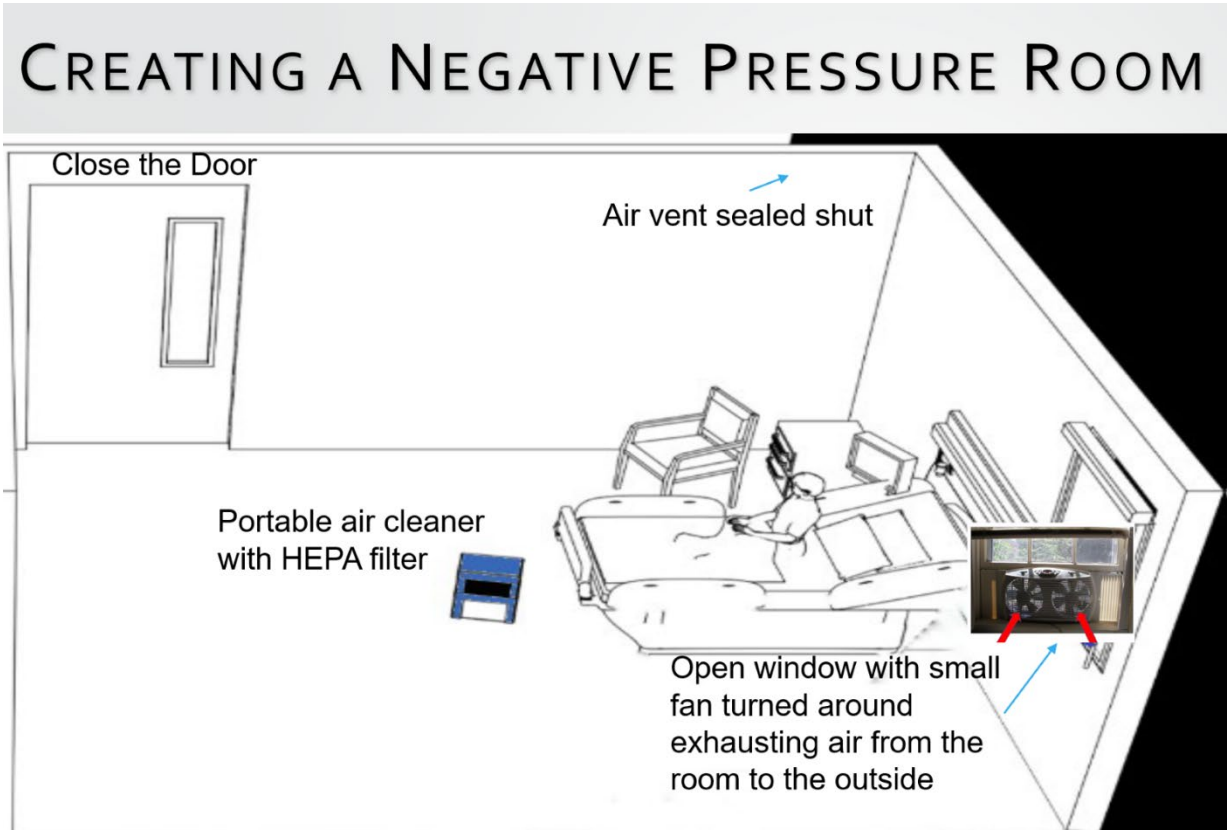


* DAY OF EXPOSURE IS DAY 0. IF TESTING IS DELAYED, CONSIDER FACILITY-WIDE OR UNIT-WIDE TESTING TWICE WEEKLY UNTIL 14 DAYS WITH NO NEW CASES

IMPLEMENTING A FACILITY-WIDE OR BROAD-BASED APPROACH TO OUTBREAK RESPONSE FOR LONG-TERM CARE FACILITIES



* DAY OF EXPOSURE IS DAY 0. IF TESTING IS DELAYED, DONSIDER FACILITY-WIDE OR UNIT-WIDE TESTING TWICE WEEKLY UNTIL 14 DAYS WITH NO NEW CASES


CREATING A NEGATIVE PRESSURE ROOM
Close the Door
Air vent sealed shut
Portable air cleaner
with HEPA filter
Open window with small
fan turned around
exhausting air from the
room to the outside