California Department of Public Health
Center for Health Care Quality
AFC Skilled Nursing Facilities Infection Prevention Call
February 2 & 3, 2022

Recordings, notes and slides for the Wednesday Webinars and Thursday calls can be accessed at the Health Services Advisory Group (HSAG) registration website:
https://www.hsag.com/en/covid-19/long-term-care-facilities/cdph-ip-webinars-past/

CDPH Weekly Call-in Information:
Tuesday 8:00am All Facilities Calls: 844.721.7239; Access code: 7993227
Wednesday 3:00pm SNF Infection Prevention Webinars: Register at: https://www.hsag.com/cdph-ip-webinars
Thursday 12:00pm SNF Infection Prevention Calls: 877.226.8163; Access code: 513711

The Wednesday Webinar covered the following topics:

- CDPH Updates
- Testing Task Force Updates
- Immunization Branch Updates
- NHSN Reporting Updates
- Healthcare-Associated Infection (HAI) Updates

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
CMS QSO-20-39-NH (REVISED 11/12/21): Visitation	https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf
State Public Health Officer Order – extended HCP booster requirement from February 1 to March 1, 2022 (Updated 1/25/2022)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx
AFL 21-34.2 COVID-19 Vaccine/Booster Requirement (Updated 1/26/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-34.aspx
CDPH Requirements for Visitors in Acute Health Care and Long-Term Care Settings (12/31/2021)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Requirements-for-Visitors-in-Acute-Health-Care-and-Long-Term-Care-Settings.aspx
AFL 22-02 Notice of Testing Supply Availability and Distribution Process (1/14/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-02.aspx
AFL 21-28.2 Testing, Vaccination Verification and PPE for HCP (Updated 1/26/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-28.aspx
AFL 22-06 Online Application Period for Patient Needs Waiver and Workforce Shortage Waiver (1/26/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-06.aspx

CDC Updated Guidance, February 2, 2022: Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes
https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#anchor_1631031561398

COCA: Updates to CDC's COVID-19 Quarantine and Isolation Guidelines in Healthcare and Non-healthcare Settings https://emergency.cdc.gov/coca/calls/2022/callinfo_011322.asp

Testing Questions & Answers

Q-1: Can we require hospitals to test their patients with an antigen test prior to transfer to our SNF?
A: No. Testing prior to transfer is a best practice, but SNFs may not require a negative test result prior to accepting a new admission. Per AFL 20-53.6, testing is still recommended for unvaccinated or partially vaccinated newly admitted residents prior to admission, including transfers from hospitals or other healthcare facilities. If the hospital does not test the patient within 72 hours prior to transfer, the SNF must test upon admission. Results for asymptomatic patients tested in the hospital do not have to be available prior to SNF transfer.

Q-2: If a family member tests positive using their own antigen test in front of our facility staff, whose responsibility is it to report the positive test?
A: To comply with the December 31, 2021, State Public Health Officer Order, visitor testing must be observed by facility staff. If a visitor conducts the entire test on their own in front of facility staff with their own over-the-counter antigen test kit, the result of the test does not need to be reported by the nursing home to NHSN or CalREDIE. To not fall under CLIA regulatory requirements, it is acceptable to have an observer watch the individual perform the test and verify the result, however the individual performing the test must read their own result first before verifying their result with the observer. If the visitor tests positive, they should report their own positive results to their PCP.

Q-3: Can hospitals and nursing homes accept negative antigen test results from family members if they conducted the test at home without facility staff observing?
A: No, the test must be observed by facility staff so they can confirm that the visitor took the test. The test can be observed virtually or in person by facility staff, or by another healthcare provider that can confirm the identity of the person that took the test and the time that the test was taken.

Q-4: If an employee has a medical exemption and tested positive, when can we start testing them again? Do we have to wait 90 days?
A: Per AFL 21-08.7, the 90-day guidance changed only when using the test-based strategy for an infected HCP to discontinue isolation and return to work at five days in routine circumstances. Regarding the testing of exposed individuals and for routine diagnostic screening testing, the 90 days exemption from testing and quarantine continues to apply for asymptomatic individuals who are within the 90 days of recovery from a previous COVID infection. This applies to staff, residents, and visitors. Individuals who develop symptoms should be tested even if they had a previous episode of COVID within the previous 90 days.

Q-5: Do you recommend POC antigen testing or PCR for return to work after an HCP tests positive?
A: Antigen test is preferred for return to work versus a PCR test.

Q-6: When reporting antigen tests in NHSN, does the information get transferred to CalREDIE, or do they need to be reported in both places?
A: CalREDIE receives the data that gets inputted into NHSN. If nursing homes are reporting individual results to NHSN then they do not need to also report them via CalREDIE.

Q-7: Do nursing students need to take a test outside of our facility before entry, or does proof of a negative test from their school professor suffice?
A: Students do not need to be tested prior to entry if they are fully vaccinated and boosted. According to the "Health Care Worker Vaccine Requirement" State Public Health Officer Order updated on January 25, 2022, students are included in the definition of workers serving in health care or other health care settings who have the potential for direct or indirect exposure to patients or SARS-CoV-2

airborne aerosols. Therefore, if they are fully vaccinated and boosted, they do not need to be tested in routine diagnostic screening testing. If they have an exemption or are booster eligible but have not received their booster, then they need to be tested twice weekly. The testing can be supervised by the student's school and does not need to occur at the nursing home prior to entry. Documentation from the school that they are vaccinated and boosted, and following testing guidelines would be helpful.

Isolation/Quarantine Questions & Answers

Q-8: Can you comment on these two articles:

- "Persistence of clinically relevant levels of SARS-CoV2 envelope gene subgenomic RNAs in non-immunocompromised individuals" Davies, et al. Published December 7, 2021 https://www.ijidonline.com/article/S1201-9712(21)01206-6/fulltext
- "Viral dynamics and duration of PCR positivity of the SARS-CoV-2 Omicron variant" Hay, et al Published January 2022 https://dash.harvard.edu/handle/1/37370587

The articles state that in 13% of infected cases there is persistent shedding of clinically relevant virus at 10 days. The study suggests that potentially active virus can sometimes persist beyond a 10-day period and could pose a potential risk of transmission. Where this would pose a serious public health threat, additional mitigation strategies may be necessary to reduce the risk of secondary cases in vulnerable settings.

A: In CDC's evaluation of the duration of infectiousness, they acknowledge that there are going to be some individuals who will remain infectious beyond the 5- and 7-day isolation period. This is referred to as residual risk of infectiousness. This is why CDPH requires a negative test for infected healthcare personnel discontinuing isolation and returning to work earlier than 10 days. These updated recommendations reflect a balance of the residual risk with operational considerations.

Q-9: Is the changing guidance in isolation days for HCP due to a change in the incubation and infectious period with Omicron?
A: Yes. The incubation time for the Omicron variant is shorter than Delta and the original COVID-19 virus which informs the current recommendation for testing immediately upon identification of exposure and shorter duration of quarantine.

Q-10: We have a non-immunocompromised, COVID positive, asymptomatic patient that completed his 10-day isolation period. Then 9 days later he began developing symptoms of ST. He tested positive with an antigen test, so we sent him back to the red zone. How long should we keep him in isolation?
A: This is a tricky situation. Even antigen tests can be persistently positive, similar to PCR tests. In this scenario, isolate and evaluate this patient for other viral pathogens like influenza or RSV. It is rare to be infected with COVID twice in that time frame, but since this patient is symptomatic, it would be wise to isolate pending further evaluation.

Q-11: Are the isolation guidelines for positive residents going to change? We have 3 alert, fully vaccinated, and boosted, asymptomatic residents that tested positive during response testing. They are in the red zone, but because they follow the CDC guidance, they requested to be tested at 5 days with an antigen test. I tested them out of curiosity, and their results came back negative. All 3 residents remain in the red zone and are completing the 10 days isolation. Will the 5 days with negative test to discontinue isolation ever apply to our residents?
A: No, at this time CDC is not changing the 10-day isolation period for patients and residents in healthcare settings. There may be unique circumstances in which the isolation period can be shortened due to operational challenges, such as space and bed availability in red zones. The challenge is that there is a spectrum in which some individual will clear their infection earlier, especially individuals who are fully vaccinated and boosted. However, there is a risk that others will not clear the virus as

quickly. Since healthcare settings are high-risk, the 10-day isolation period for patients and residents is unchanged.

Q-12: The staff assigned to the yellow zone wear full PPE (N95, face shield, gown, and gloves). If a staff member wearing full PPE tests positive, are the residents now considered exposed even if they were wearing full PPE? What if the staff-resident interaction was less than 15 minutes?
A: In healthcare settings, if an HCP provides care to a resident and then tests positive, the resident is generally considered potentially exposed, even if the HCP was wearing full PPE. This approach reflects experience that there is often extensive undetected exposures and transmission when even a single case is identified in high-risk residential healthcare settings like SNFs. Per AFL 20-53.6, there are situations in which it may be appropriate for facilities with high staff and resident vaccination and booster rates to take a more individualized contact tracing approach. In this scenario, the facility would need to have intensive investigation and follow-up capability to ensure contact tracing is implemented sufficiently. Consult with your local health department for more guidance.

Q-13: If we are doing response testing with 100% of nursing home residents, would we come out of outbreak status at day 7 if all tests are negative?
A: No. For nursing homes, response testing must be done for a minimum of 14 days, with testing every 3-7 days. All tests must be negative over 14 days, for response testing to end. If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of exposed residents until there are no new cases for 14 days. For clarity, note that the guidance for congregate living facilities is 10 days (not 14 days) of no negative tests for response testing.

Q-14: Turnaround times for PCRs are long (sometimes 6-7 days). We know POC tests can be used twice a week for response testing, but that using PCR tests in one of the rounds of response testing is a best practice. Unfortunately, some of our residents who tested negative with the antigen tests, are getting positive test results from the PCR test 6-7 days later because of the long turnaround times. In many of these cases, the resident was tested with the antigen test and PCR test concurrently on the same day, but as suspected, the PCR is picking up more infections than the antigen test. In this scenario, our LHD is asking residents to isolate for another 3 days after the PCR positive test results arrive on day 7. That way it will be 10 days on isolation since the positive test was taken.
A: It is not an optimal situation and certainly problematic to have such a long turnaround time for the PCR tests. We recommend contacting the Testing Taskforce to see if there are other options for labs that can return results quicker than you are currently experiencing. This is a situation where the antigen testing has an important role because of the long turnaround time with PCR testing. It is true that antigen tests are less sensitive at picking up a positive result. This is why antigen tests should be done at least twice a week (or even more frequently) and PCR tests can be substituted or used as confirmation for one of these rounds of testing. Also, ensure that the antigen tests are being conducted correctly to ensure optimal performance of the tests. Regarding turnaround times for PCR, we hope results will come back quicker now that the demand for testing from the general public is decreasing as cases are decreasing.

Q-15: Our NHA tested positive last week with an antigen test taken at home due to symptoms. Because the February 1st isolation/quarantine restrictions from AFL 21-08.7 ended, is he required to remain isolated for the full 10 days, or can he return to work on day 5 if he tests negative with an antigen test?
A: CDPH is in the process of updating AFL 21.08.7. The waiver that ended on February 1, 2022, was a waiver of the guidance provided in a previous update to this AFL, which was 21-08.6. Facilities can now use the isolation guidance that is outlined in the table in the AFL. That guidance aligns with the updated guidance for HCP with infection that they may return to work at day 5 with a negative test or

day 7 depending on the vaccination status. In a critical staffing shortage, there are still other considerations available.

Vaccine Questions & Answers

Q-16: Why does California continue to have a staff booster mandate during a national staffing crisis when the booster doesn't protect residents from transmission? We are aware that the booster prevents serious illness and hospitalization, but if a staff member wants to take that chance, why can't we let them make their own personal choice?
A: It is correct that the vaccines and boosters prevent serious illness, hospitalizations, and death. They also help to prevent becoming a COVID-19 case in the first place, and a person cannot transmit if they are not infected. Breakthrough infections still occur, but individuals that are boosted have a lower rate of infection when compared to individuals that are unvaccinated and those who are vaccinated but not boosted. Due to the waning immunity of the primary vaccine series, and the fact that the vaccine and boosters help prevent infection in the first place, the booster is required for healthcare personnel to help prevent exposures in our high-risk nursing facilities and other healthcare settings.

Q-17: If an individual got the Janssen vaccine for their primary series, when can they get the Pfizer or Moderna booster?
A: Recipients of the single dose Janssen COVID-19 Vaccine for primary vaccination should receive a single COVID-19 vaccine booster dose at least 2 months (8 weeks) after the primary dose. An mRNA COVID-19 vaccine is preferred over the Janssen COVID-19 Vaccine for booster vaccination. See CDC guidance page for more details: www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#booster-dose

Q-18: An employee has an approved exemption for the primary series of the vaccine. Do they need another exemption for the booster or the first approval sufficient for the requirement?
A: No, a second exemption is not required if there is already one on file.

Cohorting Questions & Answers

Q-19: Our red zone has a separate entrance we use only for staff to enter and leave from. The entrance is kept partially open to help increase air flow into our facility. Is it ok that we keep this door partially ajar, or must it always be closed?
A: Yes, it is reasonable to keep the entrance door ajar from an infection control standpoint, assuming that the doors to the residents' rooms are kept closed. But any measures to affect air flow should be reviewed with your facility engineering department. When an exterior door is open, the air pressure in the building is adjusted. Understand what opening the door does to the air pressure in the building.

Q-20: We are a large forensic psychiatric hospital. All our units currently are on quarantine due to positive staff or patients. Treatment teams have been requesting to move patients from one quarantine unit to another quarantine unit due to severe behavioral issues and/or assaultive risks. What would you recommend regarding those transfers given the fact that those units are at different stages of their quarantine and serial response testing status (also they had different exposure sources and dates). We also have patients returning to our facility from acute external hospitalization who were observed in our observation unit for 10 days and serially tested (-) on return to us but have no place to go now except for a quarantine unit. Can we allow this movement to clear spaces for other new returns?
A: From an infection control standpoint, we would generally not want to mix across populations of quarantine units where their exposure status may be different from one another either by timing or degree of exposure. But we recognize you are balancing factors other than COVID exposure for safe

placement. Consult with our HAI infection preventionists or your local health department to explore strategies.

Q-21: Does resident cohorting or "shelter in place" depend on PCR testing turnaround times? It's my understanding that if the PCR tests turnaround times are greater than 48 hours, that we should not move residents or cohort them in the physical red zone in order to avoid further transmission from moving positive residents throughout the building.
A: The longer turnaround times for testing is a problem and hopefully should be improving soon as cases and testing demands decline. In general, COVID positive residents should be moved to the designated red zone, and should cohort together. Even in a scenario in which a test comes back after 48 hours, if a resident is positive, they should be moved to the red zone, which should not in itself create new exposures to residents. More exposures could occur in a situation in which you are moving potentially exposed individuals to other areas of the facility because we don't know whether or not they will turn positive.

Q-22: Can you clarify if COVID positive residents can "shelter in place"?
A: We don't recommend a "shelter in place" strategy for residents who test positive. We prefer that COVID positive residents be cared for in a designated red zone of the facility. However, for residents that have been exposed, if possible, we recommend that those residents stay in place pending the results of response testing. In this scenario, their current unit becomes the yellow zone, which is a better strategy than having a designated yellow zone and moving exposed residents around the building.

Other Questions & Answers

Q-23: Are there new travel advisories for staff?
A: No, we are not aware of any new travel advisories or testing requirements based on travel.

Q-24: If a facility ends up using an area of the facility to cohort COVID positive residents that was not included in their licensing plan, do they have to notify licensing that it's now being used as a red zone? Their fear is that they could get a tag for failure to follow the facilities mitigation plan.
A: Mitigation plans can be updated and adjusted as needed. Flexibility should be included if the red zone exceeds what was placed in the mitigation plan. You can add an addendum to your mitigation plan, and if you have concerns, contact your local department of public health for guidance.

Q-25: Are the current visitation guidelines in the December 31, 2021, State Public Health Officer Order going to be extended past February 7, 2022?
A: Active conversations are underway at the state level about modifying the State Public Health Officer Order. CDPH will provide updates as soon as we can.

Q-26: In NHSN, how should we categorize a resident that received the 1st dose of the 2-dose series, but then the family/responsible party refused the 2nd dose? We provided education, but the family said it's against their religion. It's been a year since this resident received the first dose.
A: In NSHN, this person should be captured as partially vaccinated.

Q-27: What evidence does a facility need to have to prove to a surveyor that they qualify for having a critical staffing shortage?
A: Surveyors would expect that facilities are keeping records and tracking staffing on a daily basis. If asked for the records, the facility would need to produce them to a surveyor, and be able to communicate due diligence in attempts to mitigate the staffing shortage problem.

Q-28: Does a visitor need to be tested and vaccinated/boosted in order to enter the facility for a tour for a new admission?
A: Yes, the visitor that arrives for a tour must be treated the same as all other visitors. Per current visitation guidelines, vaccine and booster status must be validated, and they must have proof of a negative test to enter the facility.

Q-29: Does housekeeping have to wear PPE in yellow zones?
A: Yes, housekeeping needs to wear the same PPE as any HCP would when they enter rooms where transmission-based precautions are in place.