

County of Santa Clara

Public Health Department

976 Lenzen Avenue
San José, CA 95126



Link to original Health Advisory: <https://www.sccgov.org/sites/phd-p/Diseases/novel-coronavirus/Documents/updated-covid-19-requirements-for-LTCFs-090420.pdf>

MEMORANDUM

DATE: September 4, 2020; revised September 18, 2020

TO: Long-Term Care Facilities (LTCFs) in Santa Clara County

FROM: Elsa Villarino, MD MPH
Assistant Health Officer

RE: Updated COVID-19 Requirements, Guidance, and Strategies for LTCFs in Santa Clara County

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1. Introduction

The County of Santa Clara Public Health Department (PHD) is updating its COVID-19 infection prevention and control recommendations for Long-Term Care Facilities (LTCFs) including Skilled Nursing Facilities (SNFs). For LTCFs that are not SNFs, these recommendations apply if there are one or more cases of COVID-19 in the facility.

A single new case of SARS-CoV-2 infection in a resident or staff is considered an outbreak. Performing facility-wide (all residents and staff) viral PCR testing as soon as there is a new confirmed case in the facility and obtaining results with the shortest possible turnaround time (TAT) are necessary to allow rapid implementation of infection prevention and control (IPC) interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent further transmission.

2. COVID-19 Reporting Requirements

Given local community transmission in Santa Clara County and ongoing COVID-19 outbreaks in multiple LTCFs, facilities should expect to identify asymptomatic and pre-symptomatic residents with SARS-CoV-2 infection with every round of testing and, therefore, have plans in place for rapidly isolating patients and conducting a clinical assessment and communicating with the PHD for further directions.

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- a. All LTCFs are required to call PHD at (408) 885-4214, ext. 3 (ask for Provider Branch) to report (within 4 hours) suspected persons under investigation (PUI) or a newly recognized case of COVID-19 in a resident or staff.
- b. All SNFs are required to conduct and report COVID-19 surveillance testing. PHD requests weekly updates using the Weekly COVID-19 Testing Survey. The weekly report is due at 12:00 pm on Fridays.

Laboratory TAT of ≤ 72 hours allows facilities to implement actions and limit the spread of COVID-19 in congregate settings. If these conditions are not presently met at your facility, consider contracting with a different service. Review the [COVID-19 Testing Task Force Lab List](#) for a compilation of CDPH-vetted laboratories.

Each LTCF should have procedures in place for notifying the staff of their test results and providing information about isolation and quarantine at the time of initial notification. PHD has a [Patient Isolation and Quarantine Handout](#).

3. Duration of Isolation and Transmission Based Precautions (TBP)

Effective September 22nd, 2020, PHD's isolation recommendation changed to the 10/1 rule, except for persons living or working in a high risk, congregate settings such as LTCFs. For LTCFs, the recommended duration of the isolation period with transmission based precautions (TBP) for persons testing positive for COVID-19 will now follow the 10/1 rule: persons should be isolated and TBP should be used in their care for at least 10 days from the date of the positive test result AND, if ever symptomatic, at least 24 hours since resolution of fever and substantial improvement in respiratory or other symptoms.

A limited number of persons with severe illness (e.g., chemotherapy patient, organ transplant, ICU patient) may continue to shed infectious virus for longer periods of time. For these persons, the recommended duration of isolation and TBP is up to 20 days after symptom onset; this is usually determined by the hospitalist or infectious disease specialist during the course of hospitalization.

4. Update Regarding Persistent Positives

In some who have recovered from COVID-19, PCR may be persistently positive. Based on research studies, viral load is low and viral cultures are negative in specimens collected after about ten days of acute illness. Therefore, it is unlikely that persons who have recovered after the isolation period are still infectious even with a persistently positive PCR. However, reinfection (a new episode of acute COVID-19 illness) remains a possibility, cannot be disregarded, and continues to be a subject of investigation.

Presently, three (3) months is the time threshold for a persistent positive state (i.e., patient continues to test positive as part of the same clinical episode of disease). This time threshold was previously defined as 6-8 weeks. **Figure 1.** depicts decision points and the time frame to consider when re-testing or consulting a specialist regarding a person previously recovered from an episode of COVID-19.

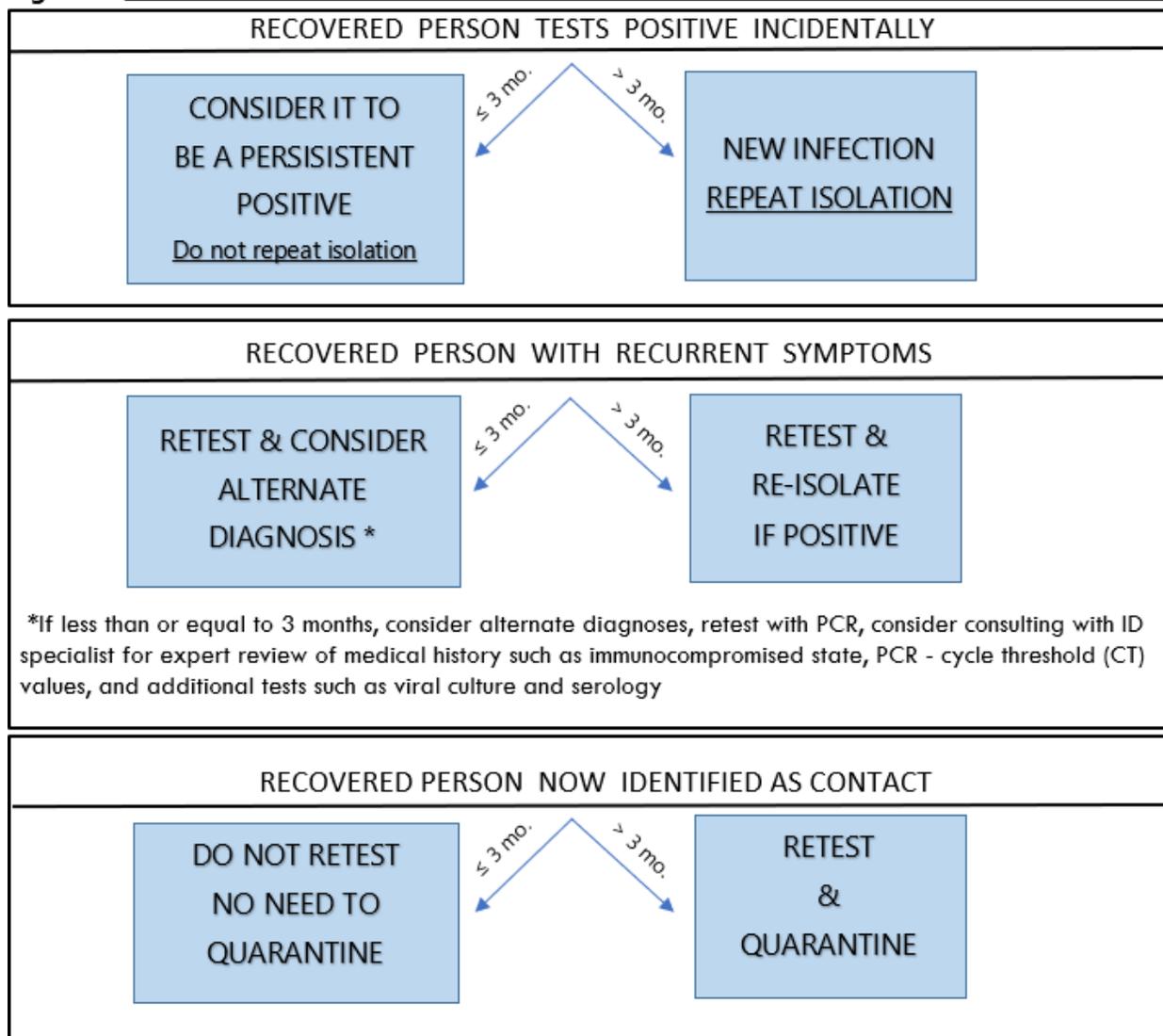
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Figure 1.



5. Testing and Quarantine of Hospital Transfers

The result of a pre-discharge test performed at the hospital does not need to be available prior to transfer; a negative test is not required prior to transfer. Newly admitted residents should be quarantined for 14 days at the LTCF and then retested. If negative, the resident can be released from quarantine.

Acute care hospital days may be counted as part of the 14-day observation period, if there is no evidence of ongoing transmission at the hospital. Retesting and quarantine are not required for residents readmitted to LTCF, again, if there is no evidence of ongoing transmission at the hospital. Absence of ongoing transmission can be determined by discussion with the discharge coordinator or hospital IP nurse at the time of planned discharge. Residents who leave

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the LTCF for ambulatory care (e.g., ED, dialysis, or clinic visits) do not need to be tested or quarantined. However, intermittent testing for residents who frequently leave the facility is recommended; this would be captured by the monthly surveillance of residents at the SNFs but is also recommended at other LTCFs (non SNFs).

For residents who are being treated for COVID-19 at the hospital and who have met criteria for discontinuation of isolation prior to transfer, no further testing or isolation is required. If the hospital deems the patient as clinically stable for discharge prior to completion of the isolation, the patient may be discharged to the COVID-19 unit of SNF (or isolated at another LTCF) and managed with TBP for the rest of the isolation period.

6. Update on Respiratory Protection Standards (N95 and Other Respirator Types)

OSHA has reminded employers of the expectation to be in full compliance with all Respiratory Protection Standards (29 CFR § 1910.134). This affects temporary recommendations that allowed extended use of disposable respirators (N95 and other types), and practices of decontamination and reuse of the respirators. Because extended use and re-use of respirators after decontamination can lower the expected level of protection of the respirators, such practices are only allowable during public health emergencies and when there are supply chain issues. Consequently, PHD recommends that LTCFs review and update their procedures and schedules for cleaning, disinfecting, storing, inspecting, repairing, discarding, and otherwise maintaining respirators. The schedule for respirator use (i.e., how often to discard respirators) is after one shift (up to 16 hours) or after no more than five (5) donnings and doffings, whichever comes first. Reusing of decontaminated masks is not allowed, although the recommendation to continue to send used and undamaged masks to the Battelle Decontamination program and storing the returned masks stands, in preparation for a future potential contingency. OSHA recommends elastomeric respirators (EM) as a first option during acute N95 shortages and has posted an informational [YouTube webinar](#) regarding EMs. OSHA will be monitoring employers' compliance to the [Respiratory Protection Standard](#) via their Compliance Safety and Health Officers (CSHOs).

7. Recommendations Regarding Family Visitations

Family visitation is now considered a right (CDPH [AFL 20-22](#)). Such visitation can take place in an outdoor space or large communal indoor space (assuming social distancing, hand hygiene, surface decontamination, monitoring of the visit).

8. Infection Prevention and Control Recommendations

Eye protection is now recommended for use in all patient care areas. This can be in the form of face shields or goggles. For extended use of masks (N95 or surgical mask), a face shield is preferred over goggles, as the face shield also protects the mask. Aerosol generating procedures (AGP) (e.g. use of nebulizers, CPAP, high flow O₂, suctioning of trach or ventilator patients) require negative air flow in resident rooms. If AGP must be performed in a shared room, the curtains between the patients' beds should be drawn. After an AGP, there should be limited entry by staff into the room for at least an hour then surface decontamination should be performed. Whenever possible, consider using non-AGP (e.g., switch from using a nebulizer to a handheld inhaler). Improved airflow is recommended for the COVID-19 and PUI units, as well as other rooms where AGP take place.