



**California Department of Public Health
Center for Health Care Quality
AFC Skilled Nursing Facilities Infection Prevention Call
February 10 & 11, 2021**

Handouts and recordings for the Wednesday Webinars can be accessed at the [Health Services Advisory Group \(HSAG\) registration website](http://www.hsag.com/cdph-ip-webinars) (www.hsag.com/cdph-ip-webinars)

Notes for the weekly calls will soon be posted at the [CDPH Skilled Nursing Facility Infection Prevention Education website](http://www.cdph.ca.gov/Programs/CHCQ/Pages/SNFeducation.aspx) (www.cdph.ca.gov/Programs/CHCQ/Pages/SNFeducation.aspx)

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 on the [Health Services Advisory Group \(HSAG\) CDPH Infection Prevention Webinars page](http://www.hsag.com/cdph-ip-webinars) (www.hsag.com/cdph-ip-webinars)

Thursday 12:00pm SNF Infection Prevention Calls: 877.226.8163; Access code: 513711

The February 10, 2021 webinar presentation covered the following updates:

- Testing Taskforce Update
- NHSN Reporting Guidance
- COVID-19 Vaccine Updates
- COVID-19 Variants

Updated February 10, 2020: CDC Public Health Recommendations for Vaccinated Persons

(<https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html#phrecs>)

Vaccinated persons with an exposure to someone with suspected or confirmed COVID-19 are not required to quarantine if they meet all of the following criteria:

- Are fully vaccinated (i.e., ≥ 2 weeks following receipt of the second dose in a 2-dose series)
- Are within 3 months following receipt of the last dose in the series
- Have remained asymptomatic since the current COVID-19 exposure

These criteria could also be applied when considering work restrictions for fully vaccinated healthcare personnel with higher-risk exposures, as a strategy to alleviate staffing shortages. Of note, exposed healthcare personnel would not be required to quarantine outside of work.

As an exception to the above guidance no longer requiring quarantine for fully vaccinated persons, vaccinated inpatients and residents in healthcare settings should continue to quarantine following an exposure to someone with suspected or confirmed COVID-19; outpatients should be cared for using appropriate Transmission-Based Precautions. This exception is due to the unknown vaccine effectiveness in this population, the higher risk of severe disease and death, and challenges with social distancing in healthcare settings. Although not preferred, healthcare facilities could consider waiving quarantine for vaccinated patients and residents as a strategy to mitigate critical issues (e.g., lack of space, staff, or PPE to safely care for exposed patients or residents) when other options are unsuccessful or unavailable. These decisions could be made in consultation with public health officials and infection control experts.

COVID-19 Vaccine Questions & Answers

Q: How do we handle staff that has not received the second vaccine and CVS is not coming back into the facility? Also, this affects newly admitted residents who want the vaccine as well?

A: CVS and Walgreens confirmed that they will give first shots at the third clinic visit. If you are still facing these issues, you can reach out to CAHF: Jason Belden, jbelden@cahf.org and/or HSAG: Jennifer Wieckowski, jwieckowski@hsag.com, 818.427.4378

Q: When there is conflicting information that we are receiving from CVS or Walgreens, how can we escalate our concern? For example, we heard today from one of our SNFs that CVS would not provide the first dose vaccination on their third visit, even though they should be doing so. When we have an in the moment challenge, how do we contact CVS/Walgreens to escalate a problem?

A: For urgent issues that require immediate action, contact Walgreens and CVS at the following emails.

- CVS: CovidVaccineClinicsLTCF@CVSHealth.com
- Walgreens: immunizeltc@walgreens.com

Q: What are the plans to vaccinate residents (new staff and admissions) after the Federal Pharmacy Partnership three vaccine clinics have passed?

A: The CDPH Immunization branch is working on a plan. You can contact your local public health department to find out if they have unique plans for your particular county. Be very specific about your needs, and provide numbers, such as number of staff/residents that need their second doses after the third pharmacy partnership vaccine clinic. If your local public health department is unable to help, contact your local hospital to see if they have supply they can share.

Q: Our resident received Pfizer COVID-19 vaccine on 1/14/21, tested positive for COVID on 1/18/21 and was hospitalized during our next clinic date which was 2/4/21. Would it be recommended to receive second dose on 2/25/21, our next clinic date, even though it will have been six weeks since the first dose was given?

A: Yes, it is appropriate if it's not possible to receive sooner.

Q: Is it recommended for a resident who completed the second dose of the COVID vaccine to receive monoclonal antibody if they become infected with the virus and develop symptoms?

A: Prior vaccination should not affect treatment decisions.

Q: What is the recommendation/advice for the residents/staff who have missed the second dose within the recommended window?

A: Second dose should be administered as close to the recommended interval as possible. The second dose may be administered up to 6 weeks/42 days after the first dose. If the second dose is administered beyond this interval, there is no need to restart the series.

Q: Monoclonal antibodies and vaccines timing question: Our patient received a monoclonal antibody infusion, and then received the Pfizer vaccine. The second dose of the vaccine has been delayed 6 weeks to ensure there is enough time from the antibody treatment to the second dose. Is it okay to give the second dose now which is 75 days following the antibody treatment? Or should we wait another two weeks to give it, which would be 8 weeks from the first dose, but closer to 90 days from the antibody treatment?

A: The CDC guidance says that if you receive an antibody treatment, you should delay receiving a vaccine for three months (90 days) as a precaution. The second dose should be deferred for at least 90 days following receipt of the antibody therapy, even though it pushes the vaccine past the six weeks. Per CDC, repeating the vaccine dose is not recommended. Guidance from CDC on persons who previously received passive antibody therapy can be found on the [CDC Vaccines & Immunizations web page](https://www.cdc.gov/vaccines/immunizations/web-page) (www.cdc.gov/vaccines/immunizations/web-page) (www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html).

Q: After completing our second dose vaccine clinics, can we stop reporting in Vaccine Finder? Or do we still need to report daily until notified?

A: You cannot stop reporting. Daily reporting needs to continue until notified further.

Quarantine/Isolation Questions & Answers

Q: What is the difference between quarantine and isolation?

A: Quarantine keeps someone who might have been exposed to the virus away from others. Isolation keeps someone who is infected with the virus away from others, even in their home. For more information on quarantine vs. isolation definitions and times, view the [ECHO National Nursing Home COVID-19 Action Network week 8 materials](http://www.hsag.com/echo) (www.hsag.com/echo) that focus on staff returning to work safely during the COVID-19 pandemic. View the video "[Post-Acute and Long-Term Care: Staff Returning Safely to Work During COVID-19](https://www.youtube.com/watch?v=XZghKiuJu6w&feature=youtu.be)" (www.youtube.com/watch?v=XZghKiuJu6w&feature=youtu.be).

Q: Our SNF is in LA county and following LA County's 14-day isolation requirement vs. CDC's 10-day isolation requirement. Scenario: If a COVID positive asymptomatic resident in the red zone discharges to home prior to the end of the 14 day isolation (they discharged on day 10), do we advise the resident's household members to self-quarantine for 14 days after the end of the resident's 14 day isolation period (not 10 days) or is the resident considered non-infectious for the purpose of discharge?

A: Once a resident is discharged and thus no longer at a higher risk in a congregate living setting, they can follow community dwelling guidance for 10-day isolation period.

Q: We have a fully vaccinated resident whose family wants to take her home for dinner on Sunday. The family said there will be no more than eight people. Since our resident is fully vaccinated, when she come back home can she come back to the nursing home without going through quarantine for 14 days.

A: It's a guideline to have this resident quarantine in this scenario, but it is not a regulation. There will be more guidance coming out on this topic in an AFL that will match the CDC guidance. In the meantime, when someone is fully vaccinated and it has been two weeks since the second dose, then you can consider that person fully vaccinated. Make decisions on case by case basis until the AFL is released.

Q: Please clarify what appears to be an inconsistency in the [language of AFL 21-08](https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx) (www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx). "HCP exposed to SARS-CoV-2 that work in a high-risk congregate living setting should also quarantine and be excluded from work for 14 days in the absence of staffing shortages." However, in the subsequent paragraph, AFL 21-08 states "In general, during an outbreak in a SNF, all HCP are considered potentially exposed and may continue working as long as they remain asymptomatic and are serially tested as part of facility-wide outbreak response testing." Which should facilities follow?

A: This addresses the options for shortened duration for quarantine, specifically for healthcare personnel. This applies to facilities that are not in an outbreak status. The ideal scenario is that exposed healthcare personnel quarantine for 14 days after high risk exposure. When an outbreak occurs, we consider all healthcare personnel to be potentially exposed which is why we do response testing repeatedly. In those situations, we do allow exposed staff to continue to work to help prevent major staffing shortages.

Q: Scenario: Our employee received both vaccine doses. Our employee's spouse works in healthcare and declined the vaccine, and recently tested positive. Our facility is in the CDPH pilot for high frequency testing and our employee continues to test negative. The question is about guidelines for quarantine regarding potential exposure, etc..... Do we allow our employee to continue to work, or should we tell them they cannot work? Are the residents at risk because our vaccinated employee is now exposed?

A: From the CDC guidance that was posted yesterday, according to this guidance, it is allowable for a fully vaccinated person to not quarantine after exposure. This can be applied when considering work

restrictions to alleviate staffing shortages. Ideally, fully vaccinated HCP who have high risk exposure should quarantine, but as a strategy to alleviate staffing shortages, facilities can opt to not require quarantine.

Q: Do new admissions who have received two doses of vaccine need to be placed in the yellow zone for 14 days, even if they tested negative on admission?

A: This relates to resident quarantine guidance. CDC guidance says that vaccinated inpatients and residents in healthcare settings should continue to quarantine after exposure to someone infected with COVID. This is a conservative ideal approach acknowledging that the vaccine is not 100% effective and we don't know the effectiveness in preventing transmission. Based on this guidance, an individual newly admitted with unknown COVID exposure status, even though vaccinated, would ideally be in quarantine based on CDC guidance.

Q: If staff travels outside of California by car (no known exposure and limited contact), is there a requirement to quarantine? What if they travel internationally by plane?

A: HCP are an exception to travel quarantine recommendations, although they need to adhere to all precautions and ideally only travel when essential. There are no quarantine recommendations because they are considered essential workers.

Q: Can residents who leave the facility often for dialysis or chemo be placed in the green zone when they return, if they have received two doses of the vaccine?

A: Residents that attend dialysis or other appointments may cohort together when they return to the facility as they might be likely to have exposures outside the facility. Some facilities place dialysis patients in a yellow area or green area if they did not have a known exposure. Once they are vaccinated, it is up to each nursing home to assess their facility's situation. They can choose to continue to manage dialysis patients in the yellow zone and cohort them together, or the facility can choose to manage them in the green zone. But to be clear, there is not a strong recommendation from CDPH that dialysis patients (or other patients that routinely leave the facility) must be placed in the yellow exposed area.

Testing, PPE and Other Infection Prevention Questions & Answers

Q: What data source should SNFs use to identify their county positivity rate?

A: Use the CDPH data at Blueprint for a Safer Economy to access and determine your county positivity rates. Do not use the CMS data to determine your county positivity rate. The county data on the CDPH Blueprint website is updated weekly. Check your county's data every week to ensure you are up to date.

- [Blueprint for a Safer Economy Home Page](https://covid19.ca.gov/safer-economy/) (https://covid19.ca.gov/safer-economy/)
- [Blueprint for a Safer Economy county level data](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID19CountyMonitoringOverview.aspx) chart can be found here. (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID19CountyMonitoringOverview.aspx).

Q: Is LA County still requiring staff to test twice per week, now that the positivity rate is below 10%?

A: CMS requires for the testing positivity rate to be <10% for at least 2 weeks before moving to the lower testing frequency. LA County has been following the CDPH Blueprint data to be consistent with the state, which so far has shown we've been at <10% for just 1 week per the data released 2/9/21. Once we see what next week's testing positivity rate is, we will notify SNFs if there will be a change to the testing frequency guidance so please be on the lookout for that communication.

Q: Can you comment on the UV technology in sanitizing and decontaminating small spaces/offices when we cannot socially distance employees. How can we find approved quality UV equipment?

A: We can't comment on specific companies, but the FDA has taken a look at UV technology and its ability to combat COVID-19. For more information visit the FDA's website "[UV Lights and Lamps: Ultraviolet-C](#)

[Radiation, Disinfection, and Coronavirus”](http://www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/uv-lights-and-lamps-ultraviolet-c-radiation-disinfection-and-coronavirus) (www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/uv-lights-and-lamps-ultraviolet-c-radiation-disinfection-and-coronavirus)

These types of enhancements are good, but as adjunct to social distancing and source control and should not be a replacement for these precautions. [CDC has guidance](http://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html) at: (www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html).

Q: Is it true that respirators, face shields and goggles are not necessary to wear in the hallways?

A: That is correct. Individuals implementing extended use of respirators might indeed be wearing them in the hallway, but it is not required. Hallways are considered clean areas.

Q: Is it safer for floating staff to wear fit tested N95s rather than surgical masks even though they are only working in the Green Zone?

A: They can wear an N95 for source control which will also provide respiratory protection. If there are respirator shortages, it would be wise to ensure there is enough supply for staff who need to wear an N95 in the yellow and red zones. If there are no PPE shortages, there is no reason that you can't wear an N95 in the green zone.

Q: For double-masking guidance in green zone for source control, will CDPH be enforcing the use of a cloth mask or face shield over a surgical mask? It seems this guidance may have been updated today. It does specifically say no double surgical masks; however, it seems a cloth overlay [mask] may still be recommended. We need to know what you will be surveying for.

A: From an IP perspective, double masking for source control in the green zone is reasonable, but not required. Double masking is not approved for employees wearing an N95 respirator. From a CDPH surveyor's point of view, we survey for Title 22 which is state regulations, CMS regulations, and takes into consideration the guidance on the AFLs. Keep in mind that Cal/OSHA also does surveys and they might cite differently based on their regulations. This can be very confusing to facilities. Cal/OSHA is primarily concerned with respiratory protection for employees. Employees who need respirator protection need to wear an N95 respirator, which should not be worn with another mask under or over them the respirator.

Q: I have a question about disinfecting of non-disposable resident care items, i.e. blood pressure cuff, gait belts, stethoscopes, etc... we have dedicated equipment for yellow and red zone. What about the green zone? CDC in 2008 and updated in 2019 stated that these are considered non-critical as they only come in contact with intact skin which provided an effective barrier to most microorganisms. Do you agree that cleaning after use is not necessary and if so, where can I find the evidence-based data?

A: No, CDPH does not agree. It's not just COVID-19 that we are concerned about. Recently, there have been increases in other pathogens that cause problems in LTC facilities, such as multidrug resistant organisms, *Candida auris* being one of them. It is vital to clean medical mobile equipment.

Q: In our hospital is it acceptable for HCP to enter a COVID positive isolation unit wearing only surgical masks. We would do the donning of the N95 and the face shields before attending to the patients. Some of our donning stations are immediately present inside the unit and not outside.

A: The answer depends on if residents are in their own rooms with doors closed. When walking into the hallway unit, a facemask for source control is okay. If the donning stations are immediately present inside the unit, it is acceptable as long as healthcare personnel know they need to don the respirator before entering the resident's room.

Q: What defines a “critical staffing shortage”?

A: Critical staffing shortage is defined as when a facility does not have enough staff to provide safe patient care.