This document outlines the COVID-19 Guidance for Long-Term Care Facilities in the Yolo County Operational Area

Yolo County Operational Area COVID-19 Guidance for Long-Term Care Facilities

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SECTION 1.0: INTRODUCTION

1.1 PURPOSE

All Yolo County long-term healthcare facilities need to be prepared to care for patients with suspected or confirmed COVID-19. The general strategies the Centers for Disease Control and Prevention (CDC) recommend to prevent the spread of COVID-19 are the same strategies long-term care facilities (LTCF) use every day to detect and prevent the spread of other respiratory viruses, like influenza. These guidelines provide specific actions you should take to help slow the spread of COVID-19.

Your facility should ensure that your staff is trained, equipped and capable of practices needed to:

- prevent the spread of respiratory viruses including COVID-19 within the facility.
- promptly identify and isolate patients with possible COVID-19 and inform the correct facility staff and public health department.
- care for a limited number of patients with known or suspected COVID-19 as part of routine operations.
- potentially care for a larger number of patients in the context of an escalating outbreak.
- monitor and manage any healthcare personnel that might be exposed to COVID-19.
- communicate effectively within the facility and plan for appropriate external communication related to COVID-19.

1.2 GOALS

The goals of the Yolo County Guidance for Long-Term Care Facilities are to:

- Provide County, State, and Federal guidelines for LTCFs during the current COVID-19 pandemic.
- Decrease the probability of transmission of COVID-19 in LTCFs.
- Increase LTCF preparedness and consistency in response to COVID-19.

1.3 GENERAL CONSIDERATIONS

The greatest COVID-19 risk comes from the movement of persons into and out of your facility. Anyone who leaves and then returns to your facility can potentially bring COVID-19 into your facility. The LTC must have a full-time, dedicated Infection Preventionist (IP). This can be achieved by more than one staff member sharing this role, but a plan must be in place for infection prevention quality control. CDPH's Healthcare-Associated Infections Program has developed training materials for LTC IP staff. The LTC must ensure HCPs receive infection prevention and control training and can work with the department to develop a reasonable implementation timeline and plan to bring on the necessary IP staff.

1.3.1 RESTRICT VISITORS

- **Restrict all visitors from entry into the facility**. This includes spouses, immediate family, and nonessential health care workers. The only exception is for compassionate care situations (e.g., end of life).
- When a resident spends time with a visitor for a compassionate visit, even if outdoors on facility grounds, they must remain at least six feet apart.
- Visitors for compassionate care situations should wear a surgical mask or cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility.
- Visitors for compassionate care situations should be carefully screened prior to entrance into the facility and should be reminded to frequently perform hand hygiene.
- Restrict all volunteers and nonessential health care personnel (HCP), including consultant services (e.g., barber).
- Develop processes to help residents and family members remain connected, including facilitating resident access to virtual visits by phone and other electronic devices.
- Assist families with placement of smart devices capable of video conferencing, if requested.
- Plan to ensure regular communication with families and residents.
- Drive-thru visitation can be provided on a limited basis.

1.3.2 Actively Screen Staff

- **Actively screen all staff for fever and symptoms of illness before starting each shift.**
- In addition to facility staff, conduct health screening for other essential health care personnel including therapy personnel, hospice, home care, dialysis, ombudsman, state surveyors, chaplain at end of life, mortician, etc.
    - *Active screening means that a trained person should physically monitor temperature of staff entering the building and ask questions regarding other COVID-related symptoms.*
- Conduct active assessment for fever (measured temperature >100.0°F) or subjective fever (chill, feeling feverish).
- Ask about new symptoms of illness (e.g., measured or subjective fever, cough, shortness of breath, chills, headache, muscle pain, sore throat, or new loss of taste or smell).
- Consider further evaluation for fever <100.0°F, or other symptoms not attributable to another diagnosis, including, nausea, vomiting, diarrhea, abdominal pain, runny nose, and fatigue.
- Staff of LTC facilities are a priority group for COVID-19 testing in California and

symptomatic staff should be tested as soon as possible.

- **Staff should not work while sick.** If illness develops while at work, staff must immediately separate themselves from others, alert their supervisor, and leave the workplace.
- **All staff should always wear a mask when** in the facility and practice strict hand hygiene.
- Employees participating in universal masking initiatives will wear different facemasks, depending on their potential exposure to residents with COVID-19 and their job responsibilities. Medical grade surgical masks should be prioritized for direct-care personnel if they are in short supply.
- **All staff should practice social distancing (≥6 feet from others) when in break rooms or common areas**. There have been clusters of staff illness in health care settings associated with lack of social distancing in nonresident care areas.

1.3.3 Limit and Monitor Resident Movement

- Cancel all field trips to locations outside of the facility.
- Residents who must leave the facility for medically necessary purposes (e.g., hemodialysis) should be allowed to do so.
- Residents should wear an alternative (cloth) facemask when they leave their room and when traveling via resident transport services.
- **Continue to not hold group activities, and not allow communal dining.**
- Residents should remain in their room as much as possible and should be encouraged to wear a face covering if they leave.
    - When outside their room, they should avoid communal and group activities. Remind residents to practice social distancing and perform frequent hand hygiene.
    - Residents who due to underlying cognitive conditions cannot be kept in their room should not be forcibly kept in their rooms nor forced to wear a face covering.

1.3.4 Plan For Staff Illness and Shortages

Consider how to implement staffing support strategies before the first case of COVID-19 occurs in the facility. Infected health care workers have been a common source of virus entry into facilities, and keeping ill health care workers out of work, including those who are mildly ill, is key to preventing outbreaks. Staffing needs might arise before a positive case is detected. Develop a plan to prepare for contacting local resources.

Broad approaches to sustain strong staffing include:

- Conduct active staff screening with all staff prior to their start of shift (described above).

- Staff should not work while sick. If illness develops while at work, staff must immediately separate themselves from others, alert their supervisor, and leave the workplace.
- Remind staff to stay home when ill.
- Implement sick leave policies that are nonpunitive, flexible, and consistent with public health measures that allow ill health care workers to remain out of work.
- Identify minimum staffing needs and prioritize critical services over nonessential ones.
- Consider health status of residents, functional limitations, disabilities, and essential facility operations.
- Develop and/or revise plans to mitigate staffing shortages and establish plans for contingency staffing. As transmission becomes more widespread in a community, facilities might face staffing shortages. If an outbreak occurs, facilities are at risk for staffing shortages.

1.3.5 Drive-Thru LTC Visitation

Per Yolo County Order of the Health Officer 2020-02, each Long-Term Care Facility, while restricting physical contact between residents and Unauthorized Visitors and Non-Essential Personnel, must make reasonable efforts to facilitate such contact by other means (such as telephone or videoconference) where such efforts will not otherwise interfere with the LTCF's healthcare mission.

- Drive-Thru Visits: Each LTCF may provide for Drive-Thru Visits so long as the LTCF ensures that proper social distancing measures are followed by all participants and with the following requirements in place:
    - No Drive-Thru visits shall occur if a LTCF is experiencing an outbreak.
    - No resident under Isolation shall be permitted to participate in a Drive-Thru Visit.
    - Drive-Thru Visits must be made by appointment only and shall be scheduled for only one resident at a time.
    - Prior to each visit, all passengers in the visiting vehicle shall satisfactorily answer screening questions. Facility shall confirm this prior to initiating the visit with the resident.
    - Each resident shall wear a face covering and be seated in a chair 10 feet away from the visiting vehicle and stay seated for the entire visit with no physical contact with visitors
    - Each resident shall be escorted by staff wearing a surgical mask and gloves to and from the visit.
    - All passengers in the visiting vehicle must wear a face covering, stay in the

vehicle the entire visit, and not attempt any form of physical contact with the resident.

- Visits must take place in the community's parking lot or other accessible area.
- All surfaces will be disinfected between each visit.

- Each Long-Term Care Facility may provide for Window Visits provided that no Unauthorized Visitors and Non-Essential Personnel enter the building, visitors wear a face covering while maintaining proper social distancing, and there is no physical contact between residents or visitors.

SECTION 2.0 INFECTION PREVENTION AND CONTROL CONSIDERATIONS

2.1 GENERAL AND COVID-19 SPECIFIC RECOMMENDATIONS

This guidance will ensure LTC facility policies and practices will minimize exposures to respiratory pathogens. For more information on infection control recommendations, visit CDC Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings.

2.1.1 HAND HYGIENE (HH)

- Healthcare personnel (HCP) and other staff members should always complete HH before and after ALL patient encounters and should also use HH at the beginning of their shifts, before and after eating, after using the restroom, and other times throughout the day to limit possible spread of germs.
- Place hand sanitizers at facility entrances and encourage all residents and staff to use every time they enter your facility.
- Make sure HH supplies, such as soap and water or alcohol-based hand sanitizer, are readily accessible in-patient care areas, including areas where HCP remove PPE.
- Sinks need to be well-stocked with soap and paper towels and hand sanitizers should be replaced as needed.
- Facilities should have a process for auditing adherence to recommended HH practices by the HCP.
- Support general hand and respiratory hygiene, as well as cough etiquette by residents and staff.

2.1.2 PERSONAL PROTECTIVE EQUIPMENT (PPE)

- All facility personnel should wear a surgical mask while they are in the facility.
- Staff must wear either an N95 respirator or a surgical mask when they are in patient care areas or in areas where residents may congregate.
    - Masks or respirators are preferred, but non-medical face coverings can be used for non-patient care activities.
    - Masks and respirators are not required for staff working alone in closed areas unless they are moving through common spaces where they may interact with other staff or residents. Extended use and reuse of masks and respirators should be based on principles set forth in prior CDC PPE optimization guidance.

- **Cloth/alternative masks are not PPE** and should not be worn by HCP when PPE is indicated.

2.1.3 TRANSMISSION-BASED PRECAUTIONS

- Use Standard, Contact, Droplet plus Eye Protection precautions while caring for residents with suspected or confirmed COVID-19. Both the CDC and World Health Organization (WHO) recommend standard, contact and droplet precautions with added eye protection for care of COVID-19 patients. This means a surgical mask or N95, gloves, eye protection. A gown is recommended, but if in short supply should be prioritized for aerosol generating procedures.
- For any aerosol generating procedures (suction, ventilation, CPR, nebulizer treatments, etc.) Standard, Contact, Airborne plus Eye Protection precautions must be observed. This means N95 or higher, gloves, eye protection, and gown.
- If there is a shortage of gowns, they should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high-contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing of HCP.

2.1.4 ENVIRONMENTAL CLEANING

In addition to CDC guidelines, below recommendations are referenced from California Department of Public Health AFL for Environmental Infection Control for the Coronavirus Disease 2019 (COVID-19).

- Facilities must have a plan to ensure proper cleaning and disinfection of environmental surfaces (including high touch surfaces such as light switches, bed rails, bedside tables, etc.) and equipment in the patient room.
- All staff with cleaning responsibilities must understand the contact time for the cleaning and disinfection products used in the facility (check containers for specific guidelines).
- Ensure shared or non-dedicated equipment is cleaned and disinfected after use according to the manufacturer's recommendations.
- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for COVID-19 in healthcare settings.
- A list of EPA-registered disinfectants that have qualified for use against SARS-CoV-2 (the COVID-19 pathogen) can be found here.
- Set a protocol to terminally clean rooms after a patient is discharged from the facility. If a known COVID-19 resident is discharged or transferred, staff should refrain from entering the room until sufficient time has elapsed for enough air exchanges to take place. CDC

air-exchange information provided here.

2.1.5 Facilities With Active COVID-19 Transmission

In a facility with active COVID-19 transmission, healthcare personnel should wear full PPE for the care of all patients, irrespective of COVID-19 diagnosis or symptoms. PPE and other infection prevention and control supplies (e.g., surgical masks, respirators, gowns, gloves, goggles, hand hygiene supplies) that would be used for both HCP protection and source control for infected patients (e.g., facemask on the patient) should be in sufficient supply and readily accessible for use.

- HCP must wear the recommended PPE for patient care. HCF must post signage on the appropriate steps for donning and doffing PPE.
    - For residents on Transmission-based Precautions (e.g., those with confirmed or suspected COVID-19), focus staff education on what to wear and when (gowns, facemask, eye protection, and gloves). Reinforce hand hygiene.
    - Post visual references like CDC's donning and doffing instruction sheets where they can be seen by staff. CDC: Using 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.
- Ensure adequate amount of PPE supplies are available. Track amount of PPE supplies on hand and update daily.
    - Use the CDC: Personal Protective Equipment (PPE) Burn Rate Calculator to assess PPE supply.
    - Contact your Medical Health Operational Area Coordinator (MHOAC) if any PPE concerns arise.
- Initiate measures to optimize current supply.
    - Consider extended use and reuse of facemasks and eye protection, and prioritization of gowns for certain resident-care activities, by using CDC guidance.
- **When supplies become critically low (4–7 days left), complete a PPE Request Form, which facilities can access here, directly sent to the MHOAC.**
    - In completing this form, there is no guarantee your request will be filled. Requests will go through a need's prioritization process. A facility can request PPE again if needed.
    - Facilities should continue to work with their PPE vendors to obtain PPE.
- Facilities should have a process for auditing adherence to recommended PPE use by HCP.

- HCP should be annually fit tested for N95 respirators to ensure appropriate seal when N95s are needed. Note that the U.S. Department of Labor/Occupational Safety and Health Administration have issued guidance regarding the temporary suspension of annual fit testing during shortages, see here.

SECTION 3.0: MONITORING AND CARE FOR HEALTHCARE PERSONNEL AND RESIDENTS

3.1 HEALTHCARE PERSONNEL GUIDELINES

3.1.1 MONITORING

All HCP should self-monitor twice daily, once prior to coming to work and the second, ideally timed approximately 12 hours later for possible symptoms of COVID-19 (i.e., elevated temperature >100.0°F and/or cough or shortness of breath).

- If HCP have symptoms (i.e., fever and/or cough or shortness of breath), they should contact the health care facility (HCF) **immediately** and stay home from work.
- HCFs should screen all HCP prior to the start of working their shifts AND at the end of the shift.
    - HCF should develop and implement screening systems that cause the least amount of delays and disruption as possible (i.e., HCP self-report, single use disposable thermometers or thermal scanners, etc.).
- HCP with a fever should be sent home and **NOT** allowed to work.
- Asymptomatic HCP who test positive for COVID-19 must stay home from work. Public Health may waive this restriction in situations of severe staffing shortages.
- Identify staff who can monitor sick staff with daily "check-ins" using telephone calls, emails, and texts.
- If HCP develop symptoms while at work, they should keep their facemask/cloth covering on, notify their supervisor, and leave the workplace.
- Any HCP with fever and/or cough or shortness of breath should be presumed to have COVID-19 and should self-isolate at home.
    - HCP with high risk exposures to COVID-19 should be excluded from work for 14 days.
        - HCP can return to work after 14 days if they have never had symptoms. Facilities should review their policies on work absenteeism and ensure that the policy is consistent with the goal of excluding sick HCP.
- Healthcare facilities should be conducting universal source control for HCP and screening for fever and symptoms before every shift.
- Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these shortages. Strategies to mitigate staffing shortages are available from the CDC.

3.1.2 Return to Work

Symptomatic HCP may discontinue home isolation when both of the following time-since-illness-onset and time-since-recovery conditions are met:

- At least 3 days (72 hours) have passed *since recovery* defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
- At least 10 days have passed *since symptoms first appeared.*

Asymptomatic HCP with laboratory-confirmed COVID-19 should be excluded from work until 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.

After returning to work they should:

- Adhere to hand hygiene (HH), respiratory hygiene, and cough etiquette (e.g., cover nose and mouth when coughing or sneezing, dispose of tissues in waste receptacles)
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen;
    - See CDC Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance).

3.2 Identifying, Isolating, and Caring for COVID-19 Patients

Residents infected with COVID-19 may vary in severity from a lack of symptoms to mild or severe symptoms. Symptoms may be mild and not require transfer to a hospital if the facility can follow the infection prevention and control practices recommended by CDC. Review current symptom status of all residents to determine if more than one patient is symptomatic with fever or has respiratory symptoms and if so, initiate contact and droplet precautions for all.

- All symptomatic patients should be put in a designated isolation area away from others.
- Consider discharge of any patients that can be cared for in the home setting.
- Limit the number of staff members interacting with the symptomatic patient(s) and try to keep the same individuals caring for the patient as much as possible.

3.2.1 Process for Rapidly Identifying and Isolating Suspected COVID-19

Monitor residents for fever, respiratory symptoms (i.e., cough and/or shortness of breath), and other possible symptoms associated with COVID-19, including chills, headache, muscle pain, sore throat, or new loss of taste or smell, nausea, vomiting, diarrhea, abdominal pain, runny nose, and fatigue every 12 hours.

- Any residents with fever, respiratory symptoms, or other symptoms concerning for COVID-19 should be confined to their room with the door closed; use single rooms whenever possible or if resident must leave the room (for example, medically necessary

procedures) have them wear a facemask, if possible.

- Report the suspect case to Public Health immediately by phone: (530) 666-8614 or (530) 321-3620 after business hours.

3.2.2 Two or More Respiratory Cases Identified Within 72 Hours

If two (2) or more respiratory cases are identified within 72 hours, facilities are advised to do the following:

- Initiate standard, contact, and droplet precautions plus eye protection for all suspect residents with fever and/or respiratory symptoms or other symptoms concerning for COVID-19.
- All symptomatic residents should be cohorted to their own single room or area with a dedicated restroom.
- Report the suspect case to Public Health immediately by phone: (530) 666-8614 or (530) 321-3620 after business hours.
- Lab testing of symptomatic patients should be done through commercial or your healthcare system labs for patients, if possible.
    - If not, contact Public Health to facilitate testing.
- Designate an area in your facility for the placement of suspect residents and cohort staff caring for suspect cases to minimize transmission.
- Increase environmental cleaning throughout the facility to three (3) times a day (if possible) with emphasis on high touch surfaces particularly in the unit where the resident was located.
- For any transfers out of the building, notify EMS and the receiving facility of possible exposures.
- Consider discharge of any residents that can be cared for in the home setting.

3.2.3 Confirmed Case Identified

If a confirmed case is identified with testing, facilities are advised to do the following (presume there is widespread distribution of COVID-19 in the facility):

- Initiate standard, contact, and droplet precautions plus eye protection for all residents, irrespective of COVID-19 diagnosis or symptoms.
- The confirmed case should be in a single-person room or cohorted in a single room with the door closed and a dedicated restroom.
- Establish isolation area --- confirmed cases may be placed in a shared room.
- Report the case to Public Health immediately by phone: (530) 666-8614 or (530) 321-3620 after business hours.

- In addition, a copy of all lab reports and a completed CMR FORM for COVID19 should be faxed to our Confidential Fax: (530) 669-1549.

- Post a notification letter at the entrance of the facility and community areas.
- Implement a line listing of all HCPs, residents, and visitors. These line lists should be faxed daily to Yolo County Public Health Confidential Fax: 530-669-1549.
- Increase environmental cleaning throughout the facility to 3 times a day (if possible) with emphasis on high touch surfaces particularly in the unit where the resident was located.
- Cancel and reschedule upcoming non-essential outpatient appointments for all residents.
- For residents receiving dialysis outside of the facility, notify their dialysis center and request that they be dialyzed in "isolation".
- Consider replacing nebulizers with metered dose inhalers to avoid unnecessary aerosol generation from nebulizer therapy.

3.3 Outbreak Identification and Reporting

All outbreaks are reportable to the California Department of Public Health Licensing & Certification local district office, California Department of Social Services Community Care Licensing local district office. ***Referenced from CDPH All Facilities Letter (AFL-17)** COVID-19 Outbreak Definition and Reporting Guidance *for more information*.

For **suspected** COVID-19 Outbreaks:

- Clusters of acute illness compatible with COVID-19 without laboratory testing or with pending laboratory testing
- If laboratory testing in a congregate setting has revealed two or more cases of another laboratory-confirmed respiratory viral infection (not COVID-19), use the CDPH Influenza and Respiratory Illness Outbreak Quicksheet (PDF).
    - Consult Public Health if testing is needed in this situation.

For **Laboratory-confirmed** COVID-19 Outbreaks:

- In a skilled nursing facility: **at least one case** of a laboratory-confirmed COVID-19 in a resident.[1]
- In other residential congregate settings: **at least one case** of laboratory-confirmed

[1] Implementation of infection control measures and active surveillance for additional cases (including testing of asymptomatic residents and staff) should be considered when a single laboratory-confirmed COVID-19 case has been identified in a resident OR staff member, even if other cases of acute illness have tested negative for COVID-19.

COVID-19 in the setting of ≥2 cases of acute illness compatible with COVID-19[2] in residents or staff members within a 14-day period. [1]

- In congregate community settings: three or more laboratory-confirmed COVID-19 cases in different households in a cluster of acute illnesses compatible with COVID-19[2] with onset within a 14-day period.

3.3.3 Reporting to Public Health and CDPH

Residential congregate facilities should notify Public Health immediately by phone: (530) 666-8614 or (530) 321-3620 after business hours if they identify a suspected or laboratory-confirmed COVID-19 outbreak, or if they identify a single resident or staff member with laboratory-confirmed COVID-19.

Congregate community settings should notify Public Health immediately by phone: (530) 666-8614 or (530) 321-3620 after business hours if they identify a suspected resident or staff member with laboratory-confirmed COVID-19 outbreak.

For testing guidance, refer to: CDC guidance for collecting, handling, and testing clinical specimens from persons for COVID-19.

3.3.4 Inter-Facility Transfers

- LTCF are expected to be able to care for patients who require Transmission-Based Precautions as currently described for management of patients with COVID-19.
- Outbreaks of COVID-19 have occurred in skilled facilities with lapses in standard infection prevention program implementation.
- The demands to care for patients are highly fluid, but we should take great care to minimize potential for outbreaks in skilled nursing facilities and our hospitals.
- Interfacility transfers should be limited as much as possible, while still maintaining appropriate levels of care for all patients.
- Patients should not be sent to the Emergency Department (ED) to obtain COVID-19 testing.
- See Return to Facility Rules for Suspected COVID-19 from ED for patients not needing hospital admission.

LTCFs experiencing confirmed or suspect outbreaks of COVID-19 should not transfer asymptomatic residents unless first cleared by the Yolo County Public Health managing the outbreak.

- If a resident is cleared for transfer to another facility by YCPH, the receiving facility

[2] At least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s), nausea, vomiting, diarrhea; OR at least one of the following symptoms: cough, shortness of breath, or difficulty breathing.

should be notified prior to transfer that the patient is potentially COVID-19 exposed; and

- Upon arrival at the receiving facility, the patient should be maintained in quarantine for 14 days after date of transfer prior to resuming normal activities.

LTCFs not experiencing confirmed or suspect outbreaks of COVID-19 may transfer asymptomatic residents without prior approval of Yolo County Public Health if the resident has not had fever or respiratory symptoms for at least 3 days prior to transfer.

- Receiving facilities should place transferred patients into quarantine for 14 days.

LTCFs should not transfer COVID-19-unexposed patients into facilities with active outbreaks of COVID-19 unless first cleared Yolo County Public Health.

3.3.5 For Patients Continuing Transmission-Based Precautions

- If there are no COVID-19 cases in your building, consider continuing contact droplet precautions after admission for an extended period.
- If you have COVID-19 cases, admit residents to isolation units.

3.3.6 Discontinuing Transmission Based Precautions for Patients with Laboratory Confirmed COVID-19

- Patients may be removed from isolation after at least 72 hours afebrile (100.0◦F or >2 degrees above baseline temperature) without the use of antipyretics plus improving respiratory symptoms **AND** 10 days after symptom onset (if originally hospitalized, then 14 days from date of hospitalization).
- These guidance rules for discontinuation of transmission-based precautions may change with evolution of the science.

3.3.7 Completion of Cohorting

Viral shedding is still not clearly defined for COVID-19 for all patient groups, therefore the recommended duration of cohorting may vary between different public health authorities. Because patients in LTCFs are at particular risk for poor outcomes, these guidelines are more stringent than for the general population or for home-dwelling individuals. Residents who test positive for COVID-19 can be removed from COVID-19 designated cohort area after they are considered no longer infectious, which is defined as:

- Asymptomatic COVID-19 residents who remain asymptomatic: 10 days from test date.
- Symptomatic COVID-19 residents that were originally hospitalized: at least 10 days from the date of hospitalization or 72 hours after last fever, whichever is longer.
- Symptomatic COVID-19 residents that were never hospitalized: at least 10 days from symptom onset and 72 hours have passed since resolution of fever without the use of antipyretics and improvement in respiratory symptoms.

- Once the outbreak has been declared over, residents who were transferred to other facilities may return to their facility of origin but must comply with any additional quarantine periods as recommended.

For more information, see CDC Guidance for:

- Discontinuation of Isolation for Persons with COVID-19 Not in Healthcare Settings
- Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings (Interim Guidance)

SECTION 4.0 FACILITY BASED TESTING STRATEGIES

CDPH recommends that all SNFs perform COVID-19 baseline testing for all residents and HCP in any facility that does not currently have a positive case. Baseline testing is necessary to detect cases quickly, stop transmission, and implement effective infection prevention and control actions. All baseline testing must be completed no later than June 30, 2020. CDPH will also accept results for those facilities that completed their baseline testing in May.

CDPH and Yolo County has identified strategies for mass testing that we shall be implementing in parallel:

4.1 STRATEGY 1: FACILITIES WITH COVID-19 POSITIVE STAFF AND/OR RESIDENTS

Facilities experiencing a single case or an outbreak with confirmed or suspected COVID-19. This strategy includes the following steps:

- Test all LTCF residents and healthcare workers as soon as possible.
- Cohort all COVID-positive residents and staff as outlined in this document or consider transferring COVID-positive staff and residents to a designated COVID receiving facility, after approval from Yolo County Public Health.
- Collaborate with Yolo County Public Health on a virtual or in-person Infection Control Assessment and Response (ICAR).
- Consider re-testing all COVID-negative residents and staff weekly until no new cases are identified. However, retesting strategies may differ based on the specific outbreak situation and circumstances at each facility and should be tailored in consultation with Yolo County Public Health.

4.2 STRATEGY 2: BASELINE AND SURVEILLANCE TESTING OF LTCF RESIDENTS AND HCP

Pre-emptive intervention: prospective surveillance of facilities not currently experiencing a single case or an outbreak. Testing facilities in this category will allow Yolo County Public Health to monitor facilities pro-actively to ensure that interventions can be made as early as possible.

- Conduct baseline testing for all LTCF residents and HCP for any facility that does not currently have a positive case.
    - Residents that test positive and are symptomatic should be isolated until the following conditions are met:
        - at least 3 days (72 hours) have passed since recovery, defined as a resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); AND

        - at least 10 days have passed since symptoms first appeared.
    - 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 symptoms-based criteria for discontinuing isolation should be applied.
- HCP who test positive and are asymptomatic must stay home from work. Public Health may waive this restriction in situations of severe staffing shortages.
- HCP who test positive and are symptomatic should be excluded from work. They may return to work after the following conditions are met:
    - at least 3 days (72 hours) have passed since recovery, defined as a resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); AND
    - at least 10 days have passed since symptoms first appeared.

Surveillance testing:

- In facilities without any positive COVID-19 cases: implement testing of 25 percent of all HCP and residents every 7 days including staff from multiple shifts and facility locations. The testing plan should ensure that 100 percent of facility staff are tested each month.
- In facilities with a positive COVID-19 case, implement response-driven testing as described, below.

4.3 Strategy 3: Response-Driven Testing of Residents

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 who test negative upon initial testing should be performed every 7 days until no new cases are identified in two (2) sequential rounds of testing; the facility may then resume their regular surveillance testing schedule for HCP. Once a resident tests positive, no additional testing is needed for that resident.

Place residents into three separate cohorts based on the test results, accordingly:

- Positive result,
- Negative result but exposed within the last 14 days, and
- Negative result without known exposure within the last 14 days.

The COVID-19 positive cohort should be housed in a separate area (building, unit or wing) of the facility and have dedicated HCP who do not provide care for residents in other cohorts and should have separate break rooms and restrooms if possible.

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

4.4 Strategy 4: Response-Driven Testing of Healthcare Personnel

As soon as possible after one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility, serial retesting of all HCP should be performed every 7 days until no new cases are identified in two sequential rounds of testing; the facility may then resume their regular surveillance testing schedule. If testing capacity is not sufficient to serially retest all HCP, consider testing HCP who worked on the unit with COVID-19 positive residents or are known to work at other healthcare facilities with cases of COVID-19. In general, HCP with COVID-19 should be excluded from work. If staffing shortages result, facilities may allow asymptomatic HCP with suspected or confirmed COVID-19 (who are well enough to work) to provide direct care only for residents with confirmed COVID-19 following CDC Guidance on Mitigating Staffing Shortages, preferably in a cohort setting and maintain separation from other HCP as much as possible (for example, use a separate breakroom and restroom) and wear a facemask for source control at all times while in the facility.

SNFs should submit proposed COVID-19 testing plans to their local Licensing and Certification Program District Office and to Yolo County Emergency Preparedness. LTCs should submit a proposed COVID-19 testing and mitigation plan to Yolo County Emergency Preparedness.

4.4.1 Testing Logistics:

Direct viral detection testing (e.g. PCR, etc.) is useful during outbreaks when patients are shedding virus in the days and weeks after initial infection.

- Direct viral detection tests should be used for facility-wide testing of staff and residents as described in this document.
- Direct viral detection tests are not 100% sensitive, so if individuals have negative tests, they still may have COVID-19.

Serologic/antibody testing may become useful in determining past infection that may no longer be identified through direct detection.

- Until there is better data on how to use of these tests, they are not recommended for patient care or cohorting decisions.

4.4.2 Individual Facilities Should Make Plans to Initiate Testing Themselves.

- While governmental help with facility-based testing is available for facilities that have no readily accessible alternative, the large scope of the pandemic will require facilities to use their own resources to obtain testing results more rapidly.
- Facilities should develop relationships with commercial laboratories.
    - Laboratories will provide testing kits.
        - If laborites do not have testing kits, you may put in a resource request with the MHOAC.
- If facility is using a healthcare system, the healthcare system will provide the testing kits.
- Facilities should identify staff who can collect nasopharyngeal (NP) swabs.

    - Any healthcare professional can collect an NP swab if they have been trained.
    - Training can be provided by commercial labs or by other healthcare providers/systems.
        - Video on how to perform a NP swab.
- Facilities do not require prior approval to perform testing on their own, but facilities should contact Yolo County Public Health to answer testing questions or for guidance about interpretation of results.
- For facilities unable to test on their own, Yolo County Public Health can help facilitate testing of the facility on a case by case basis.