Interim Guidance: Prevention and Management of COVID-19 in Skilled Nursing Facilities

UPDATED March 10, 2021

The following guidance was developed by the San Francisco Department of Public Health for use by local facilities, and will be posted at www.sfcdcp.org. This interim guidance may change as knowledge, community transmission, and availability of PPE and testing change. Please also check for recent related health orders at www.sfdph.org/dph/alerts/coronavirus-healthorders.asp.

AUDIENCE: Skilled Nursing Facilities (SNFs) that provide 24-hour medical care on site.

Summary of Changes since 12/2/2020 Version

- Visitation guidance now directs facilities to adhere to California State policies and regulations.

- Added link to All Facilities Letters under Resources

  *California State guidance on **visitation** is rapidly changing as data changes in response to increased testing and rates of vaccination.*

BACKGROUND: Long term care facilities provide both medical and personal care to people who are unable to live independently. Skilled Nursing Facilities (SNFs) are long term care facilities (LTCFs) offering more intensive medical and nursing services.

Given their congregate nature and the susceptibility of the residents served (e.g., older adults often with underlying chronic medical conditions), SNFs are at the highest risk of being affected by COVID-19.

Once introduced into a facility, COVID-19 can spread rapidly. Recent experience with outbreaks in SNFs has shown many people with COVID-19 may not experience symptoms or may be infectious before they develop symptoms. These unrecognized asymptomatic and pre-symptomatic infections likely contribute to the spread of infection.

Given the high risk of spread once COVID-19 enters a facility and the increased risk of serious illness in residents, facilities must take immediate action to protect residents and staff from severe infections, hospitalizations, and death.

Health care staff and exposures from other settings continue to be sources of introduction of COVID-19 into SNFs. Aggressive efforts are needed to keep unrecognized COVID-19 from entering the facility, to identify infections early, and to prevent further spread, especially via asymptomatic transmission.

Even among vaccinated SNF resident and staff populations, social distancing, face coverings/masks, hand-washing, and ventilation are effective and necessary supplements to prevent vaccination-break-through infections, reduce chances of asymptomatic spread, and minimize impact of emerging variants.

San Francisco Department of Public Health

General Measures to Prevent Transmission of COVID-19

Implement universal masking and use of face coverings

To help prevent transmission by asymptomatic or pre-symptomatic individuals,

- **All persons entering the facility should wear facemasks or cloth face coverings at all times while in the facility.** This includes all staff, any visitors, delivery people, vendors, etc. The only exception is EMS personnel responding to a 911 call**.** Facemasks are preferred for health care workers and visitors.

- **Residents should wear cloth face coverings or facemasks when they leave their room, including residents leaving the facility for dialysis or other procedures.** They should also wear cloth face coverings or facemasks in their room when staff or others are within 6 feet.

- **Facemasks should be prioritized for health care personnel, visitors, and residents with known or suspected COVID-19 infection**. Others may use cloth face coverings.

  If a visitor, resident, vendor or other person arrives at the facility without facemask or face covering, a facemask should be provided by the facility.

  Visitors arriving with a face covering or mask should use the facemask offered by the facility, if possible.

  When supplies of facemasks are limited, refer to CDC guidelines on extended use and re-use of facemasks www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html.

- Cloth face coverings should not be used on anyone who has trouble breathing, or is asleep, unconscious, incapacitated, or otherwise unable to remove the cover without assistance.

Facemasks vs. Cloth Face Coverings

For the purpose of this guidance,

- "Facemasks" refers to surgical masks or procedure masks. They are PPE and protect the person wearing them from sprays and splashes. They also keep the person wearing them from spreading respiratory secretions when talking, sneezing, or coughing.

- "Cloth face coverings" including cloth face masks, keep the person wearing them from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE, and it is uncertain whether cloth face coverings protect the wearer. **Cloth face coverings should not be worn when a facemask or respirator is indicated.**

Implement symptom screening and temperature checks for all persons entering the facility.

- Screen **all** persons entering the facility for symptoms of COVID-19 and check their temperature. The only exception is EMS workers responding to 911 call.

- For the purpose of screening,
  - Fever is defined as temperature >100.0°F (37.8°C)
  - People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. Symptoms may appear **2-14 days after exposure to the virus.** People with these symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body ache, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea.

- Document the temperature and absence or presence of shortness of breath, new or altered cough, sore throat, and muscle aches in a log. Collect contact information of visitors to facilitate contact tracing in case one or more individuals later test positive.

- Health care workers and consultants who work at multiple facilities can be an important source of introduction of COVID-19 into a facility. When screening staff, ask about other health care facilities where they have worked in the last 14 days, and keep a daily log.

- Persons with fever or COVID-19 symptoms on screening should not be allowed inside the building. Staff with symptoms should keep their facemask on and immediately leave the workplace.

- Facilities should limit access points and ensure that all accessible entrances have a screening station.

Prevent staff from working while ill.

In addition to screening staff upon arrival for work,

- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill employees to stay home.

- Instruct all staff to check themselves for fever and symptoms at home BEFORE coming to work. If they are symptomatic, they should not report to work, and should notify their supervisor.

- If staff develop fever or symptoms while at work, they should keep their facemask on, notify their supervisor, and leave the workplace.

- Instruct staff and consultants to notify the facility immediately if they have a work-related COVID-19 exposure at another site. If a staff reports a work-related exposure, refer to COVID-19 Exposure Investigation and Response at Outpatient Facilities under "Healthcare Exposures" at www.sfcdcp.org/covid19hcp.

   Notify SFDPH Communicable Disease Control (CD Control) at (415) 554-2830 of any staff, consultants or outside health care workers with suspected and confirmed cases of COVID-19, whether they call in before their work shift, are detected during the facility entrance screening or develop symptoms at work. After hours, call 415-554-3613 to reach the on-call physician.

Return to Work Criteria for LTCF Staff with Respiratory or Influenza-like illness

LTCF staff should not work until

At least 24 hours have passed since fever has resolved without the use of fever-reducing medications **and** since any other symptoms have improved **and**

At least **10** days have passed since symptoms first appeared (*not 7 days as for health care workers in lower-risk settings)*. If a LTCF wishes to test staff for COVID-19, to allow staff with negative results to return to work sooner, the LTCF should consult first with SFDPH Communicable Disease Control.

NOTE: The timeframe from symptom onset could be extended to 20 days for individuals who are severely immunocompromised (e.g., currently receiving chemotherapy, or recent organ transplant), or who had critical illness (e.g., required intensive care).

After returning to work, staff should

Continue to follow all preventive measures in place at the facility, including participating in daily screening, wearing a face mask and all other appropriate PPE, practicing social distancing, and practicing enhanced hand hygiene.

Self-monitor for symptoms, and seek re-evaluation if symptoms recur or worsen.

> See *SFDPH Return to Work Guidance for Healthcare Personnel With Potential COVID-19 Infection* at www.sfcdcp.org/covid19hcp

Train and educate staff

Train and educate all staff on signs of COVID-19 and infection control, including universal masking, hand hygiene, and improving ventilation in a safe and secure manner. Provide job-specific training on transmission-based precautions and appropriate use of PPE.

- Remind staff to practice social distancing in break rooms and common areas. Facilities can maximize fresh air exchange through HVAC, passive (window/door) ventilation, and/or portable air cleaners, especially in rooms used by more than 1 person without windows, per SFDPH guidance (www.sfdph.org/dph/files/ig/COVID-19-Ventilation-Guidance.pdf)

- Given that the HIGHEST risk areas of transmission are where masks are taken off (e.g. breakrooms, locker rooms), encourage staff, if safety, security, and weather allow, to eat outdoors or open windows when taking mask off indoors, especially in shared spaces.

- Review recommendations for hand hygiene before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE), including gloves (www.cdc.gov/handhygiene/providers/index.html).

Ensure that health care staff demonstrate competency with putting on and removing PPE.
See CDC graphic at www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf.

Ensure that adequate staff have been trained and fit-tested for N95 respirators. When fit-testing staff, reinforce procedures to prevent the inadvertent spread of infection, such as

- Screening of employees for symptoms or recent symptoms before fit testing them
- Thorough cleaning of any devices used between each participant

Implement recommended infection control and prevention practices

Hand hygiene

- Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).

- Make sure that sinks are well-stocked with soap and paper towels for handwashing.

- Post signs encouraging hand hygiene and cough etiquette. A hand hygiene sign with multiple translations is available for download at http://eziz.org/assets/docs/IMM-825.pdf

- Have a process, such as regular Infection Prevention (IP) audits, to monitor staff adherence

Personal protective equipment (PPE).

- Post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.

- Make necessary PPE available in areas where resident care is provided.

- Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff.

- Position a trash can near the exit of each resident room to make it easy for employees to discard PPE.

Cleaning and disinfection of residents' rooms and common areas.

- Clean all surfaces at least daily more often as needed, especially "high-touch" surfaces, mobile medical equipment, and other shared resident care equipment. Use EPA-registered, healthcare-grade disinfectants that are effective against SARS-CoV-2, the coronavirus that causes COVID-19 (www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2).

- Work with staff to identify high-touch surfaces such as door handles, bedrails, and bathroom fixtures. Commonly overlooked items include bed alarms which are often turned off with a gloved hand, PPE carts, light switches, and med carts.

Limit transmission between residents

- **Limit group activities and communal dining**. Residents may engage in small group activities. Small group size should be limited to the number of people including the instructor/leader who are able to maintain 6 feet distancing and adequate ventilation. All meals should be served in a manner that preserves social distancing norms, such as limiting the number of residents in the dining area and staggering meals. Consider cohorting residents for communal dining (i.e., same distanced group may eat together regularly, so that fewer are exposed if one or more individuals later tests positive).

- **Encourage residents to remain in their rooms.** IF a COVID-19 case is diagnosed in the facility, restrict residents to their rooms, to the extent possible, except for medically necessary purposes.
  - When residents leave their rooms, they should
    - wear a cloth face covering or facemask,
    - perform hand hygiene,
    - limit their movement in the facility, and
    - perform social distancing (stay at least 6 feet away from others).

- **Influenza Vaccination**
  Because influenza can cause a similar, severe respiratory illness in the elderly, influenza vaccination should be provided annually, routinely to all residents and healthcare personnel and staff of long-term care facilities. Vaccination can prevent influenza-related illness and death, especially among people at increased risk for severe influenza complications.

Establish processes to anticipate COVID-19 cases in the facility

- **Establish a protocol to immediately notify SFDPH Communicable Disease Control (CD Control)** of positive COVID-19 test results, suspected COVID-19 in staff or residents, and clusters of respiratory illness.

- **Plan how to regularly communicate with families, residents, and staff if COVID-19 cases are identified** in residents or staff.

- **Practice Consistent Assignment (assigning the same staff to certain residents) as much as possible,** regardless of the residents' COVID-19 status, to minimize the number of different staff interacting with residents. Staff should not work across units or floors as much as possible.

- **Identify an area of the facility to dedicate to care for residents with confirmed COVID-19**. This could be a floor, unit, or wing in the facility or a group of rooms at the end of the unit to cohort residents

with COVID-19. Create a staffing plan for that location and assign dedicated HCP to work only in this area of the facility.

- **Facilities should document the name and contact information of any visitors** to assist with contact tracing if one or more individuals later test positive.

- **Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown.** Quarantine new admissions and readmissions in a private room or designated observation unit, with full PPE use by healthcare personnel, for 14 days after admission while monitoring for signs of COVID-19. This includes residents newly admitted from hospitals or other healthcare facilities, who should be tested prior to admission. Per CDPH guidance, if the hospital does not test the resident, the receiving facility must test and quarantine upon admission. Results for asymptomatic patients tested in the hospital do not have to be available prior to SNF transfer.

- SNFs may consider acute care hospital days as part of the quarantine observation period from the date of last potential exposure, if specific criteria are met. For additional information related to this, refer to *"Discharge or Transfer of Patients with COVID-19 to a Skilled Nursing Facility: Instructions for Hospitals and Other Facilities."* Coronavirus Disease 2019 (COVID-19) Mitigation Plan Recommendations for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF) (Supersedes AFL 20-53.2).

- **Have a contingency staffing plan** for increased employee absences and staffing shortages.
  - o Create a backup/on-call system if one is not already in place.
  - o Consider developing staffing agreements, utilize staffing registries.
  - o Identify minimum staffing needs to continue essential services if on-site operations must be reduced.

- **PPE Supplies**
  - o Implement a process to track and report available quantities of PPE as well as hand hygiene products, swabs and transport media for COVID-19 testing, EPA-approved disinfectants, and other items that may be in short supply.
  - o Monitor daily PPE use to identify when supplies will run low. CDC's PPE burn rate calculator may be helpful (www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html).
  - o Implement strategies to optimize use of PPE now, before supplies are limited. These may include:
    - ▪ Bundling resident care and treatment activities to minimize entries into resident room (e.g., having clinical staff clean and disinfect high-touch surfaces when in the room).
    - ▪ Extended use of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift).
    - ▪ Do NOT re-use gloves or gowns between caring for COVID-19 positive residents if their multi-drug resistant organism (MDRO) status is unknown.
    - ▪ Prioritizing gowns for activities where splashes and sprays are anticipated, aerosol generating procedures and high-contact resident care activities.
    - ▪ Developing a process for decontamination and reuse of PPE such as face shields and goggles.
  - o Develop a strategy for how allocate to PPE if supplies are limited.

- o Develop a plan to address likely supply shortages, including alternative channels for procuring needed resources.

- **Testing**

    - o The California Department of Public Health (CDPH) recently updated guidance on COVID-19 testing and its role in mitigation and prevention in [AFL 20-53.3: Coronavirus Disease 2019 (COVID-19) Mitigation Plan Recommendations for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF)](). The guidance defines several strategies for testing appropriate to different scenarios. These include:

        - **Baseline Testing of SNF Residents and HCP**

        - **Testing for Newly Admitted and Readmitted Residents**

        - **Symptomatic Testing or Diagnostic Testing for Symptomatic Individuals:**

            - Residents or HCP with signs or symptoms consistent with COVID-19 should be tested immediately to identify current infection; SNFs should not delay testing of symptomatic individuals until scheduled screening or response-driven testing.

        - **Screening Testing (formerly "Surveillance Testing") of SNF HCP:**

            - In facilities without any positive COVID-19 cases: implement **a minimum weekly screening testing** of all HCPs.

            - In facilities with a positive COVID-19 case, implement response-driven testing as described, below.

            - Additional testing considerations may include regular screening testing of residents who frequently leave the facility for dialysis or other services.

            - Facilities should plan on conducting screening testing independently of the SFDPH and PHL.

        - **Response-driven Testing (formerly "Outbreak Testing"):**

            - As soon as possible after one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility, serial retesting of all residents and HCP who test negative upon the prior round of testing should be performed at least every seven days until no new cases are identified among residents in two sequential rounds of testing; the facility may then resume their regular screening testing schedule for HCP.

            - The SFDPH and PHL will continue to assist facilities with response-driven testing.

    - o **Antigen testing:** [CDPH guidance]() includes the use of available antigen tests for COVID-19 for symptomatic, screening, and response testing, summarized in the flow chart below. The guidance discusses considerations for interpretation of antigen tests results and when positive, and negative antigen tests results should be confirmed by RT-PCR testing.

        - **Antigen testing for minimum weekly screening of HCP.** Because antigen testing has lower sensitivity than PCR testing resulting in possible false negatives, and there is also the possibility of false positive results, the SFDPH strongly recommends PCR as the preferred test when feasible. Nonetheless, the CDPH and [SFDPH]() allow the use of the antigen test for screening of HCPs if the following conditions are met:

- Testing is done at least weekly. Frequent testing alleviates some of the concerns over lower sensitivity of antigen testing.

- At least one week of screening per month must be PCR testing. For example, PCR testing can be done for 1 week per month with antigen testing conducted 3 weeks per month. The more PCR testing included in the weekly rotation of testing the better. That is, alternating PCR with antigen testing each week is better than 3 weeks of antigen testing plus 1 week of PCR testing.

- The likelihood of a false positive or a false negative depends on the background prevalence of COVID-19 in the population. Thresholds for determining low positivity or prevalence can be decided by the facility. A useful framework is the California "Blueprint for a Safer Economy" – Tiers 3 and 4 represent a positivity rate for tests <5% or case rate <4 per 100,000 (see updates at: www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID19CountyMonitoringOverview.aspx). The updated dashboard provides the current data on positivity for San Francisco, available at: https://data.sfgov.org/stories/s/d96w-cdge.

- Confirmatory testing of antigen positive results by PCR testing is optional and not required at this time. However, SFDPH recommends confirmatory PCR testing when there is low prior probability of COVID-19 infection. For example, confirmatory PCR testing should be sent if a symptomatic individual's antigen test is negative, if an asymptomatic individual with exposure/close contact has a positive antigen, or if an asymptomatic individual with no known exposure (e.g. surveillance testing without close contacts and with no known outbreak or exposure at the facility) has a positive antigen test. **While awaiting confirmatory testing, manage antigen-positive cases as you would COVID-19 confirmed cases.** Symptomatic persons with a positive antigen test and asymptomatic persons with a negative antigen test do not require confirmatory testing.
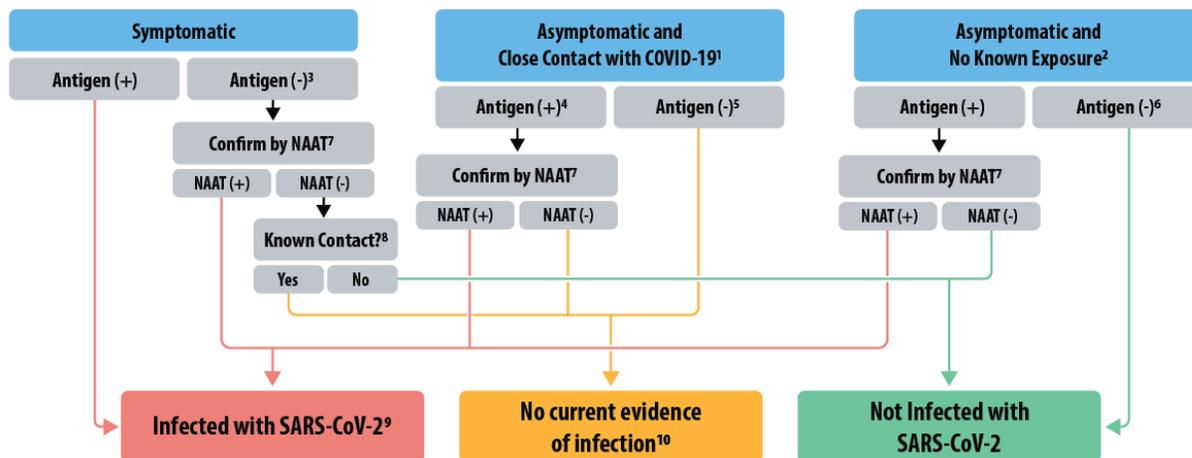
- **Reporting of antigen testing results to the SFDPH.** When onsite point of care antigen testing is done, positive and negative results must be reported to the SFDPH. With PCR testing, this responsibility usually falls to the laboratory. Therefore, standard operating procedures for reporting onsite antigen testing results to the SFDPH must to be established for each SNF. Requirements for COVID-19 reporting can be found on the SFDPH Health Orders page.

- **Special Considerations for Memory Care and Behavioral Units:**

  o Prioritize Memory Care units and behavioral units (locked units) for early, aggressive measures to prevent infection. These units can be challenging for infection control because PPE and cleaning supplies may need to be locked up, and ambulatory residents can sometimes be difficult to redirect. An outbreak on such a unit has the potential for rapid transmission.

  o In addition to universal masking/face covers, hand hygiene and social distancing for both staff and residents. Consider the following:

    ▪ Supervised hand hygiene for residents.

    ▪ Opening windows for ventilation when feasible.

    ▪ Cohorting staff to the memory unit or behavioral unit alone.

    ▪ Frequent Infection Control team spot checks for adherence on the unit.

    ▪ Cordoning off an area of the memory unit to use as an COVID-19 isolation/cohort area.

    ▪ Strategies to keep ambulatory residents out of the rooms of residents under isolation.

Implement symptom screening and temperature/oxygen saturation checks for all residents

- Evaluate all residents on <u>admission, readmission after transfer for acute care</u> and <u>at least once daily</u>. Check for respiratory and other symptoms (new or altered cough, sore throat, shortness of breath or difficulty breathing, muscle or body aches, fever or chills, cough, fatigue, headache, new loss of taste or smell, congestion or runny nose, nausea or vomiting, and diarrhea).

- Check for fever using a thermometer and check heart rate and O2 saturation via pulse oximeter. A log should be kept.

  o If there are confirmed COVID-19 cases in the facility, all residents should be checked at least <u>twice</u> daily, or once per shift.

  o Consider screening potentially exposed residents <u>three</u> times a day, with temperature, pulse and oxygen saturation, including residents who

    ▪ Regularly leave the facility for dialysis, infusions, or other complex care.

    ▪ Were transferred or readmitted from an acute care setting in the last 14 days.

    ▪ Have known exposure to COVID-19 (ex. roommate of a patient with COVID-19).

  o Screen for fever, cough, shortness of breath, and muscle aches. Also consider COVID-19 if other symptoms are reported including decreased appetite, fatigue, new or worsening malaise, headache, confusion, sore throat, runny nose, vomiting and diarrhea.

    ▪ Elderly patients with COVID-19 infection may not be able to mount a fever, so any change from their usual (baseline) temperature should be brought to the attention of a provider.

    ▪ Residents who are medically fragile and those with neurological or neurocognitive conditions may manifest atypical signs and symptoms of viral infection (e.g., confusion, behavior change, poor oral intake, falls, or weakness) and may not exhibit fever. Astute clinical judgement and flexibility in applying the clinical definition should be used.

- **Place a face mask on residents with symptoms of COVID-19** ASAP, until they can be isolated.

Visitors and Non-Essential Personnel

California State guidance on visitation is rapidly changing as testing and rates of vaccination increase.

Facilities are now directed to adhere to California State policies and regulations.

As of 9 March 2021, the current California State guidance is [AFL 20-22.6](#).

Isolation is a serious issue for older adults. Family and meaningful connection are important to mental and physical health. Encourage and create ways for all residents to have frequent video and phone call visits with family members, friends, or other persons in care. To the extent possible, find ways to connect with loved ones virtually through FaceTime, Zoom, WhatsApp, etc (see www.sfcdcp.org/safersocial). **If shared devices are used for video calls, facilities should ensure appropriate infection control measures are in place.**

There are multiple types of visits permitted. In all circumstances, facilities must implement prevention and mitigation activities to reduce the risk of COVID-19 transmission.

- "Necessary" visits may occur when there is an urgent health, legal, time-sensitive, or other critical need.

- "Allowed" visits by non-essential persons under certain parameters include, in increasing order of risk:
  - **Vehicle**, with visitor remaining in vehicle. An open window visit in this circumstance may mean that the resident is inside or outside of the facility. A closed window visit would mean the resident is inside of the facility behind a closed facility window.
  - **Facility**, with visitor outside of facility and resident on the other side of a window. This may be an open window or a closed window visit.
  - **Outdoor**, in-person
  - **Indoor,** communal space
  - **Indoor,** in-room

Facilities are permitted to temporarily modify their facility's visitation policies to ensure visits can be conducted safely. Please see the [California Department of Public Health Visitation Fact Sheet for Skilled Nursing Facilities](#) for visitation rules.

Contact DPH Outbreak Management Group (OMG) with any specific questions for their sites and guidance: COVID.OMG.SNF@sfdph.org

If A Resident Has Symptoms of COVID-19

Isolate symptomatic residents as soon as possible.

- Place symptomatic residents in a single-person room with the door closed. The room should have a private bathroom if possible. An Airborne Infection Isolation Room (AIIR) is not required and should be reserved for residents undergoing aerosol-generating procedures.

- Residents should leave their rooms only for medically essential purposes, and those who must leave should wear a facemask. If unable to tolerate a facemask, they should use tissues to cover their mouth and nose when sneezing or coughing.

- Ensure physical distancing for both residents and staff.

- Roommates of residents with suspected COVID-19 infection should be considered potentially exposed, placed in a private room with a private bathroom if possible for 14 days from the last date of exposure, and full PPE used for any resident interaction. See "Bed Placement of Residents" below for details of placement when private rooms are unavailable.

- Contact SFDPH COVID-19 Communicable Disease Control to discuss the case.

SFDPH Communicable Disease Control (CD Control)
(415) 554-2830
After hours, call 415-554-3613 to reach the on-call physician.

Notify SFDPH CD Control immediately of

- Suspected or lab-confirmed COVID-19 in residents or staff
- Three (3) or more residents or staff with new-onset respiratory symptoms within 72 hours of each other
- Residents with severe respiratory infection resulting in hospitalization or death

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Implement appropriate PPE for resident care.

- SFDPH recommends the following PPE when caring for SNF residents with COVID-19 or other respiratory illness. This level of PPE should also be utilized for potentially exposed residents as well as new admissions/re-admissions throughout their 14-day observation period.

PPE AND SOURCE CONTROL FOR PATIENT CARE INTERACTIONS

	Residents in isolation for suspected or known COVID-19 infection, exposure to COVID-19 *(including asymptomatic roommates and other close contacts of a case)*	New admissions/re-admissions during 14-day quarantine observation period *(COVID-status is unknown)*	Residents with respiratory symptoms and a negative COVID-19 test result*	Asymptomatic residents
Staff wears	Respirator (preferred) or facemask Goggles or face shield Gloves Gown, for ANY resident interaction	Respirator (preferred) or facemask Goggles or face shield Gloves Gown, for ANY resident interaction	Facemask Goggles or face shield Gloves Gown, when there is a risk of exposure to blood or bodily fluids	Facemask (to be worn at all times in the facility) Other PPE as indicated
Resident wears	Facemask (surgical or procedure mask) if tolerated	Facemask (surgical or procedure mask) if tolerated	Facemask if tolerated	Cloth face covering if tolerated

* These residents may still have influenza, RSV, or other respiratory pathogens that could spread through the facility.

- o **Respirator (or facemask)**
    - A fit-tested N95 respirator or powered air purifying respirator (PAPR) is recommended if available. Facemasks are an acceptable alternative when respirators are in short supply,
        - When supplies of respirators are limited, they should be reserved for aerosol-generating procedures on residents with suspected or confirmed COVID-19 and for care of residents whose infections require airborne precautions (e.g., tuberculosis, measles).
        - When supplies are limited consider extended use (where staff continue to wear the same respirator or facemask and eye protection for the care of more than one resident, for example, a cohort of COVID-19 positive residents), of respirators per OSHA guidelines, for 8-12 hours ONLY, and not beyond one work shift.
        - Staff should take care not to touch their eye protection, mask or respirator with their hands. If they do, they should immediately remove their gloves, perform hand hygiene, and put on a new pair of gloves.
        - Per CDC guidance, eye protection and respirator/facemask should still be changed when caring for residents with different respiratory pathogens or illnesses where the pathogen is unknown.
- o **Eye protection (goggles or face shield)** should cover the front and sides of the face. Personal eyeglasses and contact lenses are not considered adequate eye protection.
- o **Gloves and gown** should be removed after each resident encounter, and immediately perform hand hygiene. If gowns are in short supply, they should be prioritized for:
    - aerosol-generating procedures
    - care activities where splashes and sprays are anticipated and
    - high-contact patient care activities where virus may be transferred to the clothing of the health care staff, such as dressing, bathing/showering, transferring, changing linens, changing briefs, toileting, wound care, and device care or use
- o If the multidrug resistant status (MDRO) of residents are unknown, gloves and gowns should be changed in between residents.

- **Perform hand hygiene before and after each resident encounter.** Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands as PPE was removed.

- **As respirators and other PPE become more available, healthcare facilities should promptly resume standard PPE use practices**.

Test for COVID-19 and other respiratory infections.

- Collect a single swab for COVID-19 according to instructions published in the SFDPH at www.sfcdcp.org/covid19hcp, under "Clinical Testing and Guidance."

- Submit specimens for COVID-19 testing to a laboratory that has rapid turn-around time of results.

- Send a test concurrently for influenza and other respiratory pathogens. If possible, test for a full respiratory viral panel. Note that while commercial respiratory viral panels may test for other coronaviruses, they do not detect COVID-19.

Closely monitor the ill resident.

- Monitor symptomatic residents <u>at least 3 times day</u>, including symptom checks, vital signs, oxygen saturation via pulse oximetry, and respiratory exams.

- Clinicians should maintain a low threshold for obtaining a chest radiograph to exclude pneumonia or ARDS and refer for further evaluation and hospitalization if the resident exhibits clinical worsening.

Guidance on removing residents with suspected COVID-19 and asymptomatic residents exposed to COVID-19 from isolation

- If the resident with suspected COVID receives a negative COVID-19 test result, they may be removed from isolation for COVID-19. If they continue to have respiratory symptoms, the usual protocol for residents with respiratory symptoms should be followed.

- Residents who were exposed to COVID-19 and are asymptomatic, for example, roommates, may be removed from isolation after 14 days following the last exposure if they remain asymptomatic. Refer to the section below regarding testing of exposed residents.

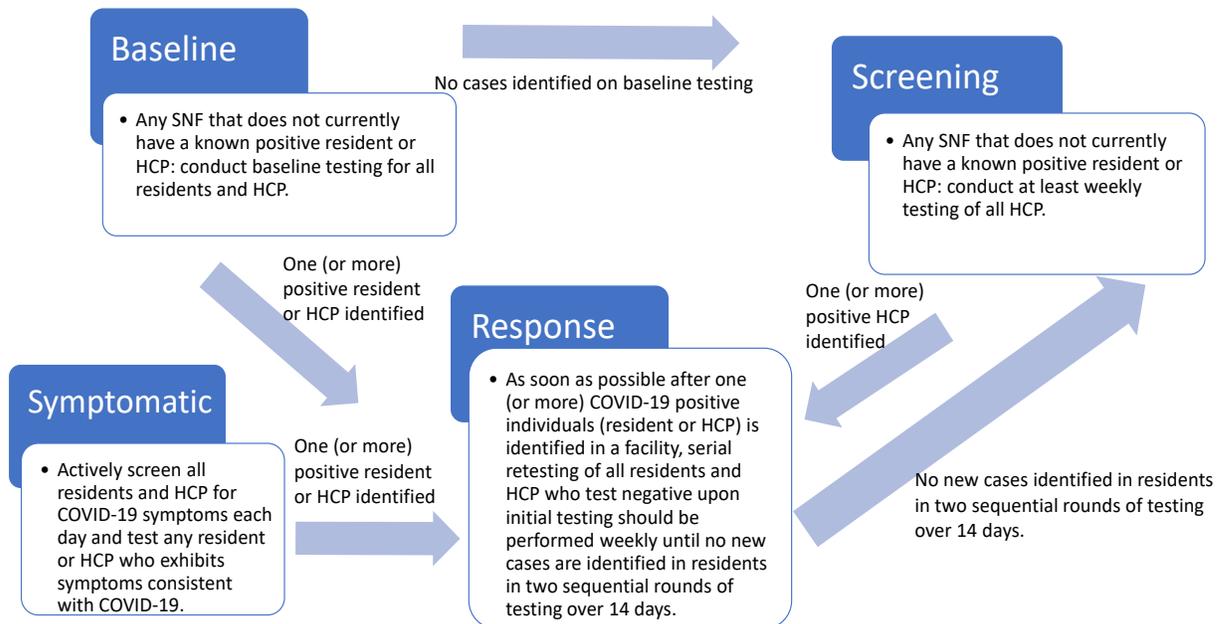## Further Steps if Resident or Staff has a positive COVID-19 Test Result

Presume widespread distribution of COVID-19 infection in the facility and be prepared for additional cases. Residents are most likely to acquire COVID-19 from an infected health care worker or visitor from the community. Given the time period for between infection and the onset of symptoms, as well as the risk of asymptomatic transmission, it is likely that if one resident is identified, multiple residents and staff have already been exposed.

- Continue to monitor the positive resident closely in isolation, <u>at least twice a shift</u>. AFL 20-74 has a helpful chart on appropriate zoning of patients who have tested positive

- **Call SFDPH Communicable Disease Control (CD Control) <u>as soon as a confirmed COVID-19 case is identified</u> at (415) 554-2830,1,1,2,1,1** for management to limit further spread of COVID-19. After hours, call 415-554-3613 to reach the on-call physician. The following actions will be required in consultation with SFDPH:

  o A facility experiencing an active outbreak should generally not accept new admissions. However, if the following criteria are met, a facility may consider accepting a new admission in consultation with SFDPH per AFL 20-87:

    o SNF has implemented outbreak control measures, as appropriate, such as response testing, cohorting, dedicated staff for the COVID-19 positive zone with no crossover, transmission-based precautions, and chemoprophylaxis (for influenza, assuming adequate availability).

    o SNF has no staffing shortage or operational problems (e.g., administrator or director of nursing out sick). SNF must have a trained infection preventionist. Long term staffing plans should be documented.

- o SNF has adequate personal protective equipment (PPE), staff from all shifts have access to N95 respirator fit testing and all staff have been fit-tested to the respirator model(s) currently available for use in the facility, and access to adequate hand hygiene and environmental cleaning supplies.

- o SNF has a well-demarcated "yellow" COVID-19 observation area (unit or wing) for new admissions.

- o Quarantine and monitor residents who were in close contact with the case.

- o Test exposed residents and staff for COVID-19 as recommended by SFDPH and AFL 20-53. Test symptomatic persons for COVID-19 and other respiratory pathogens.

Baseline, Symptomatic, Screening and Response COVID-19 Testing of SNF Residents and HCP

Baseline
- Any SNF that does not currently have a known positive resident or HCP: conduct baseline testing for all residents and HCP.

No cases identified on baseline testing

Screening
- Any SNF that does not currently have a known positive resident or HCP: conduct at least weekly testing of all HCP.

One (or more) positive resident or HCP identified

Response
- As soon as possible after one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility, serial retesting of all residents and HCP who test negative upon initial testing should be performed weekly until no new cases are identified in residents in two sequential rounds of testing over 14 days.

Symptomatic
- Actively screen all residents and HCP for COVID-19 symptoms each day and test any resident or HCP who exhibits symptoms consistent with COVID-19.

One (or more) positive resident or HCP identified

One (or more) positive HCP identified

No new cases identified in residents in two sequential rounds of testing over 14 days.

- o Monitor employees who were in close contact with the case per AFL 20-53.3.

- o Check all residents for COVID-19 symptoms, temperature, heart rate, and O2 saturation via pulse oximeter at least twice daily.

- o Notify external facilities and transport services prior to transferring any ill resident for further care.

- o For residents receiving dialysis outside of the facility, notify their dialysis center and request that they be dialyzed in "isolation." Given the ongoing and continual need for dialysis, these residents do not need to be placed in an observation unit each time they leave the facility. However, these residents should be monitored for symptoms closely and can be considered for more frequent testing, such as the screening testing schedule for staff.

For residents with a positive COVID-19 test:

- o Record a log of all persons who care for or enter the room or care area of the ill resident.

- o Maintain isolation of the ill resident with appropriate infection control precautions, including

appropriate PPE use, following the *CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or PUIs for COVID-19 in Healthcare Settings* guidance (www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

- o Minimize of the number of staff providing care for residents with COVID-19 infection. Restrict staff from floating to more than one unit. Staff in contact with ill residents/units should not work with well residents/units or in other health care facilities until no new cases have been identified for 28 days.

  Determine additional control measures and duration of implementation in consultation with SFDPH.

- **Guidance on removal from isolation for LTCF residents with lab-confirmed COVID-19**

  - o CDPH guidance (AFL 20-53.3) recommends residents that test **positive and are symptomatic** should be isolated until the following conditions are met:

    - At least **10** days have passed since symptoms first appeared (*not 7 days as for patients in lower-risk settings)*
    - At least 24 hours have passed *since recovery*, defined as
      - resolution of fever without the use of fever-reducing medications **and**
      - improvement in any other symptoms (e.g., cough, shortness of breath)

    NOTE: The timeframe from symptom onset could be extended to 20 days for individuals who are severely immunocompromised (e.g., currently receiving chemotherapy, or recent organ transplant), or who had critical illness (e.g., required intensive care)

  - o Residents that test **positive and are asymptomatic** should be isolated for 10 days from the date of their positive test, as long as they have not subsequently developed symptoms, in which case the symptom-based criteria for discontinuing isolation should be applied

  - o If the resident meets criteria for removal from isolation but continues to have persistent symptoms (e.g., persistent cough), they should be remain in a private room, be restricted to their room, and wear a facemask or cloth face covering during care activities until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.

  - o If the resident was diagnosed based on non-respiratory symptoms (e.g., lethargy or altered mental status) or is immunocompromised, consult with SFDPH prior to removal from isolation.

- *This guidance on when to discontinue transmission-based precautions may change as new information about COVID-19 becomes available.*

Cohorting Residents During an Outbreak

- Consider designating entire units or pods within the facility, and cohort staff to care for only for known or suspected COVID-19 residents during their shift. The ability to separately house suspect and confirmed will vary by facility, and this decision can be made on case-by-case basis in consultation with SFDPH.

- o **Only residents with the same respiratory pathogen may be housed in the same room. For example, a resident with COVID-19 should not be housed in the same room as a resident with influenza or an undiagnosed respiratory infection.**
- o If there is a shortage of private rooms,
  - ▪ Residents with confirmed COVID-19 may be housed in the same room.
  - ▪ Asymptomatic residents without suspected or known exposure to COVID-19 may be housed in the same room.
  - ▪ Persons exposed to COVID-19 and symptomatic residents without confirmed COVID-19 infection should be isolated in private rooms if possible.

    See "Bed Placement of Residents" below for detailed information.

- Increase environmental cleaning throughout the facility to three (3) times a day, if possible, with emphasis on high touch surfaces every 2 hours per CDPH, particularly in the unit where the resident was located.
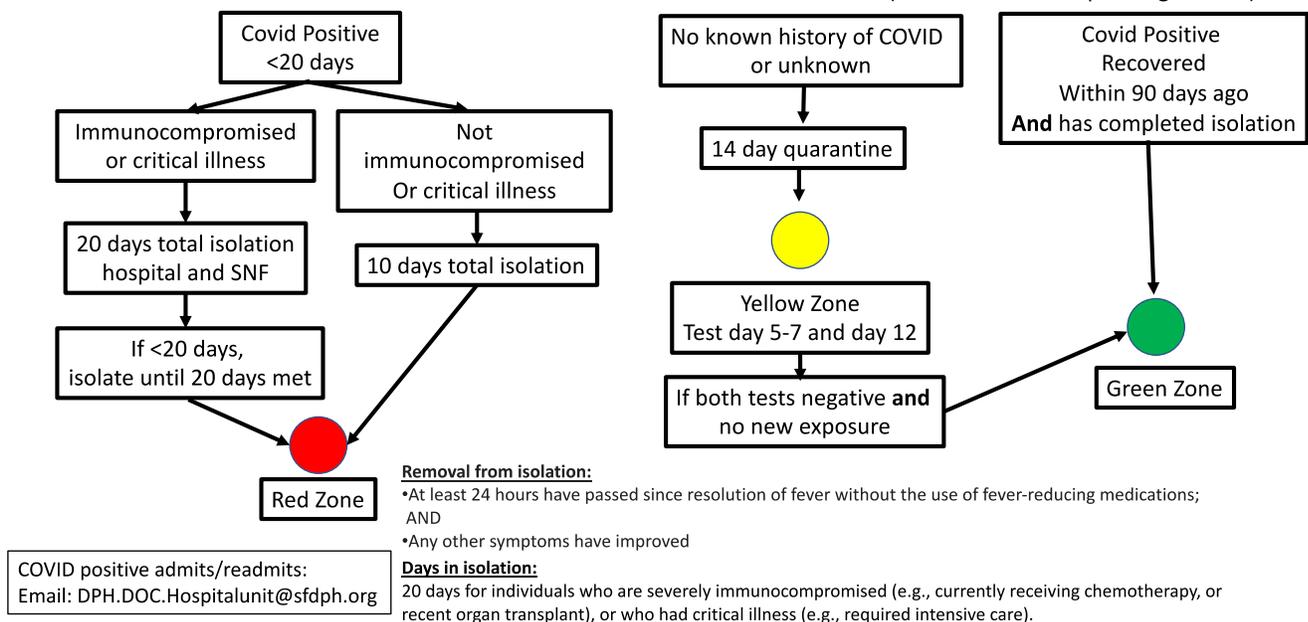
Bed Placement of Residents

- **Residents with confirmed COVID-19** should ideally be cohorted together in a designated unit/area for residents with lab-confirmed COVID-19 infection. Otherwise, they should be roomed with other residents with lab-confirmed COVID-19 or isolated in a private room with their own bathroom.

- **Residents with suspected COVID-19 and test results pending** should be isolated in a private room with their own bathroom. If that is not possible, please discuss cohorting alternatives with SFDPH CD Control, as the goal is to minimize potential exposures among susceptible patients.

- **Asymptomatic roommates of residents with known or suspected COVID-19** should be considered potentially exposed to COVID-19. *Avoid placing exposed residents in a new room with residents who do not have known exposures to COVID-19.* They should be roomed as described below, in order of desirability.
  1. (Preferred) Move the exposed roommate to a private room, preferably with a private bathroom.
  2. (Alternative) Move the resident with known or suspected COVID-19 out of the room where the exposure occurred. Keep the exposed roommate in the original room without a new roommate. Facilities should be aware, however in this scenario, this risks infection of the
  3. If bed capacity, staffing availability, or other constraints prevent any of the first 3 placement options, it is reasonable to keep the roommate in the same room as the suspect/known COVID-19 case. This is preferable to having the roommate share a room with residents who do not have known exposures to COVID-19. If this is the case, to mitigate potential ongoing risks of transmission to the roommate,
     - ▪ Place resident beds as far apart as possible.
       Instruct mobile residents to socially distance (stay 6 feet away) from their roommate while in the room.
     - ▪ Place a surgical mask on the resident with suspected or known COVID-19 resident, if tolerated.
     - ▪ Use privacy curtains as possible barrier protection between the resident beds

- ▪ Open windows for ventilation if feasible.
  - ▪ Enhance/increase frequency of daily environmental cleaning of the room, focusing on shared bathroom and high-touch surfaces.

- **Residents who are new admissions/re-admissions should be managed according to CDC guidance and AFL 20-74:**

  - o **If COVID-19 status is positive or positive test within the last 20 days**: Facilities should communicate with the transferring facility to confirm that they have received guidance from SFDPH Hospital Unit COVID-19 transfer coordinator (email DPH.DOC.Hospitalunit@sfdph.org). The SFDPH Hospital Unit COVID-19 transfer coordinator must review and approve each COVID-19 positive discharge/transfer patient before facilities can accept a new patient/readmission, to confirm appropriate isolation/quarantine plans and bed placement at the residential care facility. Facilities then place the resident in isolation ("red zone") if continued isolation is required per AFL 20-74 guidance.

  - o **If COVID-19 is unknown or there is no history of COVID-19**: resident should be quarantined in a single-person room or in a designated observation area "yellow zone" so the resident can be monitored for signs of COVID-19. Residents can be transferred out of the observation area and moved into a shared room/general population area if they remain afebrile and without symptoms for 14 days after admission. Per AFL 20-74, new admissions in quarantine should not room with residents who are in quarantine due to symptoms or to exposure.

  - o **If COVID-19 recovered within the last 90 days AND completed isolation** per SFDPH Medical Branch COVID-19 transfer coordinator: Residents may be admitted into the "green" or "green-recovered red" zone.

SNF Admissions/Readmissions - Zoning

(See AFL-20-74 for specific guidance)

Covid Positive <20 days
- Immunocompromised or critical illness → 20 days total isolation hospital and SNF → If <20 days, isolate until 20 days met
- Not immunocompromised Or critical illness → 10 days total isolation
→ Red Zone

No known history of COVID or unknown → 14 day quarantine → (yellow) Yellow Zone Test day 5-7 and day 12 → If both tests negative **and** no new exposure → Green Zone

Covid Positive Recovered Within 90 days ago And has completed isolation → (green) Green Zone

COVID positive admits/readmits:
Email: DPH.DOC.Hospitalunit@sfdph.org

Removal from isolation:
•At least 24 hours have passed since resolution of fever without the use of fever-reducing medications; AND
•Any other symptoms have improved

Days in isolation:
20 days for individuals who are severely immunocompromised (e.g., currently receiving chemotherapy, or recent organ transplant), or who had critical illness (e.g., required intensive care).

- **Considerations for residents in Memory Care or Behavioral Units**

  - The benefits of transferring a resident with known or suspected COVID-19 infection from a Memory Care or Behavioral Unit to a designated COVID-19 or quarantine unit must be weighed with the risks of such transfers, especially if significant exposure has already occurred for other residents and staff in the locked unit. Such a transfer may have adverse effects, including potential falls, and can be extremely distressing and disorienting for the resident.

  - Transfers should be carefully controlled and planned to avoid unnecessary exposures when moving through the building. The ability of the receiving COVID-19 or observation unit to keep the resident from wandering after transfer should also be considered.

Transfer of Patients with COVID-19 to LTCFs

- Per CDPH, patients with COVID-19 may be transferred to skilled nursing facilities (SNFs) as long as they are clinically stable, even if they still require isolation/transmission-based precautions.

- All new admissions/readmissions who have been diagnosed with COVID-19 or a positive test must have the **approval of transfer** and new admission/readmission from SFDPH Hospital Unit's COVID-19 transfer coordinator at DPH.DOC.Hospitalunit@sfdph.org

- A checklist for LTCF to accept a resident with suspected or known COVID-19 is posted at: www.sfcdcp.org/covid19hcp under Long-Term Care and Senior Care.

- In brief, the facility should have the following:

  - For lab-confirmed COVID-19 infection, placement in
    - designated unit or pod for residents with lab-confirmed COVID-19 infection (preferred),
    - a room shared with another resident with lab-confirmed COVID-19 infection, or
    - a private room with a private bathroom.

  - For suspected COVID-19, a private room with a private bathroom

  - Adequate staffing and PPE to maintain transmission-based precautions. *Patients should not be accepted if the receiving facility cannot maintain transmission-based precautions.*

Additional Resources

Stay informed. Information is changing rapidly. Updated CDC, local and state COVID-19 activity and recommendations can be found at

- Centers for Disease Control and Prevention (CDC)

  - Preparing for COVID-19: Long-term Care Facilities, Nursing Homes
    www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

  - Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States
    www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html

- CMS COVID-19 Long-Term Care Facility Guidance
  www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf

- San Francisco Department of Public Health (SFDPH)
  www.sfcdcp.org/covid19

- California Department of Public Health (CDPH)
  All Facilities Letters: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL.aspx
  www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx