The California Department of State Hospitals

COVID-19 Transmission-Based Precautions and Testing

Approved by the DSH Executive Team on July 25, 2024

Contents

Introduction

The guidelines and protocols included in this document were developed in partnership between DSH and the California Department of Public Health, Healthcare Associated Infections (HAI) Program to provide guidelines for COVID-19 transmission-based precautions and testing. These guidelines represent current best practices and may require regular updates. These are the minimum requirements. Each hospital develops local operating procedures to support these protocols based on their resources, staffing and physical plant layout.

These guidelines are intended for use at the five state hospitals (Atascadero, Coalinga, Metropolitan, Napa, and Patton) and provide flexibility for the hospitals to put in place more conservative precautions when the community cases or hospital infections are high and relax precautions when low. Hospitals should discuss plans to increase or decrease precautions with their local health department for guidance. The guidance for DSH-Sacramento can be found in SQI-OP-8309 COVID-19 Procedures for DSH-Sacramento.

These guidelines are updated regularly. This document reflects current guidance as of July 25, 2024.

Definitions

Close Contact: Determined through Proximity & Duration of exposure:

Proximity- Someone who was < 6 feet away from an infected person (laboratory-confirmed or clinical diagnosis) AND;

Duration- For a TOTAL of 15 minutes or more over a 24-hour period (Can be 3 separate 5-minute exposure for total of 15 mins)

COVID-19 Illness Severity:

- Mild Illness – Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.
- Moderate Illness: Individuals who have evidence of lower respiratory disease, by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.
- Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.
- Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Exposure: Having come into contact with a cause of, or possessing a characteristic that is a determinant of, a particular health problem.

Facemask: OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as 'medical procedure masks.'" Facemasks should be used according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Other facemasks, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Healthcare Personnel (HCP): All paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

Isolation Area: Separates patients who refuse testing from those that are under serial testing. Isolation areas may be in a home unit or any specified locations within each hospital.

Isolation Unit: Separates confirmed COVID-19 (+) patients from people who are not infected.

Persons Under Investigation (PUI) Unit/Rooms: Separates patients in individual rooms that who are potentially exposed and have symptoms consistent with COVID-19 disease who are not confirmed to be infected.

Personal Protective Equipment (PPE): Refers to protective clothing, helmets, gloves, face shields, goggles, surgical masks and/or respirators or other equipment designed to protect the wearer from injury or the spread of infection or illness, and chemical and biological hazards.

Quarantine Unit: Houses asymptomatic patients that have been exposed to a person(s) with a confirmed COVID-19 infection.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

Transmission-Based Precautions: The second tier of basic infection control and are to be used in addition to Standard Precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Please see DSH's Aerosolized Transmissible Disease (ATD) Guidelines for more information.

Up To Date Vaccination Status: A person is considered up to date with their COVID-19 vaccine if they have received the most updated vaccine per CDC guidance. For example, as of July 2024, up to date is defined as having received a 2023-2024 updated COVID-19 vaccination.

Section I: Admission Testing to Any DSH Unit

Patients who are directly admitted to their home unit as a new admission or readmission (left >24 hours) undergo COVID-19 testing and may proceed to their designated home unit if they have negative infectious disease admission clearance form and a negative COVID test.

Serial testing is no longer required. Patients undergo one COVID test at admission to DSH.

If the patient develops symptoms consistent with COVID-19 disease, they are immediately moved to a patient under investigation (PUI) room where the patient is isolated and undergoes testing.

At any time, if a test returns positive, the patient is immediately moved to an isolation unit. Isolation units house confirmed COVID-19 patients.

Section II: Testing Exposed Patients and Healthcare Personnel

A. General Principles

Patient(s) with known exposure to a suspected or confirmed COVID-19 infection undergo testing and may be placed under quarantine. Whole units may be quarantined when indicated. HCP working in or around quarantined units may be required to test daily. HCP wearing a respirator are NOT considered exposed even if they meet the exposure duration and proximity definitions below.

1. Close Contact (Exposure Duration):
    a. An exposure of 15 minutes or more is considered prolonged. (This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period.)
    b. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. (For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.)

2. Close Contact (Exposure Proximity):
    a. Being within 6 feet of a person with confirmed COVID-19 infection or
    b. Having unprotected direct contact with infectious secretions or excretions of the person with confirmed COVID-19 infection.
    c. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.

3. Determining the time period when the patient, visitor, or HCP with confirmed COVID-19 infection could have been infectious:
    a. For Symptomatic individuals with confirmed COVID-19, consider the exposure window to be **2 days before symptom onset** through the time period when the individual meets criteria for discontinuation of isolation.
    b. For Asymptomatic individuals with confirmed COVID-19 infection, if the date of exposure cannot be determined, consider using a starting point of **2 days prior to the positive test** through the time period when the individual meets criteria for discontinuation of isolation.

B. Patient Close Contact or Exposure:

1. All close contact or exposed patients undergo serial testing.
    a. Baseline – **DAY 1** (Antigen or PCR testing) **not earlier than 24 hours after exposure**
2. Test at **DAY 3** and **DAY 5.** Consider unit quarantine if testing of patients reveals (+) case(s).
3. Consider quarantine based on contact tracing analysis.
4. If any patient chose not to test, consider quarantine and release after Day 10. Perform serial testing on patients who agree to test.
5. Any asymptomatic patient that is (+) by RAT or PCR is immediately placed in isolation, unless they have been recently infected with COVID-19 (see #7 and 8 below). Positive RAT does not need confirmatory PCR testing.
6. Any patients that develop symptoms are placed in an area of no contact with other patients and tested by antigen or PCR. If antigen tested first and antigen is negative, then test using PCR. If PCR (-), the patient is allowed to reintegrate to the unit. If antigen or PCR (+), the patient is placed in isolation and the unit undergoes serial testing. Consider unit quarantine. Some facilities may choose to place the patient in isolation upon an antigen positive test result.
7. Testing is not recommended for asymptomatic patients who have recovered from COVID in the prior 30 days.
8. Testing for those recovered from COVID in prior 31-90 days should use the antigen test instead of the nucleic acid amplification test (NAAT)-PCR.

C. Unit Exposure from Positive (+) Staff

1. If an HCP tests positive, contact tracing is initiated and serial testing of patients should be considered.
2. If staff are identified through contact tracing as having higher risk exposures, serial testing should be considered for those staff.
3. Any HCP that tests positive on antigen or PCR follows return to work protocol.
4. Consider unit quarantine if testing of patients reveals (+) case(s) or if contact tracing analysis support immediate quarantine of the unit. Quarantine is required if more than 3 or more (+) cases are revealed from serial testing.

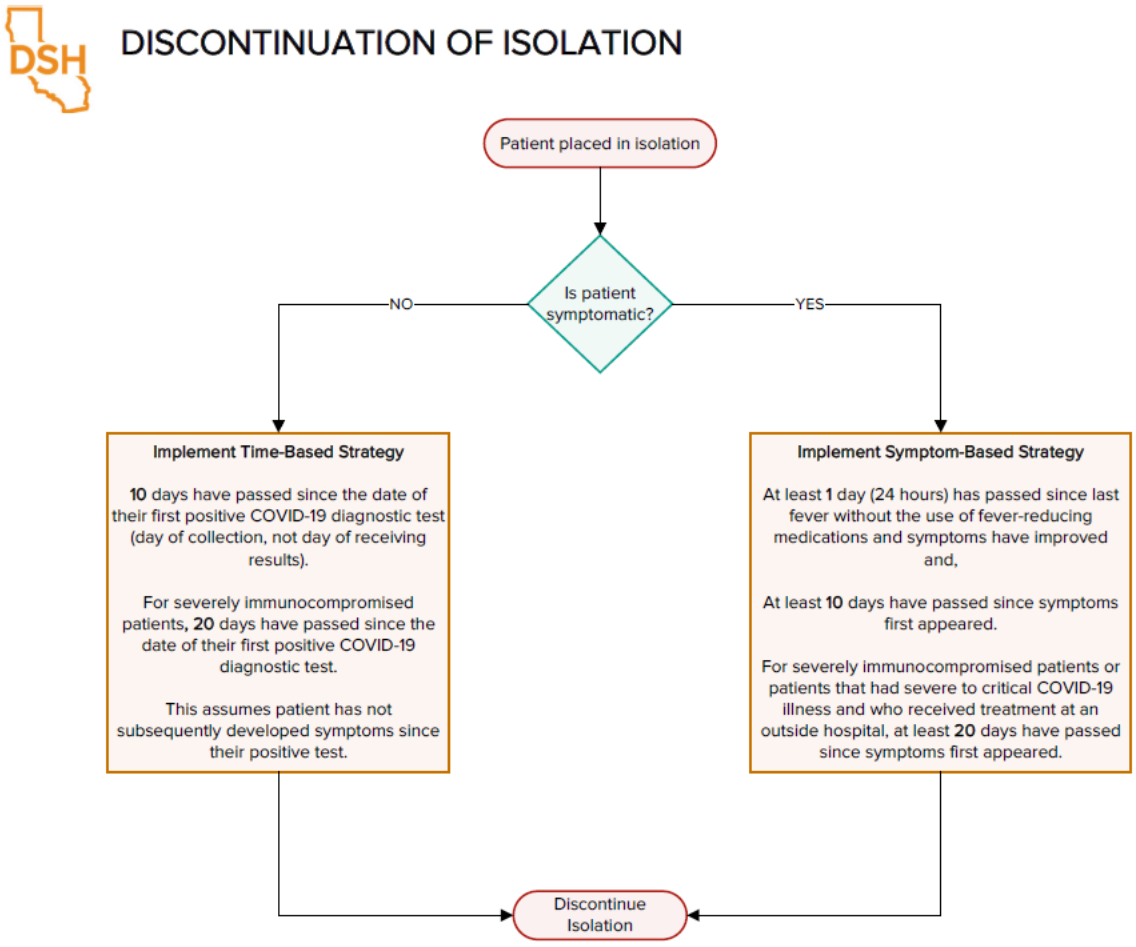
Section III: Isolation Unit Timeline and Discontinuation

Isolation units house patients confirmed to have COVID-19 disease. All patients have had a positive test result. Patient's transmission-based precautions are discontinued using a symptom-based or time-base strategy. Please note that local public health officials may adjust this guidance based on hospital bed availability and other factors. In situations where local guidance differs from the guidance below, hospitals may defer to local guidance. For example, during outbreaks, some hospitals have been permitted to have patients isolate in their housing unit or be released from isolation with negative testing on days 6 or 7.

A. Symptom-based strategy:
    - At least 1 day (24 hours) have passed **since last** fever without the use of fever-reducing medications and;
    - Symptoms consistent with COVID-19 disease (e.g., cough, shortness of breath, etc.) have improved, and;
    - At least 10 days have passed **since symptoms first appeared**.
        - For severely immunocompromised patients or severely symptomatic patients, a time frame of 20 days since symptoms first appeared is recommended after consultation with either the Chief of Primary Care, Chief Physician & Surgeon, Medical Director, or an ID specialist. In this situation a negative "Test-based Strategy" may also be used.

B. Time-based strategy:
    - 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.
        - For severely immunocompromised patients, a time frame of 20 days since the date of their first positive test is recommended after consultation with either the Chief of Primary Care, Chief Physician & Surgeon, Medical Director, or an ID specialist. In this situation a negative "Test-based Strategy" may also be used.

Figure 1. Discontinuation of Isolation for Patients



Section IV: Diagnostic COVID-19 Testing of Symptomatic Patients and HCP

A. Symptomatic Patient:

1. Patients with signs/symptoms consistent with COVID-19 should be tested immediately by RAT or Cepheid PCR.
2. For Initial Rapid Antigen Testing:
    - If initial RAT is negative (-) but symptoms remain:
        - Place patient in area with no patient contact and perform confirmatory PCR (Cepheid).
        - May consider Multiplex Cepheid testing to r/o other pathogens causing symptoms (Influenza A, B, or RSV).
    - If initial RAT is positive (+):
        - No confirmatory COVID-19 test is needed.
        - Patient is transferred to an isolation unit.
        - The patient's unit will undergo serial testing and may be placed in quarantine.
    - If 2nd PCR result is negative (-):
        - Patient is integrated back to the unit and should follow all non-pharmaceutical interventions (NPI).
    - If 2nd PCR result is positive (+):
        - Patient is transferred to an isolation unit.
        - Patient's unit will undergo serial testing and may be placed on quarantine.
3. For Initial PCR Testing (Cepheid):
    - If initial PCR is negative (-) for COVID-19 but symptoms remain:
        - If influenza or another contagious disease is highly suspected after a negative COVID test, the patient should remain in area upon physician request, with no contact with other patients until the diagnosis is established.
    - If initial PCR is positive (+):
        - Patient is transferred to an isolation unit.
        - Patient's unit will undergo serial testing and may be placed on quarantine.

Those with prior positive test who develop new symptoms should be tested if within 31-90 days from prior infection with RAT.

B. Symptomatic HCP:

1. HCP with signs/symptoms consistent with COVID-19 should be tested immediately by either a RAT or PCR, regardless of vaccination status.
2. For Initial Rapid Antigen Testing:
    - If initial RAT is negative (-) but symptoms remain:
        - HCP quarantines at home and needs to be retested by either RAT or PCR 48 hours after first negative test for total of at least 2 tests.
        - If after 24 hours, HCP has improved symptoms they may be retested by RAT and return to work if negative (-).
    - If 2nd RAT or PCR is negative (-), but symptoms remain:
        - HCP may return to work if screening shows no fever in the last 24 hours (<100 degrees without fever reducing medications) with improving symptoms.
        - Otherwise, the HCP may use available leave credits until symptoms improve per the guidance of their own primary care provider.
    - If 2nd RAT or PCR is positive (+):
        - HCP to follow their local return to work policy and table. HCP may use available leave credits or other benefit options as available.
3. For Initial PCR Testing (Cepheid/Personal Provider)
    - If initial PCR is negative (-) but symptoms remain:
        - HCP may return to work if screening shows no fever in the last 24 hours (<100 degrees without fever reducing medications) with improving symptoms.
        - Otherwise, the HCP may take their own sick time until symptoms improve per the guidance of their own primary care provider.
    - If initial PCR is positive (+):
        - HCP to follow return to work policy and table.

Those with prior positive test who develop new symptoms should be tested if within 31-90 days from prior infection with RAT.

Figure 2. Diagnostic COVID-19 Testing of Symptomatic Patients

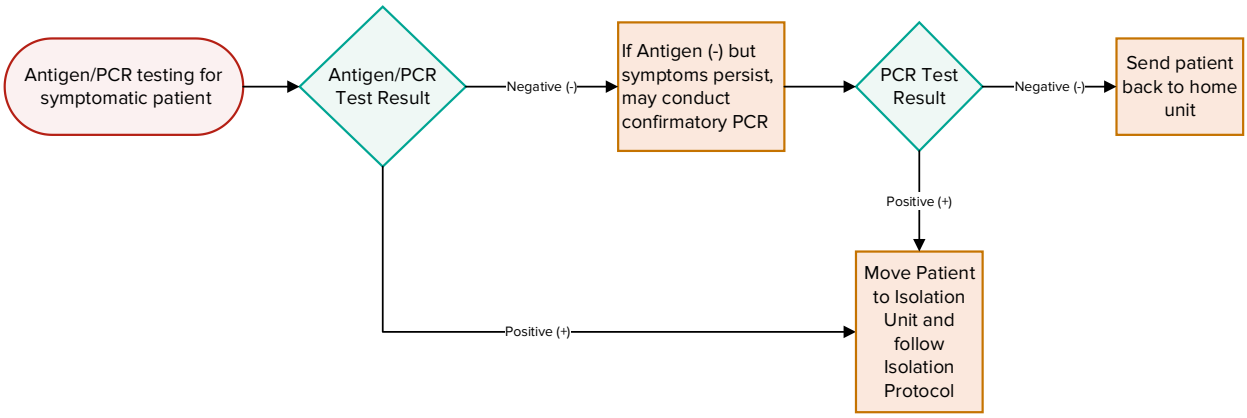
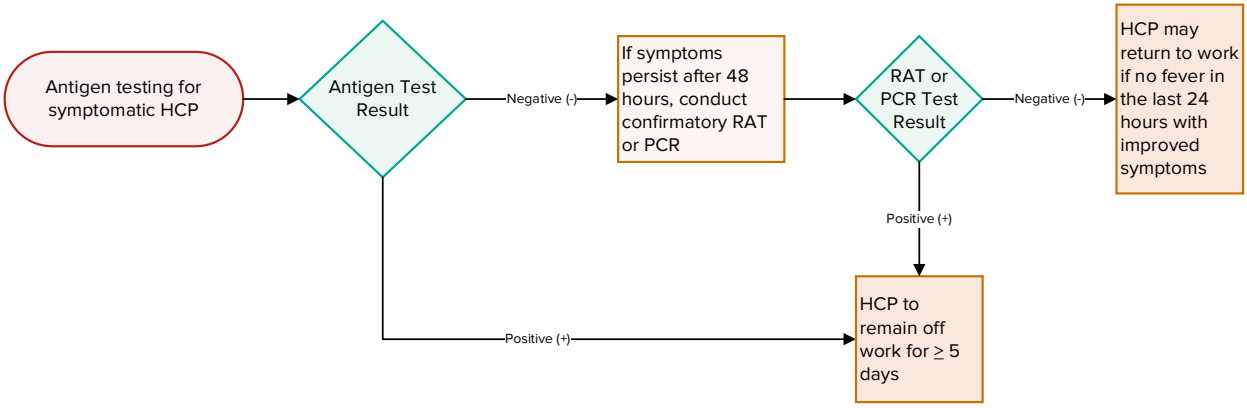


Figure 3. Diagnostic COVID-19 Testing of Symptomatic HCP



Note: Those with prior positive (+) test who develop new symptoms should be RAT tested if within 31 – 90 days from prior infection

Section V. Diagnostic Screening Testing During a COVID-19 Outbreak

Considerations for reactivating daily rapid-antigen testing are based on whether the facility is having a COVID-19 outbreak. An outbreak may be defined locally by Public Health Officials or by the definitions below.

COVID-19 Outbreak Definition for Non-Healthcare Settings:

For large settings (residential congregate facilities with >100 persons present in the setting), particularly during high levels of community transmission, local health departments may determine that a higher proportion (at least 5%) of cases within a 14–day period may be appropriate for defining an outbreak, even in the absence of identifiable epidemiological linkages.

Long-Term Care Facilities and Long-Term Acute Care Hospitals:

≥3 suspect, probable or confirmed COVID-19 cases in HCP with epi-linkage and no other more likely sources of exposure for at least 2 of the cases.

Hospitals may work with local County Public Health Offices on managing outbreaks depending on size of the outbreak, availability of isolation space, and other factors.

Section VI. Patient Testing Refusal

Patients refusing to test poses a challenging situation for other patients and staff. Reasonings for refusal may be multifactorial and dependent on different situations. The hospital administration in consultation with clinical staff may address patient testing refusal on an individualized approach to maintain transmission-based precautions and safety.

A. Refusal of testing during admission:
    1. If patient agrees to test, they may transfer to a regular unit.
    2. HCP to provide patient education about monitoring for symptoms and reporting any symptoms to health care personnel.
    3. Treatment team members to develop an incentivization plan for patient participation.

B. Refusal of testing after close contact exposure:
    1. Consider placing unit in quarantine if refusing patient(s) can't be house separately.
    2. If able to house separately, release the refusing patient(s) after 10 days or earlier if they agree to test.
    3. HCP to provide patient education

Section VII: HCP Screening

All DSH facilities shall post signage or utilize other broad communications to individuals entering the facility to screen themselves for COVID-19. A DSH facility may also elect to maintain HCP screening, which may be conducted in-person, at sign-in, or electronically. Reportable symptoms or findings include:

- Fever or chills
- Cough, dry or productive
- Dyspnea or difficulty breathing
- Fatigue
- Myalgia/muscle aches or body aches
- Headaches
- New loss of taste or smell
- Sore throat
- Nasal congestion or runny nose
- Nausea, vomiting and diarrhea

HCP exhibiting a reportable symptom or exposure risk should immediately contact their supervisor for further instructions to follow Section V. Diagnostic COVID-19 Testing for Exposed and Symptomatic HCP. Any personnel with known symptoms, elevated temperature, or exposure risk should not come to work.

Section VIII. Vaccinations

COVID-19 vaccination is available at all DSH facilities for staff and patients.

COVID-19 vaccination is an important way to protect staff and patients from contracting or having serious illness from COVID-19. COVID-19 vaccines are updated on an ongoing basis to adjust to new strains, and people need to receive updated COVID-19 vaccines to remain “up to date” in their vaccination status.

DSH follows CDC’s COVID-19 vaccine guidance. Staff should contact their supervisor if they are interested in receiving a COVID-19 vaccination.

Vaccines for COVID-19 | CDC

Section IX. Return to Work

For HCP who were initially suspected of having COVID-19 but following evaluation another diagnosis is suspected or confirmed, return to work decisions should be based on their other suspected or confirmed diagnoses.

Hospitals always have the option to implement more protective procedures and follow prior guidance for a longer (10-day) isolation period for infected HCP. In addition. Local Public Health Officials may provide guidance that shortens isolation or quarantine time. Hospitals may defer to local authority.

A. Exposure Risk Assessment for HCP

Hospitals use the CDC's updated risk assessment framework to determine exposure risk for HCP with potential exposure to patients, residents, visitors, and other HCP with confirmed COVID-19 in a health care setting[1].

Higher-risk exposures generally involve exposure of HCP's eyes, nose, or mouth to material potentially containing COVID-19, particularly if these HCP were present in the room for an aerosol-generating procedure.

Other exposures not classified as high-risk, including having body contact with the patient (e.g., rolling the patient) without gown or gloves, may impart some risk for transmission, particularly if hand hygiene is not performed and HCP then touch their eyes, nose, or mouth.

When classifying potential exposures, specific factors associated with these exposures (e.g., quality of ventilation, use of PPE and source control) should be evaluated on a case-by-case basis. These factors might raise or lower the level of risk; interventions, including restriction from work, can be adjusted based on the estimated risk for transmission.

For the purposes of this guidance, higher-risk exposures are classified as HCP who had prolonged close contact with a patient, visitor, or HCP with confirmed COVID-19 infection and:

- HCP was not wearing a respirator (or if wearing a facemask, the person with

[1] Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

COVID-19 infection was not wearing a cloth mask or facemask)

- HCP was not wearing eye protection if the person with COVID-19 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure. For more details, please refer to DSH's Aerosolized Transmissible Disease (ATD) plans, section on High Hazard Procedures.

For this guidance an exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes during a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, any duration should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure[2].

CDC guidance for assessing travel and community-related exposures apply to HCP with potential exposures outside of work (e.g., household,) and among HCP exposed to each other while working in non-patient care areas (e.g., administrative offices).

For the purpose of contact tracing to identify exposed HCP, the exposure period for the source case begins from two days before the onset of symptoms or, if asymptomatic, two days before test specimen collection for the individual with confirmed COVID-19.

B. Isolation and Work Restriction for HCP

Hospitals use the table, below, to guide work restrictions for HCP with SARS-CoV-2 infection and for asymptomatic HCP with exposures based upon facility staffing level.

[2] Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#aerosol

Table 1. Work Restrictions for HCP with COVID-19 Infection (Isolation)[3]

Clinical Status	Routine	Critical Staffing Shortage
All HCP regardless of vaccination status	5 days* with at least one negative diagnostic test same day or within 24 hours prior to return OR 10 days without a viral test	<5 days with most recent diagnostic test† result to prioritize staff placement‡

Table 2. Management of Asymptomatic HCP with a COVID-19 Exposure

Clinical Status	Routine	Critical Staffing Shortage
All HCP regardless of vaccination status	No work restriction with **negative** diagnostic test† upon identification (but not earlier than 24 hours after exposure) and if negative, test at days 3 and 5	No work restriction with diagnostic test† upon identification (but not earlier than 24 hours after exposure) and at days 3 and 5

* Asymptomatic or mildly symptomatic with improving symptoms and meeting negative test criteria; facilities should refer to CDC guidance for HCP with severe to critical illness or moderately to severely immunocompromised.

t Either an antigen test or nucleic acid amplification test (NAAT) can be used. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for discontinuation of isolation and return-to-work for SARS-CoV-2 infected HCP and for HCP who have recovered from SARS-CoV-2 infection in the prior 90 days; NAAT is also acceptable if done and negative within 48h of return.

+ If most recent test is positive, then HCP may provide direct care only for patients/residents with confirmed SARS CoV-2 infection, preferably in a cohort setting. This may not apply for staff types or in settings where practically infeasible (e.g., Emergency Departments where

[3] https://www.cdph.ca.gov/Programs/CHCQ/LCP/pages/afl-21-08.aspx

patient COVID status is unknown) or were doing so would disrupt safe nurse to patient ratios, and for staff who do not have direct patient/resident care roles.

§ In general, asymptomatic HCP who have recovered from SARS-CoV-2 infection in the prior 90 days do not require work restriction following a higher-risk exposure.

HCP whose most recent test is positive and are working before meeting routine return-to-work criteria must maintain separation from other HCP as much as possible (for example, use a separate breakroom and restroom) and wear a N95 respirator for source control at all times while in the facility. In addition, healthcare facilities should make N95 respirators available to any HCP who wishes to wear one when not otherwise required for the care of patients or residents with suspected or confirmed COVID-19.

Section X: COVID-19 Units/Process and Personal Protective Equipment (PPE)

The PPE guidelines included for PPE usage in the table below can be modified to comply with local health departments. N-95 respirators are highly encouraged for all staff during a hospital surge in COVID-19 cases.

Masking is strongly encouraged in all patient care areas and where HCP may encounter patients within 6 feet indoors or outdoors. Staff who are not in patient care areas or are not providing care are encouraged to mask at their discretion.

Masking or a higher level of masking may be reinstituted at any time based on COVID-19 cases, community-based transmission rates, and/or outbreak status in any area of the hospital or the hospital as a whole.

Table 3. COVID-19 Units/Process and Personal Protective Equipment (PPE)[4]

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Isolation Unit:	• N-95 Respirator • Face Shield (when providing direct patient care) • Gloves (when providing direct patient care)	• Gown
PUI Room(s)	• Surgical mask in all areas when not providing direct patient care • N-95 Respirator (when providing direct patient care) • Face Shield (when providing direct patient care) • Gloves (when providing direct patient care)	• Gown

[4] Please refer to DSH's Aerosolized Transmissible Diseases (ATD) Guidelines for more detailed information on these recommendations.

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Quarantine Unit	• Surgical mask in all areas when not providing direct patient care • N-95 Respirator (when providing direct patient care) • Gloves (when providing direct patient care) N-95 Respirator strongly encouraged to be always worn by staff not up to date with COVID-19 vaccination. • Face shield when testing patients for Covid	• Gown • Face Shield
Regular Unit: • Unit that has not been placed on quarantine and does not have patients being treated, under investigation, or being observed for COVID-19.	• Surgical mask is strongly encouraged in all patient care areas and where HCP may encounter patients within 6 feet indoors or outdoors.	• N-95 Respirator • Face Shield • Gloves
CPR/ACLS for COVID+ patient	• CAPR/PAPR • Gloves • Gown	
Aerosol Generating Procedures	• CAPR/PAPR • Gloves • Gown	
Transportation Staff: • Any staff assigned to transport or escort a COVID+ patient or PUI in a vehicle (Example: To OMF appointments or on bus between compounds).	• N-95 Respirator • Face Shield • Gloves	

UNIT TYPE or PROCESS	REQUIRED PPE	AVAILABLE UPON REQUEST
Administrative or Non-Treatment Areas With No Patient Contact	None	• Surgical mask • N-95 Respirator

-END OF REPORT-