California Department of Public Health
Center for Health Care Quality
AFC Skilled Nursing Facilities Infection Prevention Call
October 26, 2022

Weekly Call-in Information:

- 1st & 3rd Tuesdays, 8:00am All Facilities Calls: 844.721.7239; Access code: 7993227
- Tuesday 11:30am NHSN Updates & Office Hours (Hosted by HSAG NHSN Experts)
  - https://bit.ly/NHSNofficeHours2022AugSep
- 2nd & 4th Wednesdays, 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
CDPH Vaccine Guidance and Resources	https://eziz.org/resources-for-longterm-care-facilities/
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

AFL	Date	Title	Website
20-88.3	10/5/22	COVID-19 Testing Recommendations for Patients and HCP at GACHS (supersedes AFL 20-88.2)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-88.aspx
21-34.4	10/5/22	COVID-19 Vaccine Requirement for HCP (supersedes AFL 21-34.3)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-34.aspx
22-13.1	10/5/22	COVID-19 Mitigation Plan Recommendations for Testing of HCP and Residents at SNFs (supersedes AFL 20-53.6 & AFL 22-13)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-13.aspx
21-14.2	10/6/22	Visitation Guidance for ICF/DD-H-N-CN Facilities During COVID-19 Pandemic (supersedes AFL 21-14.1)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-14.aspx
21-31.1	10/6/22	Visitor Limitation Guidance at GACHs (supersedes AFL 21-31 & AFL 20-38.7)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-31.aspx
22-07.1	10/6/22	Guidance for Limiting the Transmission of COVID-19 in SNFs (supersedes AFL 22-07)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-07.aspx
22-21	10/5/22	Enhanced Standard Precautions for SNFs (supersedes AFL 19-22)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-21.aspx

CMS QSO	Date	Title	Website
20-38-NH	9/23/22	Long-Term Care Facility Testing Requirements	https://www.cms.gov/files/document/qso-20-38-nh-revised.pdf
20-39-NH	9/23/22	Nursing Home Visitation - COVID-19	https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

PPE Questions & Answers

Q-1: Do visitors and HCP need to wear masks for source control while in a nursing home?
A: Yes. In healthcare settings, CDPH continues to require universal masking (source control) of all visitors and HCP, *regardless of vaccination status or community transmission rates*. Surgical masks or higher-level respirators (e.g., N95s, KN95s, KF94s) with good fit are highly recommended. In healthcare settings, masks continue to be required in non-patient care areas, including meeting or break rooms. CDPH Guidance for the Use of Face Masks

Q-2: Does "healthcare settings," where universal masking is required of all individuals, include outpatient facilities and assisted living facilities?
A: Yes, "health care settings" refers to places where healthcare is delivered and includes, but is not limited to, acute care facilities, long-term acute-care facilities, inpatient rehabilitation facilities, nursing homes, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, dental offices, and others.
Q&A: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Face-Coverings-QA.aspx

Q-3: Are visitors required to mask when visiting nursing homes regardless of vaccination status?
A: Yes, visitors and HCP are required to wear a mask regardless of vaccination status. See guidance document for more information: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx.

Q-4: When can masks be removed in high-risk settings, such as nursing homes?
A: Examples when individuals are exempt from wearing masks are:

- Persons with a medical condition, mental health condition, or disability that prevents wearing a mask. This includes persons with a medical condition for whom wearing a mask could obstruct breathing or who are unconscious, incapacitated, or otherwise unable to remove a mask without assistance.
- Persons who are hearing impaired or communicating with a person who is hearing impaired (i.e., the mouth is essential for communication).
- Persons who are working alone in a closed office or room.
- Persons/providers who are obtaining or providing a speech, occupational or language therapy session.
- People do not need to wear masks when outdoors.
- For residents who are not in isolation and not exposed, masks may be removed while actively eating or drinking, and while participating in group/social activities together (when outside visitors are not present).

More information can be found in the CDPH Q&As:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Face-Coverings-QA.aspx

Q-5: Can HCP wear KN95s instead of surgical masks in the green zone and non-patient care areas?
A: Yes, surgical masks, KN95s, KN94s, and N95s can be worn as source control by SNF HCP in the green zone and non-patient care areas. While KN95s are acceptable, CDPH cautions against the use of KN95s as source control to avoid confusion with N95s. Because of concerns that some KN95s are counterfeits, only NIOSH-approved N95s should be worn as PPE for transmission-based precautions.

Q-6: Do COVID-19 positive residents having a visit outdoors need to wear a mask?
A: Yes. COVID-19 positive residents in isolation should generally not be leaving their rooms during their isolation period unless medically necessary. They can have in-room visits while in isolation (visitors must wear proper PPE). On a case-by-case basis, an outdoor visit would be reasonable if their room has an attached outdoor patio.

Q-7: Are residents required to wear masks in nursing homes?
A: Masks are not required for residents in their rooms (i.e., their home); however, they are still required during in-room visits (unless eating or drinking). Masks are recommended, but not required, for residents when outside of their rooms (i.e., hallways, common areas). If outside visitors are present (e.g., during large communal space visitation), both residents and visitors must wear a mask unless eating or drinking. If residents have been exposed to an individual with COVID-19, they must wear a mask for 10 days following the most recent exposure, even during group activities. Residents who

have been exposed should not participate in communal dining since masks must be removed during eating and drinking.

Q-8: Can exposed residents still participate in group activities and communal dining?
A: Exposed residents can still participate in group activities as long as they wear a mask throughout the activity for a minimum of 10 days following the exposure. Residents who have been exposed should not participate in communal dining (in which masks need to be removed).

Q-9: When do HCP need to wear eye protection (face shields, goggles)?
A: HCP need to wear eye protection when caring for COVID-19 positive residents in isolation. Eye protection should also be worn when performing tasks that could generate splashes or sprays of blood, body fluids, secretions, and excretions per Standard Precautions.

- Universal eye protection is no longer required during care of residents who do not have COVID-19 or for recently exposed residents, regardless of community transmission rates.
- Universal eye protection and N95 respirators for AGPs can be considered:
    - During a surge or periods of high community transmission
    - During a COVID-19 outbreak in the facility.
    - If recommended by the local health department.
- Eye protection is not necessary in non-patient care areas (i.e., kitchen, hallways, nurses' station).

Active vs. Passive Screening Questions & Answers

Q-10: Do healthcare settings need to continue to 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. 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.

Q-11: Do healthcare settings need to continue to screen HCP prior to entry?
A: CDC still recommends screening for signs and symptoms of COVID-19, and potential exposures, but has transitioned from an **active** screening to a more **passive** self-screening process.

- Examples of passive screening, include posting signs at entrances, and sending emails and letters providing guidance to HCP about recommended actions for HCP who have:
  - a positive viral test for COVID-19
  - symptoms of COVID-19, or
  - close contact/higher-risk exposure with someone with COVID-19.

There is no longer a requirement for nursing homes to actively ask screening questions prior to entry, and temperatures do not need to be checked. Facilities may choose to continue to screen HCP in an active way, especially when community transmission rates are high or during a surge if they choose.

Q-12: With passive visitor screening now acceptable, can nursing homes have multiple entrances?
A: Yes. The single point of entry made it feasible for a facility to actively screen staff and visitors prior to entry. Now that passive screening is acceptable, it would be reasonable to have more than one entry point to the facility. However, visitors that enter the facility still need to check-in to sign a visitor log like they did pre-pandemic so that the facility is able to track who is in the building. Visitors no longer need to complete a screening log to indicate their vaccination records, testing results, or that they have screened themselves for signs and symptoms of COVID, or exposures.

Testing Questions & Answers

Q-13: When will the CDPH weekly survey be updated to reflect the updated testing guidance?
A: The changes should be reflected in next week's reporting period (week of October 31, 2022) to align with the updated testing guidance in AFL 22-13.1. There is an option to say how many rounds of testing you've conducted. The "none" option is currently dependent on vaccination status; that will be changed to reflect if there is a need for response testing versus surveillance testing. If a facility has no active COVID-19 cases, then reporting on testing would not be required.

Q-14: If a COVID recovered individual is tested again days 31-90 due to symptoms or exposure, is it still recommended to NOT use a PCR test?
A: Antigen testing is still preferred over a PCR test when testing an individual who has previously recovered within the prior 90 days. Per AFL 22-13.1, the interval from a prior infection and recovery and the recommendation to test an asymptomatic person who has been exposed has been shortened from 90 to 30 days.

Isolation and Quarantine Questions & Answers

Q-15: Do nursing homes need to have a yellow zone anymore to quarantine residents?
A: Yellow zones are not routinely needed anymore because exposed residents and new admissions no longer need to quarantine, and empiric transmission-based precautions are no longer routinely recommended for exposed residents. 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 does not successfully prevent transmission, in consultation with the local health department, the facility may need to revert back to the unit-based quarantine approach wherein all residents would be considered exposed. In this scenario, the facility would essentially have a yellow zone.

Q-16: Can COVID recovered residents be transferred to their previous room assignment even if their roommate is still under investigation for COVID?
A: Yes. In general, the resident can return to their previous room.

Q-17: AFL 22-13.1 states that new admissions and residents who have had a close contact to somebody with COVID do not require empiric transmission based precautions (TBP) or quarantine. However, the CDC guidance does allow the use of TBP in certain circumstances (i.e., patient unable to wear source control for 10 days following exposure; patient is moderately to severely immunocompromised; patient is on unit experiencing ongoing COVID transmission that is not controlled with initial interventions). Is it acceptable for a nursing home to take a more conservative approach of utilizing TBP and quarantine for exposed residents or new admissions?
A: A more protective approach can be reasonable and may be recommended by the local health department in some scenarios. Per AFL 22-13.1 and in alignment with the CDC guidance referenced above, "A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) 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 does not successfully prevent transmission, the facility and local health department, may need to revert back to the unit-based quarantine approach wherein all residents would be considered exposed. In this scenario, the facility would essentially have a yellow zone.

Q-18: We have cases in which residents, within 30 days of COVID recovery who have ended isolation, are being hospitalized (not related to COVID) and are testing positive at the hospital with a POC antigen test. The hospital isolates them thinking they are reinfected. When the patient returns, does the SNF have to re-isolate them to complete their second 10-day isolation period of the month?
A: Re-isolation would depend on the context of the test (i.e., patient was symptomatic). It sounds like the hospital may have reisolated the patient because they were symptomatic, and may be experiencing COVID rebound, which could occur even in the absence of Paxlovid treatment. If that is the case, it would be reasonable for the SNF to complete the second isolation period once the patient returned.

Other Questions & Answers

Q-19: How often do vital signs need to be taken?
A: CDC and CDPH infection control guidance for nursing homes recommend:

- Vital signs for COVID-19 negative or recently recovered residents should be monitored daily.
- Vital signs, including pulse oximeter measures for residents symptomatic for COVID-19 should be monitored every shift, which can be defined as either an 8- or 12-hour shift, i.e., twice daily, allowing residents to get uninterrupted sleep.
- Vital signs for COVID-19 positive residents in isolation should be monitored every 4 hours and include pulse oximeter measurements.

Refer to CDPH AFL 20-25.2 Attachment (https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-25-Attachment-05-SNF-Assessment-Checklist.pdf).