California Department of Public Health
Center for Health Care Quality
AFC Skilled Nursing Facilities Infection Prevention Call
January 11, 2023

Weekly Call-in Information:

- 1st & 3rd Tuesdays every month, 8:00am All Facilities Calls:
  - 844.721.7239; Access code: 7993227
- Every Tuesday, 11:30am NHSN Updates & Office Hours (Hosted by HSAG NHSN Experts)
  - January-March 2023 registration https://bit.ly/NHSNofficehours2023JanFebMarch
- 2nd & 4th Wednesdays every month, 3:00pm SNF Infection Prevention Webinars:
  - Register at: https://www.hsag.com/cdph-ip-webinars
  - Recordings, call notes and slides can be accessed at https://www.hsag.com/en/covid-19/long-term-care-facilities/cdph-ip-webinars-past/

Important Links to State and Federal Guidance	
Important Links and FAQs to CDPH State Guidance	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Guidance.aspx
2020 CDPH All Facilities Letters (AFLs)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL20.aspx
2021 CDPH AFLs	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL21.aspx
2022 CDPH AFLs	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL22.aspx
CDC COVID-19 Data Tracker	https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk&null=Risk
CDPH Vaccine Guidance and Resources	https://eziz.org/resources-for-longterm-care-facilities/
CDPH Long-Term Care COVID-19 Vaccine Toolkit	https://eziz.org/assets/docs/COVID19/LTCFToolkit.pdf
CDC's Interim Infection Prevention and Control Recommendations for HCP During COVID-19 (9/23/2022)	https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
HSAG NHSN and Booster Website	www.hsag.com/nhsn-help https://www.hsag.com/6-week-booster-sprint

CDPH Funding Opportunity

Request for Application 22-10924: CA Nursing Home and Long-Term Care Infrastructure and Preparedness
https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/LTC_InfrastructureProject_RFA.aspx

- CDPH is requesting applications from eligible organizations and entities to receive funding of $21.5 million to:
  - Support California skilled nursing and other long-term care facilities during their response to SARS-CoV-2 infections,
  - Build and maintain the infection prevention infrastructure necessary to support resident, visitor, and facility healthcare personnel safety.
- The maximum to be distributed to each Awardee is anticipated to be between $50,000 to $750,000, depending on the nature and scope of the proposed activity.
- Submit questions to HAIProgram@cdph.ca.gov by January 13.
- **Applications Due:** February 24, 2023, by 5 p.m. PT.

California Department of Aging (CDA)—
Office of the Long-Term Care Patient Representative Program (OLTCPRP)

The interdisciplinary team (IDT) process is changing on **January 27, 2023**. SNFs and intermediate care facilities will be required to include a patient representative who is unassociated with the facility when they convene an IDT for proposed medical interventions that require informed consent (Health and Safety Code 1418.8). A patient representative is required to participate in an IDT if:

- The patient is unable to provide informed consent and
- The patient has no legal surrogate to make decisions on their behalf and
- The patient has no friend or relative who can represent them on an IDT

Prior to this date, the CDA OLTCPR will provide training for facility staff on:

- How to request a public patient representative
- What notices facilities are required to provide residents, patient representatives, and LTCPRP
- What specific data related to IDTs convened pursuant to HSC 1418.8 facilities are required to report to the CDA-OLTCPRP

Please register at https://bit.ly/3Z7hGwi for the OLTCPR webinar on January 19, 2023, from 2:00 – 3:30 p.m. PT, to learn more and review how facilities can request a patient representative.

- OLTCPR Website
- CDA OLTCPRP Wednesday Webinar Slides

Educational Opportunities

CALTCM Free Webinar

- ***A New Year's Path to Person-Centered Care***
- Monday, January 23, 2023, at 4:00pm Pacific
- Register: https://www.caltcm.org/covid-19-webinars

HSAG Free Webinars

- **Emergency Preparedness Webinars:**
  - 3rd Wednesdays every month, 3pm
  - February 15th Topic: ***Hazard Vulnerability Assessment (HVA)***
  - Register: bit.ly/epp-series

- **Care Coordination Quickinars:**
  - 1st Tuesdays every month, 11am
  - February 7th Topic: ***Strategies to Prevent UTI and Pneumonia-Related Readmissions***
  - Register: bit.ly/cc-quickinars2

- **Health Equity Quickinars: Strategies to Remedy Systemic Barriers**
  - 2nd & 4th Thursdays every month, 10am
  - January 26th Topic: ***Engaging Leadership in Health Equity***
  - Register: www.hsag.com/health-equity-quickinars

- **Patient & Family Engagement Quickinars:**
  - 1st & 3rd Thursdays month, 10am
  - February 2nd Topic: ***Introduction to Patient and Family Engagement***
  - Registration Link: https://www.hsag.com/pfe-quickinars

Q-1: Do nursing homes still need to have a yellow zone to quarantine residents?"
A: The "yellow zone" is no longer generally applicable because quarantine and empiric transmission-based precautions are no longer routinely required for COVID-19 exposed and newly admitted residents. However, per AFL 22-13.1, "A facility-wide or group-level approach with quarantine for exposed groups should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission." If a contact tracing approach is infeasible or does not successfully halt COVID-19 transmission, in consultation with the local health department, the facility may need to revert back to the unit-based approach wherein all residents on a unit where a case was identified would be considered exposed and placed in quarantine with empiric transmission-based precautions. In this scenario, that unit would essentially be what we previously referred to as a yellow zone.

Q-2: Do nursing homes still need to have a red zone even if there are no COVID-19 positive residents?
A: SNFs still need to have a dedicated COVID-19 isolation area (formerly referred to as "red zone"). Per AFL 22-13.1, "SNFs should continue to ensure residents identified with confirmed COVID-19 are promptly isolated in a designated COVID-19 isolation area. The COVID-19 isolation area may be a designated floor, unit, or wing, or a group of rooms at the end of a unit that is physically separate and ideally includes ventilation measures to prevent transmission to other residents outside the isolation area. SNFs that do not have any residents with COVID-19 and do not have a current need for an isolation area should remain prepared to quickly reestablish the area and provide care for and accept admission of residents with COVID-19."

Q-3: For symptomatic residents, can we still use yellow zone terminology?
A: We are moving away from the color zone framework that was developed early in the pandemic to guide infection control precautions for groups of residents solely based on their COVID status. We now need to consider COVID-19 along with many other transmissible pathogens (e.g., influenza, MDROs) and individualize precautions based on a resident's specific situation. A symptomatic resident should be empirically isolated and cared for with transmission-based precautions based on their suspected diagnosis, which might be COVID-19, influenza, or another pathogen. While test results are pending, isolate the resident in their current room with empiric transmission-based precautions, and avoid moving the resident so that new exposures throughout the facility are not created. If the resident tests positive for COVID-19, then move them to the designated COVID-19 isolation area and consider the roommate(s) exposed.

Q-4: Do nursing homes need to have dedicated staffing for caring for residents in the red zone?
A: Dedicated staffing for the COVID-19 isolation area and sequencing care for uninfected residents before positive residents are no longer required.

- Dedicated staffing and/or sequencing care might be preferable from a practical standpoint when there are large numbers of residents in the COVID-19 isolation area (i.e., to facilitate extended use of N95s).
- Ensure all HCP perform hand hygiene and change gloves and gowns between residents and when leaving the resident's room, or area of care (e.g., treatment or therapy room).
- Ensure all HCP strictly adhere to masking for source control (to prevent an infected HCP from inadvertently exposing the residents they are caring for).

The facility's full-time infection preventionist should assist with adherence monitoring of hand hygiene and PPE donning/doffing between all residents and provide just-in-time feedback.

Q-5: Can HCP working with residents in isolation share the same breakrooms and bathrooms with other HCP?
A: Yes. Dedicated staffing for the COVID-19 isolation area is no longer required, therefore HCP can share the same breakrooms and bathrooms. Reinforce teaching about the importance of hand hygiene, managing PPE, avoiding crowding, and performing environmental cleaning for shared spaces. During critical staffing shortages, if COVID-19 positive HCP return to work early per AFL 21-08.9, these workers should:

- Wear a fit-tested N95 for source control through day 10.
- Take meal breaks outdoors, or in a well-ventilated area, away from other HCP or residents when removing their N95.
- If break rooms are shared, N95s should not be removed; avoid crowding in break rooms.

PPE Questions & Answers

Q-6: For routine staffing purposes, when COVID-19 positive HCP return to work on day 6 after testing negative, do they need to wear an N95?
A: Yes. Per AFL 21-08.9, under routine staffing conditions, COVID-19 positive HCP may return to work after 5 days with proof of a negative antigen, or after 10 days without a negative test (and afebrile x 24 hours and symptoms improving). Even if the HCP tests negative on day 5 with an antigen test, they should wear a fit-tested N95 for source control through day 10 to provide an additional layer of safety because of the limited sensitivity of a single antigen test.

Q-7: Is there a specific form or process we should follow when fit-testing HCP for N95s?
A: Please refer to the California Code of Regulations for Fit Testing Procedures (https://www.dir.ca.gov/title8/5144a.html).

Isolation and Quarantine Questions & Answers

Q-8: If our SNF has all private rooms, can COVID-19 positive residents isolate in place?
A: No. It is still preferrable to have a designated isolation area in the SNF to care for COVID-19 positive residents. This separate isolation area to manage infected residents needs to have recommended ventilation and air flow that will minimize exposure via shared air with residents in other areas of the facility that are not infected.

Q-9: Are nursing homes required to have signage for physical distancing?
A: Signage is needed to signify the transmission-based precautions that are needed for resident rooms. Signage that reminds all individuals of what they need to do (i.e., avoid crowding, masking, hand hygiene, physical distancing) is a best practice, however, it is not a requirement. Refer to CDC: Transmission-Based Precautions (https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html#anchor_1564058235). For COVID-19, we recommend Contact Precautions and Airborne Precautions signs. Note that the CDC Airborne Precautions sign does NOT include a requirement for an airborne infection isolation room.

Q-10: When can COVID-19-positive HCP return to work?
A: Recognizing that staffing shortages continue to persist, per AFL 21-08.9, under routine staffing conditions, COVID-19 positive HCP may return to work after 5 days with proof of a negative antigen, or after 10 days without a negative test (and afebrile x 24 hours and symptoms improving). To provide an additional layer of safety, these HCP should wear a fit-tested N95 for source control through day 10.

- If there is a critical staffing shortage, no additional testing is required to return beyond the initial positive test. Per the table below from AFL 21-08.9, positive asymptomatic HCP,

regardless of vaccination status, may return to work immediately with a fit-tested N95 for source control. When returning to work early, use the results of the most recent test result (which may be the test at diagnosis) to determine work placement:

- If the most recent test result is positive, HCP can only provide direct care to residents with confirmed SARS-CoV-2 infection, preferably in a cohort setting. This may not apply for staff types or in settings where practically infeasible (e.g., Emergency Departments where patient COVID status is unknown) or where doing so would disrupt safe nurse to patient ratios, and for staff who do not have direct patient/resident care roles.

HCP who aren't already fit-tested for their role do not need to become newly fit-tested solely for the purpose of being able to return to work; these workers should wear a well-fitting N95. COVID-19 positive staff should take meal breaks outdoors, or in a well-ventilated area, away from other HCP or residents when removing their N95. If break rooms are shared, N95s should not be removed; avoid crowding in break rooms. Notify the L&C District Office and LHD if there is an anticipated staffing crisis.

Work Restrictions for HCP with SARS-CoV-2 Infection (Isolation)

Vaccination Status	Routine	Critical Staffing Shortage
All HCP, regardless of vaccination status	5 days* with at least one negative diagnostic test† same day or within 24 hours prior to return OR 10 days without a viral test	<5 days with most recent diagnostic test† result to prioritize staff placement‡

Q-11: How are the days counted for return-to-work purposes (routine staffing) for COVID-19 HCP in isolation?

A: Per CDPH AFL 21-08.9, in routine staffing circumstances, COVID-19 positive HCP may return to work after 5 days with proof of a negative antigen, or after 10 days without a negative test (and afebrile x 24 hours and symptoms improving). The five days is counted in the following way (see image of calendar as an example):

- Day 0 = Day of symptom onset, or if asymptomatic, day of first positive test
- Day 5= Last day of isolation with proof of a negative antigen test. Return to work would be Day 6.
- Day 10= Last day of isolation without a negative test. Return to work would be Day 11.

CDC isolation guidance for the general public (including the calendar image) can be found at: (https://www.cdc.gov/coronavirus/2019-ncov/downloads/your-health/COVID-19_Isolation.pdf).

Q-12: Does a resident who had close contact with a positive visitor, HCP or resident need to quarantine?
A: No. Per AFL 22-13.1, a resident who is in close contact with any COVID-19 positive person does not need to quarantine, regardless of vaccination status.

- Resident should wear a mask outside their room for source control for a minimum of 10 days following the exposure.
- Resident should not participate in communal dining for 10 days following the exposure because masks must be removed during eating and drinking.
- Resident should be tested promptly (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and at 5 days after the exposure.

Q-13: Do new newly admitted, readmitted residents, need to be tested and quarantined on admission?
A: Per CDPH AFL 22-13.1, guidance for new admissions and residents who have left the facility for >24 hours (i.e., readmitted), regardless of vaccination status or COVID-19 community transmission levels, includes the following:

- All new admissions should have a series of three SARS-CoV-2 tests; immediately upon admission and, if negative, again at 3 and 5 days after their admission. Antigen or PCR tests are acceptable. Testing is not required for asymptomatic new admissions who tested positive and met criteria for discontinuation of isolation and precautions prior to admission and are within 30 days of their infection.
- Quarantine is not required for asymptomatic newly admitted and readmitted residents, regardless of vaccination status.
- Newly admitted residents and those who have left the facility for > 24 hours should wear source control when outside their room for 10 days.

Vaccine Questions & Answers

Q-14: Who is eligible to receive a COVID-19 updated (bivalent) booster?
A: Everyone ages 6 months and older is recommended to receive 1 bivalent mRNA booster dose after completion of any FDA-approved or FDA-authorized monovalent primary series or previously received monovalent booster dose(s) with the following exception: children age 6 months–4 years who receive a 3-dose Pfizer-BioNTech primary series are not authorized to receive a booster dose at this time regardless of which Pfizer-BioNTech vaccine (i.e., monovalent or bivalent) was administered for the third primary series dose. Refer to CDC: Stay Up to Date with COVID-19 Vaccines Including Boosters.

Q-15: Is the monovalent vaccine still recommended for the 1st and 2nd dose of the primary series for an unvaccinated patient?
A: For primary series vaccination, monovalent Moderna, and Pfizer-BioNTech, and Novavax COVID-19 vaccines are recommended.

Q-16: When did the bivalent booster vaccines start? How do we know if the booster the patient received is a bivalent?
A. The bivalent boosters became available starting September 2, 2022. The physical and digital COVID-19 Vaccine Record should be updated and will show that a booster vaccine dose has been administered.

Q-17: Is the COVID-19 bivalent booster safe for pregnant mothers?
A: COVID-19 vaccination is recommended for all people aged 6 months and older. This includes people who are pregnant, breastfeeding, trying to get pregnant now, or those who might become pregnant in the future. Please visit "CDC COVID-19 Vaccines While Pregnant or Breastfeeding."

Communal Dining & Group Activities

Q-18: Can exposed residents participate in communal dining and group activities?
A: Please see the following guidance from AFL 22-07.1.

- **Communal Dining:** Residents who are not in isolation and have not recently been exposed to COVID-19, may eat in the same room without masks or physical distancing (when no visitors are present), regardless of vaccination status. Avoid crowding within spaces. Residents who have been exposed to COVID-19 must wear a mask for 10 days following the most recent exposure. Therefore, they should not participate in communal dining because masks must be removed during eating and drinking.
    - Visitors can dine with the resident they are visiting, regardless of the visitor's vaccination status. Masks may be removed while eating or drinking. Physical distancing should be maintained between resident-visitor groups in communal indoor spaces
- **Group Activities:** Residents who are not in isolation may participate in group/social activities together without masks or physical distancing (when no visitors are present), regardless of vaccination status. Exposed residents can participate in group activities as long as they wear a mask throughout the activity for a minimum of 10 days following the most recent exposure.
- Facilities should consider, in consultation with their local health department, reimplementing limitations on communal activities and dining based on the status of COVID-19 infections in the facility, (e.g., when one or more cases has been identified in facility staff or residents).

Visitation Questions & Answers

Q-19: Do healthcare settings need to actively screen visitors prior to entry?
A: No. CDPH AFL 22-07.1 is now aligned with CMS QSO 20-39 and CDPH SPHO "Requirements for Visitors in Acute Health Care and Long-Term Care Settings" which was rescinded Sept 15, 2022. Visitors are no longer required to show proof of vaccination or a negative test to have indoor visitation. While not required, facilities may offer and encourage testing for visitors. Visitors must continue to comply with CDPH Masking Guidance. Visitor screening for COVID-19 signs and symptoms, and exposures is still required, but may be conducted via passive screening as recommended by CDC. Options for passive screening to ensure visitors are educated to screen themselves prior to entry, include **posting signs at entrances and sending emails or letters to families and visitors to provide guidance** about recommended actions for visitors who have:

- a positive viral test for COVID-19
- symptoms of COVID-19, or
- have had close contact with someone with COVID-19.

If they have a confirmed COVID-19 infection or symptoms consistent with COVID 19, they should defer non-urgent in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact. Refer to "CDC Notice on Facility Access" for more information, including the "CDC Facilities COVID-19 Screening Tool" (https://www.cdc.gov/screening/privacy-notice.html). A facility may decide to return to active screening if visitors with symptoms or exposure are continuing to visit.

Other Questions & Answers

Q-20: Are there any COVID-19 restrictions regarding pet therapy?
A: There are no COVID-19 restrictions of pet visitation. Allowing pets to visit is at the discretion of each facility. Please refer to the CDC Website: "Information about COVID-19, Pets, and Other Animals" (https://www.cdc.gov/healthypets/covid-19/index.html) to learn more about COVID-19 and pets. Please ensure any pet therapy program encourages good hand hygiene before and after touching the pet.

Q-21: Are nursing homes able to use plastic barriers to indicate a separation between the isolation area (red zone) and the other areas of the facility?
A: Avoid using plastic barriers to separate different zones of care. The use of visual clues is preferred to identify your cohort zones and keep unauthorized personnel from entering the unit. If a plastic barrier is used to keep air from the isolation unit from leaving that zone, there are site-specific considerations based on the building design, properties of the barrier, and the resident population. Consultation with a professional who understands the airflow of the building is advised. Any time barriers are deployed, airflow distribution testing with tracer "smoke" or a handheld pressure monitor should be used to be certain that air flow is from clean to dirty, (e.g., from hallway to room where infected individuals may be housed). For more information, visit CDC Ventilation in Buildings (https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html) and the CDPH Interim Guidance for Ventilation, Filtration, and Air Quality in Indoor Environments (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Interim-Guidance-for-Ventilation-Filtration-and-Air-Quality-in-Indoor-Environments.aspx).

Q-22: What is the guidance regarding the usage of water fountains for residents in the facility?
A: The use of water fountains can be problematic due to challenges with potential contamination of the fountain, pipes, water supply, or drains. For example, organisms or biofilms in pipes can lead to residents breathing in aerosolized organisms such as Legionella. If your facility uses water fountains, please include the cleaning, disinfection, and water management of the device in your facility water management plan (https://www.cdc.gov/hai/prevent/environment/water.html; https://www.cdc.gov/hai/prevent/environment/water.html).

Q-23: Where can SNFs request more COVID-19 antigen test kits?
A: Contact your local Medical Health Operational Area Coordinator (MHOAC). MHOAC program contact information can be found at: https://emsa.ca.gov/medical-health-operational-area-coordinator/.

Q-24: Is the influenza vaccination summary report in NHSN mandatory for all nursing homes?
A: Yes, influenza vaccine data for staff is new QRP measure for this year. If a CMS Certified SNF fails to submit the required quality data, the SNF will be subject to a two percentage (2%) point reduction in the Annual Payment Update (APU) for the applicable performance year.

Q-25: Is there a form that shows me how to submit the influenza vaccination summary report?
A: Yes, the instructions for flu reporting can be found on page 2 and 3 of the HSAG Overview of National Health Safety Network (NHSN) Reporting Requirements for Long-Term Care Facilities (LTCFs) (https://www.hsag.com/globalassets/12sow/nhsn/nhsnassistancefinal112022.pdf).