



Long Term Care Facility COVID-19 Outbreak Control Recommendations

Updated 09/12/2022

These recommendations supplement the California Department of Public Health (CDPH) All-Facilities Letters [All Facilities Letters \(ca.gov\)](#) and California Department of Social Services (CDSS) Provider Information Network ([ASC PINs page](#)) and include additional precautions and actions to control a suspected or confirmed outbreak.

Note: All changes to this document as of 09/12/2022 in red.

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Definitions for Skilled Nursing or Residential Care Facilities

Confirmed COVID-19 Outbreak LTCF: ≥ 1 facility-acquired¹ COVID-19 case in a resident.

Other Reportable Events:

- ≥ 1 probable² or confirmed COVID-19 case in a resident or Health Care Personnel (HCP)
- or ≥ 3 cases of acute illness compatible with COVID-19 in residents with onset within a 72-hour period.³

Clinical Criteria for Probable COVID-19: at least one of the following symptoms: new or worsening cough, shortness of breath or difficulty breathing, new olfactory/taste disorder(s); **OR** at least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, nausea, vomiting, diarrhea, fatigue, congestion, or runny nose.

Epidemiologic linkage: One or more of the following exposures in the prior 14 days: Close contact with a confirmed or probable case of COVID-19 disease; Member of a risk cohort as defined by public health authorities during an outbreak. [Coronavirus Disease 2019 \(COVID-19\) 2021 Case Definition | CDC](#)

Fully vaccinated: refers to a person who is: ≥ 2 weeks following receipt of the second dose in a 2-dose series, or ≥ 2 weeks following receipt of one dose of a single-dose vaccine.

Up-to-date (fully vaccinated and boosted if booster eligible): a person who has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible. [CDC Clinical Considerations - COVID-19 Vaccines](#) [QSO-20-38](#)

HCP with Higher Risk Close Contact: HCP with prolonged close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection. [Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC](#)

Worker: all paid and unpaid individuals who work in indoor settings where care is provided to patients, or individuals with whom patients have access to for any purpose.

Contact Tracing: The practice of identifying, notifying, and testing close contacts, or people who have been exposed to someone with an infectious disease

Close Contact: A close contact is someone sharing the same indoor airspace (examples: home, clinic waiting room, airplane, office, bathroom, break rooms) for a cumulative total of 15 minutes or more over a 24-hour period (for example, three individual 5-minute exposures for a total of 15 minutes) with someone infected with COVID-19 <https://covid-19.acgov.org/isolation-quarantine>

¹ Facility-acquired COVID-19 infection in a long-term care resident is defined as a confirmed diagnosis 14 days or more after admission for a non-COVID condition, without an exposure during the previous 14 days to another setting where an outbreak was known or suspected to be occurring.

² Probable case is defined as any one of the following: a person meeting clinical criteria AND epidemiologic evidence with no confirmatory laboratory testing performed for COVID-19; a person meeting presumptive laboratory evidence AND either clinical criteria OR epidemiologic evidence; a person meeting vital records criteria with no confirmatory laboratory testing performed for COVID-19.

³ See CDPH AFL 20-75 for more information <https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-75.aspx> See CDC update <https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html> 3-29-2021



Reporting Requirements

- Report **confirmed outbreak or reportable event** to the Alameda County Public Health Department (ACPHD) at (510) 268-2785 or email LTCFOutbreak@acgov.org Mon-Fri 8:30 am to 5:00 pm. Begin isolation and quarantine of any confirmed/suspected cases. On weekends, if there are urgent issues call Alameda County Fire Dispatch at (925) 422-7595 and ask to speak to the Public Health Duty Officer on call.
- Complete a line list using [ACPHD's Line List Template](#) for all **new** cases (residents, staff, or visitors) and update with **any changes**. Submit to ACPHD by secure email to LTCFOutbreak@acgov.org unless instructed otherwise by ACPHD.
- Submit a map/floor plan of your facility to ACPHD within 24 hours of reporting the outbreak.
- Skilled Nursing Facilities** (SNFs) should report cases and outbreaks to Licensing and Certification East Bay District Office: (510) 620-3900.
- Residential Care Facilities** (RCFE and ARF) should report cases and outbreaks to Community Care Licensing and Certification Regional Office: (510) 286-4201 and CCLASCPOaklandRO@dss.ca.gov.
- Laboratories and LTCF's testing under CLIA waivers (CalREDIE) must report all **positive** SARS-CoV-2 antigen and PCR test by Electronic Laboratory Reporting (ELR). [Testing Strategies for SARS-CoV-2 | CDC 5-5-2022](#)
- Providers or facilities on behalf of providers, complete a Confidential Morbidity Report (CMR) within 24 hours for COVID-19 cases that result in hospitalization or death. CMRs should be submitted by email to COVIDreport@acgov.org or Fax 510-273-3944. [Order of the State Public Health Officer: Revision of Mandatory Reporting of Covid-19 Results by Health Care Providers](#)
- For **other reportable diseases and contact information**, see [Reportable Communicable Diseases](#)

Outbreak Control Recommendations

Communication

- In addition to notifying ACPHD and Licensing & Certification about a new outbreak, notify:
 - Infection Preventionist and Director of Nursing
 - Facility Administrator
 - Medical Director
 - Health Services Director
 - HCP and caregivers who work at the facility
 - Primary Care Provider of:
 - Residents who reside on a unit where an outbreak is occurring **or**,
 - Residents who are a close contact of a resident, staff, or visitor who tested positive for COVID-19
- Notify HCP, residents, and families promptly about identification of SARS-CoV-2 infections in the facility and maintain ongoing, frequent communication with HCP, residents, and families with updates on the situation and facility actions.** [CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes and LTCF](#)
- Distribute an outbreak communication letter to all residents and their families.
- Post instructions for visitors, information on COVID-19 signs and symptoms, infection control precautions and other facility practices at entries/exits and other routes. Provide visual alerts instructing residents and staff to report symptoms of COVID-19 to a designated person. Utilize the CDC latest versions of instructional signage throughout the facility. [CDC print resources](#)



Vaccination

- Vaccination against COVID-19 is the most effective means of preventing infection with SARS-CoV2, transmission of the virus, outbreaks, and severe disease outcomes. Facilities are encouraged to provide easy access, education, and outreach to residents, their families, and the staff on the value and importance of being up-to-date with vaccinations.
 - All **workers in SNFs, ICF's, Congregate Living Health Centers, Adult and Senior Care Facilities (all LTCF's)** must have their first dose of either Johnson and Johnson/Janssen or second dose of either Moderna or Pfizer-BioNTech Vaccinations by September 30, 2021 (CDPH) and November 20, 2021 (CDSS).
 - All LTCF workers are required to be vaccinated, including first booster if eligible, by March 1, 2022. [Adult Care Facilities and Direct Care Worker Vaccine Requirement](#)
 - HCP who have completed their primary vaccination series and who provide proof of COVID-19 infection may defer booster administration for up to 90 days from the date of diagnosis or first test.
 - Residents are considered **up-to-date if they have received all recommended COVID-19 vaccines, including any booster dose(s) when eligible.** [QSO-20-38](#)
 - **For assistance with booster vaccinations:**
<https://app.smartsheet.com/b/form/b95aacad6ed24f7cb7a15118659d1514>
 - Workers in acute and skilled nursing facilities who are not up-to-date with vaccinations are required to test for COVID-19 at least twice weekly and workers in other Long Term Care Facilities are required to test for COVID-19 weekly.
 - All Long-Term Care Facilities must maintain records of worker vaccination or exemption status.

- Flu Vaccines:** LTCF's should vaccinate residents with the influenza vaccine at the beginning of every influenza season. Mild illness is not a contraindication to flu vaccinations, and residents may receive vaccination regardless of COVID status.

Treatments

- Effective treatment** for residents with mild to moderate COVID-19 is available and **should be offered** if they meet criteria for treatment based on EUAs. **Older age ≥ 50 is one of the many reasons a person is at higher risk.** For other higher risk conditions:
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-care/underlyingconditions.html>
- During an outbreak, LTCF should assess daily residents who may be eligible for treatment (high risk with symptoms) and ensure providers are notified. Treatments often have a short timeline to initiate **(5 days for oral anti-virals and 7 days for IV treatments)** so it is important to have timely consideration. Facilities should actively engage providers with information on COVID treatment. The following documents can assist with accessing treatment:
 - [Access Treatment - SNF](#)
 - [Access Treatment - other LTCF's](#)
 - [Checklist for Treatment](#)
- [Test-to-Treat-Playbook.pdf \(ca.gov\)](#)
- [Know Your Treatment and Prevention Options for COVID-19](#)
- [NIH COVID-19 Treatment Guidelines](#)



Know Your Treatment and Prevention Options for COVID-19

There are more treatment options available now for COVID-19. While most people do not need treatment, treatments can prevent hospitalization and death for persons who are high risk. **Talk to your healthcare provider** if you are at risk of serious illness and interested in preventive therapy OR if you are at high risk and test positive for COVID-19.

Treatments are not a substitute for vaccination. Vaccination remains the safest, most effective way to protect you from COVID-19. Treatments must be started early, so don't delay testing. Here is information on the available COVID-19 treatments.

	Evusheld	Paxlovid	Remdesivir	Babtelevimab	Molnupiravir
Who can get it?	<ul style="list-style-type: none"> Ages 12+ Persons without COVID-19 infection OR recent exposure; AND who Are immunocompromised, Have received treatment that weakens the immune system, OR Can't get vaccinated due to severe allergic reaction. 	<ul style="list-style-type: none"> Ages 12+ Persons with COVID-19 who are at high risk of serious illness 	<ul style="list-style-type: none"> Adults and children 28 days of age and older and over 3.0 kg (7lbs.) Persons with COVID-19 who are not hospitalized but are at high risk of serious illness 	<ul style="list-style-type: none"> Ages 12+ Persons with COVID-19 who are at high risk of serious illness 	<ul style="list-style-type: none"> Ages 18+ Persons with COVID-19 who are at high risk of serious illness
When do I need to get it?	Before infection to help prevent COVID-19	Within 5 days from start of symptoms	Within 7 days from start of symptoms	Within 7 days from start of symptoms	Within 5 days from start of symptoms
How is it given?	Injection	Pills taken orally for 5 days	Once daily Intravenous Infusion (IV) for 3 days	One-time Intravenous Infusion (IV)	Pills taken orally for 5 days
Where can it be given?	Healthcare Facility/ Infusion Center	Home	Healthcare Facility/ Infusion Center	Healthcare Facility/ Infusion Center	Home

For more information, visit: <https://covid-19.acgov.org/treatment>

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

*Adapted from materials provided by the County of Santa Cruz
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Surveillance of Staff and Residents

- ❑ Measure temperature and **oxygen saturation** and assess for symptoms of suspected COVID-19 every shift among all residents.
 - Residents in the **Red** and **Yellow** zones should be assessed every 4 hours with vital signs including oxygen saturation (e.g., twice a shift). See [Resident Placement, Movement Restrictions & Transferring Residents](#)
 - For residents with confirmed or suspected COVID-19, check for subtle changes in mental status, somnolence, hydration status, and respiratory rate. A change in baseline temperature (up or down) and/or a drop in oxygen saturation should trigger a more thorough assessment. Residents over 60 may present with atypical signs and symptoms such as loss of appetite, confusion, weakness & falls.
 - Older adults with SARS-CoV-2 infection may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, more than two temperatures >99.0°F might also be a sign of fever in this population.
 - Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection. [CDC Evaluating and Managing Personnel and Residents.](#)
- ❑ Maintain Standard precautions while performing all surveillance activities. See CDC guidance [COVID-19 Personal Protective Equipment \(PPE\) | NIOSH | CDC](#)
- ❑ Institute symptom monitoring and temperature checks of all staff at the facility entrance or within main reception area. See [COVID-19 Screening Guidance for Businesses and Organizations](#) & [COVID-19 Self-Assessment Screening Guidance for Personnel](#)
 - Exclude from entrance any staff presenting with the following symptoms: new or worsening cough, shortness of breath or difficulty breathing, fever (measured or subjective), chills, rigors,



myalgias, headache, sore throat, new or worsening congestion & runny nose, new olfactory and taste disorder(s), nausea, vomiting or diarrhea.

- See “Managing Ill Staff & Exposure” section for details on handling ill staff.

Monitor and report staff absenteeism due to any suspected COVID-19 symptoms.

Testing

Develop and implement plans to conduct testing at your facility. [Testing Guidelines for Nursing Homes \(CDC\)](#)

Consider implementing Antigen testing for fast results in order to Isolate and Quarantine effectively **and evaluate for timely COVID-19 treatments**

See guidelines and resources for Antigen Testing:

- [California COVID-19 Testing Task Force](#)
- [CDSS PIN 21-16 Guidance on the Use of Antigen Tests](#)
- [CDSS PIN 22-10 Use of At-Home, Over-the-Counter \(OTC\) COVID-19 Antigen Testing Kits](#)
- [CDSS PIN 21-11 Options for Accessing Testing](#)
- **Please email CalREDIEHelp@cdph.ca.gov for assistance with reporting Antigen Test results.**

Test for additional respiratory viruses when the symptoms, or existing surveillance in the facility warrants, for example, influenza A and B during flu season, and RSV. **Consider testing for MDRO's such as Carbapenem Resistant Organism (CRO)**

Follow infection control precautions when collecting nasopharyngeal (NP) and other swabs:

- Patient should be in a single room with door closed.
- Minimum number of staff should be in room.
- Perform hand hygiene immediately before donning and immediately after doffing. [COVID-19 Personal Protective Equipment \(PPE\) | NIOSH | CDC](#)
- Wear N-95 respirator (or equivalent), eye protection (face shield or goggles), disposable gown and gloves.
- For further guidance on proper specimen collection, see CDC guidelines for methods of specimen collection.
 - [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 \(COVID-19\)](#)
- Please check with your testing laboratory to confirm the most appropriate specimen, transport medium, etc. for collection.

Screening and Diagnostic Testing

For Information re: Screening and Diagnostic Testing (performed when not in Outbreak Response)

Please see [AFL 21-28](#) [AFL 22-13](#) [PIN 22-16](#) [CMS QSO 20-38-revised](#)



Facility Wide Response Testing

- ❑ As soon as possible after one (or more) COVID-19 positive individuals (resident or facility staff) is identified in a facility, perform serial retesting at least weekly with molecular testing or a minimum of twice weekly with antigen testing of all residents (excluding independent retirement community residents (CCRC) unless they have been in communal settings with other residents) and facility staff, regardless of vaccination status. Serial retesting should continue to be performed until no new cases are identified in sequential rounds of testing covering a **14-day** period. The facility may then resume their regular screening testing schedule as outlined above.

[AFL 22-13](#) [PIN 22-16](#)

Using Antigen Testing for Response Testing

Antigen tests provide timely results for purposes of immediately cohorting residents, providing treatment and isolating staff. It is the preferred testing method.

- ❑ If using a **rapid antigen** test for **Facility Wide Response testing** of residents and staff, **test twice a week** and refer to [Considerations for Interpreting Antigen Test Results in Nursing Homes \(cdc.gov\)](#)
- ❑ **Asymptomatic people who test antigen positive** may not need confirmatory testing if they have high pre-test probability (e.g., person resided in a facility with a large outbreak) and the individual should be treated as infected. https://www.hsaq.com/globalassets/covid-19/cdph_faqsipwebinars.pdf
- ❑ **Symptomatic individuals who test negative** should be isolated and receive a PCR **test and consider repeating Ag Test the following day if PCR result is still pending.**
- ❑ [SARS-CoV-2 Antigen Testing in Long Term Care Facilities | CDC](#)
- ❑ [Testing for SARS-CoV-2/COVID-19](#)
- ❑ CDSS [PIN 21-16 Guidance on the use of Antigen Tests and Reporting Requirements](#)
- ❑ [CDSS PIN 22-10 USE OF AT-HOME, OVER-THE-COUNTER \(OTC\) CORONAVIRUS](#)

Antigen Testing Reporting Requirements:

- ❑ All **positive** SARS-CoV-2 antigen and PCR tests must be reported by Electronic Laboratory Reporting (ELR). [Testing Strategies for SARS-CoV-2 | CDC 5-5-2022](#)
- ❑ **Please email CalREDIEHelp@cdph.ca.gov for assistance with reporting Antigen Test results.**

- ❑ **Response testing should continue until no new cases are identified over 14 days of testing every 3-7 days.**
 - Once a resident or HCP tests positive, no additional testing is needed for that individual for 90 days if they remain asymptomatic.
 - If staff test positive, identify contacts during the infectious period (two days before symptom onset or two days before positive test result if no symptoms) to determine exposure to residents.
- ❑ Residents or HCP with signs or symptoms potentially consistent with COVID-19 should be isolated and tested immediately to identify current infection, **regardless of their vaccination status.** Do not delay testing of symptomatic individuals until scheduled diagnostic screening or response-driven testing.
While awaiting test results, move only if the resident can go into a private room.
 - For residents or HCP who develop new symptoms consistent with COVID-19 during the three months after the date of initial symptom onset, if an alternative etiology cannot be identified, then



retesting can be considered in consultation with the medical director, infectious disease, or infection control experts.

- Results should be used to immediately implement cohorting of residents and HCP who provide direct patient care. Refer to your mitigation plan strategies for testing and cohorting.
- Staff should ideally be included in the overall facility testing. As an alternative, they can be tested by their health care provider or at [community testing sites](#).
- All testing must be ordered by a clinician who will be responsible for informing the patient and arranging for appropriate clinical follow-up or testing should comply with [Alameda County Health Officer Order No. 20-19](#)

ACPHD helps coordinate testing but has limited ability to support testing in facilities; If there are support needs for testing, contact your assigned PHN or LTCFoubreak@acgov.org. Do not send specimens directly to the Alameda County Public Health Laboratory without approval.

HCP Testing Recommendations in SNFs and other LTCF

Vaccination Status	Routine Diagnostic Screening	Response Testing	Testing following a High-Risk Exposure	Symptomatic Testing	Testing for Return to Work for Positive HCP
Fully vaccinated and boosted	Not required but strongly recommended	Yes	Yes	Yes	Yes, if returning at day 5 after symptom onset or positive test
Fully vaccinated and booster eligible but not yet boosted	Yes, twice weekly in SNFs and once per week in other LTCFs	Yes	Yes	Yes	Yes, if returning at 7 days after symptom onset or positive test
Unvaccinated or incompletely vaccinated with exemption	Yes, twice weekly in SNFs and once per week in other LTCFs	Yes	Yes	Yes	Yes, if returning at 7 days after symptom onset or positive test
Recovered from COVID within 90 Days	No	No	Consider, antigen test preferred	Yes, with new symptom onset	Yes, if reinfected and returning at 5-7 days after symptoms onset



Using the Contact Tracing for Response Testing Approach

- There are two response testing approaches to consider for preventing further spread in a facility, contact tracing or facility wide testing (as above). Contact tracing can be considered if:
 1. If greater than 90 % for residents up-to-date with vaccinations and greater than 90% **HCP** are boosted or have completed their primary series but are not yet booster eligible (**if no, proceed to facility wide response testing**)
 2. Also consider:
 - a. Is community transmission high?
 - b. Is the case a resident or staff? (resident case may be an indicator of facility spread)
 - c. Is there shared air space? (communal dining, break rooms, activity rooms, therapy rooms)
 - d. What is the size of the facility and census? (may be more difficult to contact trace if near capacity)
 3. Perform contact tracing:
 - a. Is there a clear link to exposure outside of the facility (i.e family, friends)?
 - b. Is there exposure within the facility? If yes, where and when was the exposure? Who was exposed?
 - c. Identify contacts during the infectious period (two days before symptom onset or two days before positive test result if no symptoms) to determine exposure.
 - d. Can all potential contacts be identified?
 - e. Do facility staff that tested positive have resident contact or have contact with other facility staff who provide care or have contact with residents?
- After reviewing above, consult with assigned Nurse Investigator or contact ltcfoutbreak@acgov.org **before proceeding with Contact Tracing for Response Testing**
 - All exposed residents and HCP, regardless of vaccination status, should be tested promptly (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure
 - **Quarantine Guidance for Exposed Residents identified During Contact Tracing:**
 - Residents who are not up-to-date with vaccination need to quarantine for at least 7 days, even if they test negative.
 - **Residents who are up-to-date do not need to quarantine but should wear source control.**

[CMS QSO 20-38-revised](#) [PIN 22-16](#) [AFL 22-13](#)
- If testing of close contacts reveals additional facility staff or residents with COVID-19 infection, contact tracing should be continued to identify residents with close contact or facility staff with higher-risk exposures to the newly identified individual(s) with COVID-19 infection
- A facility-wide or group-level** (e.g., unit, floor, or other specific area(s) of the facility) approach should be performed if all potential contacts cannot be identified or managed with contact tracing or **if contact tracing fails to halt transmission**



Resident Placement, Movement Restrictions & Transferring Residents

Plan for and create three distinct cohort areas to be ready as soon as you have a positive case. These could be a separate wing, unit, or rooms at the end of the hallway.

Red Zone: (designated area)

- COVID-19 positive for duration of Isolation period, regardless of their vaccination status
- Should have dedicated HCP who do not provide care for residents in other cohorts and should have separate break rooms, nurses' stations, and restrooms if possible.

Yellow Zone - COVID-19 unknown status*

Yellow Zone Quarantine:

- 7 days and until day 5-7 tests results are available before releasing into the Green Zone. Without testing, they should be quarantined for 10 days.
- **During facility-wide response testing, all SNF residents on the unit or wing where a case was identified in a resident or HCP are considered exposed and should remain in their current rooms unless sufficient private rooms are available. Every time there is a new case diagnosed in a resident, the exposed residents need to be quarantined for at least 14 days, regardless of vaccination status**. [AFL-22-13](#)**

Observation: (designated area)

- New admissions that are not up-to-date with vaccinations.
- **SNF (Skilled Nursing Facility) Residents** who have prolonged close contact with someone with SARS-CoV-2 infection while outside the facility should be tested immediately, at 5–7 days after exposure and again prior to return to their usual room in green-unexposed/recovered area, regardless of their vaccination status.
[AFL 22-07](#)
- **SNF residents** that are not up-to-date with vaccinations and leave the facility for > 24 hours tested prior to return to their usual room in green unexposed/recovered area.

Exposed: (avoid movement)

- Residents recently returned from a hospital with a known outbreak regardless of vaccination, single room if possible.
- Residents who are symptomatic, single room if possible.
- **SNF residents** who have been in an area staffed by a person who is COVID-19 positive regardless of vaccination status** [AFL 22-13](#) [AFL 22-07](#)
- Exposed **SNF residents** regardless of vaccination status** [CDPH Skilled Nursing Facilities Infection Prevention Call FAQs](#)
- **CDSS Licensed facilities: Residents** who are not up-to-date with vaccinations and have a known exposure. Consider quarantine for exposed residents regardless of vaccination status if there is widespread outbreak or resident is moderately or severely immunocompromised. [PIN 22-15](#)
- Residents who refuse response driven testing should be quarantined until no further response



driven testing is required.

- When transferring out of the **Yellow Zone**, residents should remain on [Enhanced Standard Precautions](#) if they have another indication (for example, colonized with multidrug resistant organism [MDRO], have an active *C. difficile* infection, etc.).

*Residents with known exposures, residents returning from a hospital with a known outbreak, suspected or probable cases pending lab results should not be placed in the same room as a newly admitted unvaccinated resident with unknown status. Avoid movement of residents that could lead to new exposures, for example, moving a resident into a room where one of the new roommates is subsequently found to have unidentified asymptomatic infection.

**If using facility wide response testing

Green Zone:

- COVID-19 negative without known exposure in the last 14 days
- COVID-19 recovered
- New admissions and readmissions who have recovered from SARS-CoV-2 infection in the prior 90 days and have **not** had high-risk contact
- New admissions that are up-to-date with vaccination do not need to be quarantined.
- Resident with no known exposure

- Exposed residents who have recovered from COVID-19 in the previous 90 days and are asymptomatic should wear source control for 10 days but do not need to be quarantined, restricted to their rooms, or cared for by HCP using full COVID-19 PPE. In general, testing is not necessary unless they develop symptoms; however, if testing is performed, an antigen test is recommended. Consider quarantine for residents who are moderately to severely immunocompromised.

- [CDPH Skilled Nursing Facilities Infection Prevention Call FAQs AFL-22-13](#)

- DO NOT MOVE probable or suspected-cases from their rooms within the **Green** or **Yellow Zones** unless they are COVID-19 (+). While awaiting test results, move only if the resident can go to a private room; otherwise, leave in current room with as much space as possible between beds and curtains drawn. Do not move to Observation area. Call your assigned ACPHD outbreak nurse for additional instructions on moving patients between zones.

- Instruct staff on the importance of using separate equipment, cleaning, and disinfecting the equipment between residents, and fully changing PPE whenever going from one resident to the next to provide care.

- Facilities should consider, in consultation with their assigned nurse investigator, implementing limitations on communal activities and dining based on the status of COVID-19 infections in the facility, e.g., when one or more cases has been identified in facility staff or residents.

[AFL 22-07](#)

- Regardless of vaccination status, residents in **Yellow** and **Red Zones** should stay in their rooms **with doors closed if possible**, should not participate in communal dining, nor group activities, nor access shared facility amenities, equipment, or non-essential services (e.g., salon and barber services) until they meet the conditions to discontinue isolation or quarantine.

- All Residents who must leave their room should perform hand hygiene, wear a face mask before leaving the room and maintain social distancing.

- Before transferring ANY resident outside of the facility, such as to outpatient appointments, dialysis



centers, acute care hospitals, and other facilities, you **must** use the [Alameda County Infection Control Transfer Form](#) to communicate to transport personnel and other HCP accepting the resident that your facility is experiencing a suspected or confirmed COVID-19 outbreak. If the resident is a probable or confirmed COVID-19 case, you must also include symptoms, signs, date of illness onset, laboratory test results, and infection control precautions.

- [CDC Evaluating and Managing Personnel and Residents AFL-22-13](#)

Ventilation

- In **Red** and **Yellow Zones**, review and address ventilation to ensure air flow is adequate. Observe ceiling vents, the use and position of fans, and if air can travel from **Red Zones** and/or **Yellow Zones** to other areas of the facility.
 - A portable air cleaner with a HEPA filter should be placed in their rooms.
 - A room window should be open with a small fan turned around and pulling the air from the rooms to the outside if possible.
 - Bathroom fans should always remain on.
 - Ceiling fans in **Red** and **Yellow Zone** rooms should be turned off and portable fans circulating “dirty air” should not be used.
- If there are two ceiling vents in the **Red** and **Yellow Zone** rooms, one vent is likely pushing air into the room and the other is pulling air out of the room and potentially recirculating the “dirty” and potentially contaminated air to other resident rooms. If this is the case, completely cover the vent pulling “dirty” air out of the **Red** and **Yellow Zone** rooms when they are occupied with positive or PUI residents.
- Consider placing** portable air cleaners in areas with poor air flow such as, poorly ventilated dining rooms, therapy rooms, **activity rooms** and staff breakrooms. Portable air cleaners are designed to take in “dirty air,” filter contaminants, and release fresh air back into the room. HEPA filtration is proven; ozone and “ionizers” are not recommended.
- Resources:
 - [Interim Guidance for Ventilation, Filtration, and Air Quality in Indoor Environments \(ca.gov\)](#)
 - [Ventilation in Buildings | CDC](#)



Transmission-Based Precautions and Other Infection Control Measures

- Follow PPE (Personal Protection Equipment) guidance from your **licensing** agency:
 - [CDSS PIN 22-15 Resident Cohorting, Isolation and Quarantine, Staffing and Use of Personal Protective Equipment \(PPE\)](#)
 - [CDPH COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category](#)
 - Include clear and visible signage for PPE donning and doffing and appropriate infection prevention precautions. [CDC Instructions for putting on and removing PPE](#)

Recommendation	COVID Positive Residents (Red Area)	Symptomatic, Suspected COVID, Awaiting Test Results (Yellow PUI, Single Room if Available) ††	COVID Exposed Residents (Yellow – Exposed) ††	Newly Admitted Residents Under Observation (Yellow – Observation) ††	Residents with No Known Exposure, or COVID Recovered (Green Area)
N95 respirator *	Yes	Yes	Yes	Yes	Yes, during an outbreak.
Facemask *	Only in crisis if N95 not available	Only in crisis if N95 not available	Only in crisis if N95 not available	Only in crisis if N95 not available	Yes
Eye Protection	Yes	Yes	Yes	Yes	Yes, during an outbreak, or per Standard precautions
Gowns	Yes	Yes	Yes	Yes	As needed per Enhanced Standard precautions
Gloves with hand hygiene before donning and after doffing gloves	Yes, upon room entry and between residents (if multi-occupancy room)	Yes, upon room entry and between residents (if multi-occupancy room)	Yes, upon room entry and between residents (if multi-occupancy room)	Yes, upon room entry and between residents (if multi-occupancy room)	As needed per Enhanced Standard precautions

Sourced from [AFL 20-74](#)

- Residents who leave their rooms should always cover their nose and mouth with a well-fitted mask (surgical mask recommended) and physically distance while in the facility.
 - If surgical masks are not available, a clean and dry cloth mask with two or more layers of washable, breathable fabric shall suffice.
- Use a fit-tested N-95 respirator or equivalent when performing Aerosol Generating Procedures. **Healthcare workers should also wear appropriate PPE, including gloves, a gown and eye protection.**
- [Clinical Questions about COVID-19: Questions and Answers | CDC 6-8-2022 under Infection Control Questions](#)
- HCP should perform hand hygiene before and after donning and doffing personal protective equipment (PPE). PPE should be discarded after every contact with every resident.
- Eye protection should be worn when providing direct care to residents in **all areas** during Outbreak Response and ensure appropriate cleaning and disinfection after each use if reusable face shields or goggles are used. [CDC Eye Protection Strategies](#)
- Identify dedicated HCP to care for residents with COVID-19 and ensure they are fit-tested for an N-95 respirator. Fit-testing of N-95 respirators must be performed at least annually or when there is a change in type of mask used. Ask the nurse assigned to your facility about fit testing options. [Cal/OSHA enforces CCR, Title 8, Section 5144](#) which includes a requirement for an employer to develop and implement a written respiratory protection program with required worksite-specific procedures and elements for required respirator use, including, but not limited to, respirator Fit Testing. [PIN-21-10 Alameda County Respiratory Resource](#)



- Source Control** protects others and is the use of well-fitting cloth masks, facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. When N95's are used as source control (i.e., not used as Personal Protection Equipment (PPE), in the yellow or red zone) they can be used for the entire shift. A seal check should be performed. The mask should be discarded whenever damaged or soiled and whenever it's removed (i.e. lunch break).
- [How do I test the seal on my N95 - CDC Project First Line video](#)
- N95's for HCP that are unvaccinated, exempt or booster-eligible who have not yet received their booster:
 - LTCFs are required to offer their unvaccinated staff an N95 mask and encourage them to be used for source control.
 - Unvaccinated are not required to wear a N95 mask but must always wear a surgical mask inside the LTCF[AFL 21-28](#) [CDSS PIN 21-32.1](#) [CDSS PIN 21-38](#)
- Educate HCP on hand hygiene, respiratory hygiene, cough etiquette, and document training activities. (Consider use of Glo Germ^R for training of hand hygiene. <https://www.glogerm.com/>)
- Ensure all HCP are familiar with Standard, Droplet, and Contact precautions, as well as eye and respiratory protection, and document training activities.
- Verify all HCP can demonstrate competency in proper PPE donning and doffing procedures, and document competency assessments. [CDC Donning](#) and [Doffing PPE](#) [CDC Instructions for putting on and removing PPE](#)
- Conduct ongoing monitoring of compliance with hand hygiene and PPE procedures and provide on-the-spot correction as needed.** [HAI Training and Resources](#)
- Ensure an adequate supply of test kits, facemasks, N-95 respirators (in size and model for fit-tested staff), face shields/goggles, gowns, and gloves. Place supplies in all areas where patient care is provided. **Ensure 2-week supply of PPE at minimum, preferable 30-day supply.** [CDC Burn Rate Calculator](#) is a spreadsheet-based model that will help healthcare facilities plan and optimize the use of PPE for response to COVID-19.
- Ensure an adequate supply of **alcohol-based hand rub** (at least 60% ethanol or 70% isopropanol) and that it is easily accessible both **inside and outside every patient room, common areas and break rooms**. Ensure that hand-washing stations are easily accessible and equipped with soap and paper towels.
- Cohort HCP caring for residents with COVID-19. Do not allow these staff to interact with other residents or the staff who care for residents without COVID-19. Cohorted HCP staff should not take breaks with other staff. Provide separate locker rooms, bathrooms and/or break areas if possible; otherwise, consider staggering the use of these areas and clean and disinfect thoroughly after each use.
- Ensure all HCP practice source control measures and social distancing in the break room and other common areas** (i.e., HCP wear a facemask and sit more than 6 feet apart while on break).
- Whenever possible, bundle care & treatment activities to minimize entries into resident room (e.g., having clinical staff clean and disinfect high-touch surfaces when in the room), and minimize the overall number of HCP assigned to the COVID-19 positive cohort.
- Use single-use equipment for residents with COVID-19 infection whenever possible; otherwise, dedicate reusable medical equipment to residents with COVID-19 infection (e.g., thermometers, stethoscopes, Hoyer lifts, medication carts, wheelchairs) and clean/disinfect between each use.



Discontinuation of Transmission-Based Precautions for COVID-19 Recovered Residents (Transferring Out of **Red** Zone)

- Discontinuation of transmission-based precautions should be determined by using a time and symptom-based strategy for patients with lab-confirmed or suspected COVID-19 as follows:
 1. For residents who have never been symptomatic, transmission-based precautions may be discontinued 10 days from date of COVID-19 (+) test.
 2. For residents who were symptomatic and **NOT** severely immunocompromised, discontinue Transmission-based precautions after at least 24 hours have passed since last fever (without fever-reducing medications), **and** improvement in symptoms (e.g., cough, shortness of breath); **and** at least 10 days have passed since symptoms first appeared.
 3. For residents with severe or **critical illness**, transmission-based precautions may be discontinued after at least 24 hours have passed since last fever (without fever-reducing medications), **and** improvement in symptoms (e.g., cough, shortness of breath); **and at least 10 days and up to 20 days** since symptoms first appeared. [CDC Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure](#).
 4. Persons who are **moderately or severely immunocompromised** may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. Consultation with infectious diseases specialists is recommended. Use of a test-based strategy for determining when Transmission-Based Precautions may be discontinued could be considered in these rare situations.
- The **moderately or severely immunocompromised** category includes patients under cancer treatment, bone marrow or organ transplant recipients, immune deficiencies, poorly controlled HIV or AIDS, on immunosuppressant medications such as prolonged use of corticosteroids and other immune weakening medications, and patients who were critically ill with COVID-19 (intubated and/or in ICU). [People with Certain Medical Conditions | CDC](#)

Note: After recovering from COVID-19, a resident may have a residual cough, which can last days or weeks after any virus. Residents with a cough should wear a face mask when outside their room until resolution of cough and physically distance if in communal settings.

Environmental Cleaning

- Clean and disinfect high-touch surfaces and shared resident care equipment with EPA-registered, healthcare-grade disinfectants. See the EPA Pesticide Registration List: N: Disinfectants for Use Against SARS-CoV-2 for products with label claims against COVID-19. <https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>. When dealing with *Candida Auris*, *C. difficile* and other resistant organisms refer to other EPA list disinfectants (verify that these are effective against SARS-CoV-2 as well).
- Increase frequency of environmental cleaning to at least twice per shift and whenever surfaces or equipment are soiled or contaminated with body fluids or respiratory secretions. Greater frequency of cleaning will also be needed for any areas where someone must take off their mask to eat or drink.
- Perform **Terminal Cleaning** when an infected patient (COVID, other infectious agent and/or MDRO) is moved out of one room to another or discharged from the facility.
- [Environmental Cleaning Procedures | Environmental Cleaning in RLS | HAI | CDC](#)



- Educate Environmental Services staff on proper hand hygiene, PPE donning & doffing procedures & appropriate cleaning and disinfectant contact times. Document training.
- Consider placing EPA-registered disinfectant wipes on or next to frequently used equipment so they are easily accessible for all staff to use.

Managing Staff Illness & Exposure

- Long Term Care Facilities should use the CDC Risk Assessment Framework to determine exposure risk for HCP with potential exposure to patients, residents, visitors, or other HCPs with COVID-19. [AFL 21-08 CDC's updated risk assessment framework PIN 22-09](#)
- ACPHD guidance should be applied to HCP with community 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) <https://covid-19.acgov.org/isolation-quarantine>
- Instruct HCP who develop any symptoms suspicious for COVID-19 while at work to immediately stop work, alert their supervisor, leave the facility, and self-isolate at home. These HCP should be tested immediately for COVID-19, if possible, regardless of vaccination status.
- Instruct HCP who develop symptoms for COVID-19 before work to stay home and report these to their supervisor. Advise HCP to see their Primary Care Physician to determine if symptoms are due to COVID-19 or another diagnosis before returning to work.
- Instructions for HCP who test positive for COVID-19:**
 - HCP who test positive and are **symptomatic (regardless of their vaccination status)** should be excluded from work for 10 days from the date of their symptom onset **and advised to consult with their primary care provider regarding COVID treatments.**

Work Restrictions for asymptomatic HCP with SARS-CoV-2 **INFECTION**

Vaccination Status	Routine work restriction	Critical staffing shortage
Up-to-Date	5 days* with negative diagnostic test [†] same day or within 24 hours of return-to-work OR 10 days without a viral test	<5 days with most recent diagnostic test [†] result to prioritize staff placement [‡]
Unvaccinated or not Up-to-Date	7 days* with negative diagnostic test [†] same day or within 24 hours of return-to-work OR 10 days without a viral test	5 days with most recent diagnostic test [†] result to prioritize staff placement [‡]

Work Restrictions for asymptomatic HCP with **EXPOSURE** to SARS-CoV-2

Vaccination status	Routine work restriction	Critical staffing shortage
Up-to-date	No work restrictions with negative diagnostic test [†] upon identification, and at 5-7 days	No work restriction with diagnostic test [†] upon identification and at 5-7 days
Unvaccinated or not Up-to-Date	7 days with negative diagnostic test [†] upon identification AND negative diagnostic test within 48 hours prior to return to work	No work restriction with diagnostic test [†] upon identification and at 5-7 days



*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.

† 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 48 hours of return.

‡ If most recent test is positive, then HCP should 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 patient COVID status is unknown) or where 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.
- CP whose most recent test is positive and are working before meeting routine return-to-work criteria must maintain separation from other HCPs as much as possible (for example, use a separate breakroom and bathroom) and wear a N95 for source control at all times while in the facility.
- Similarly, exposed and not up-to-date HCP who are working during their quarantine period should also wear a N95 for source control at all times while in the facility until they meet routine return-to-work criteria.
- These HCP are restricted from contact with severely immunocompromised patients.
- Healthcare facilities should make N95 respirators available to any HCP

[ACPHD HOO 20-05g Quarantine](#) [ACPHD HOO 20-06t Isolation](#) [AFL 21-08](#) [PIN 22-09](#)
<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

Please provide Isolation and Quarantine information to staff who test COVID-19 positive or are quarantined. See ACPHD Isolation and Quarantine Guidance (available in multiple languages)
<https://covid-19.acgov.org/isolation-quarantine>

Work restrictions for fully vaccinated and up-to-date HCP populations with higher-risk exposures should still be considered for HCP who have underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact level of protection provided by the COVID-19 vaccine.

Do **NOT** require a negative test or doctor's note for return to work.

Plan for worker absences. Do not require a healthcare provider's note for employees who are sick to validate their illness.

Facilities must avoid as much as possible using employees who have worked at another Licensed Facility or Other Agency in the past 14 days, while maintaining adequate staffing needs of the facility. If this is unavoidable, then consider the following:

- Ask HCP who arrive directly from another facility to change scrubs or uniform prior to entering your facility.
- Maintain consistency of assignments as much as possible (same registry staff caring for the same residents in the same cohort unit).
- Instruct HCP who work at multiple facilities to notify all other employers that they are working at a facility that is currently experiencing an outbreak.
- Encourage HCP tested routinely at another facility to share these results with all other employers or to participate in routine surveillance testing at this facility.

Facilities shall keep a daily log of employees present, identifying any other facilities they have worked at in the previous 14 days. That log shall be made available to local health department if requested.

Travel Guidance: [CDC Travel](#)



Facility Admissions and Re-admissions

Covid-19 Positive Admissions and Re-admissions:

- Facilities must develop plans for managing new admissions and providing care for residents with COVID-19 who require transmission-based precautions in a **Red Zone**, while still maintaining the capacity to provide care safely for other residents. A negative test result is not required for admission.
- Hospitalized patients with COVID-19 should be discharged when they no longer require the level of care provided in an acute care setting. Hospital discharge and admission or re-admission to a facility should not be delayed or prevented due to the COVID-19 status of the patient. Facilities should be prepared to accept and care for COVID-19 (+) patients and provide care safely.

For new or returning residents who were hospitalized for COVID-19 and are clinically ready for discharge from the hospital, implement transmission-based precautions and place resident in a single room in the **Red Zone** until they qualify for discontinuation of precautions. If a single room is not available, residents with laboratory-confirmed COVID-19 may be cohorted in the same room.

Consider these questions when deciding about new admissions, with the priority of preventing and mitigating spread of COVID-19*.

1. Is the facility able to conduct initial testing of residents, and cohort based on test results, optimally with second round (additional testing) of residents at days 3-7?
2. Can the facility isolate, and quarantine residents as described in these recommendations?
3. Are all staff trained on the use of infection prevention measures (hand hygiene, PPE use, cleaning/disinfecting) and can staff maintain hand hygiene (handwashing), proper use of PPE and cleaning/disinfecting protocols, optimally validated by adherence monitoring?
4. Does the facility have adequate supplies of PPE to meet the needs of current patients and future patients for a minimum of 2 weeks?
5. Does the facility have sufficient staffing to meet the safety requirements of all residents (i.e., designated staff for Red Zone)?

*Note: if unable to follow the applicable testing strategies (i.e., significant delays in lab TAT, no/low supply of rapid test kits), it is difficult to isolate and quarantine appropriately.

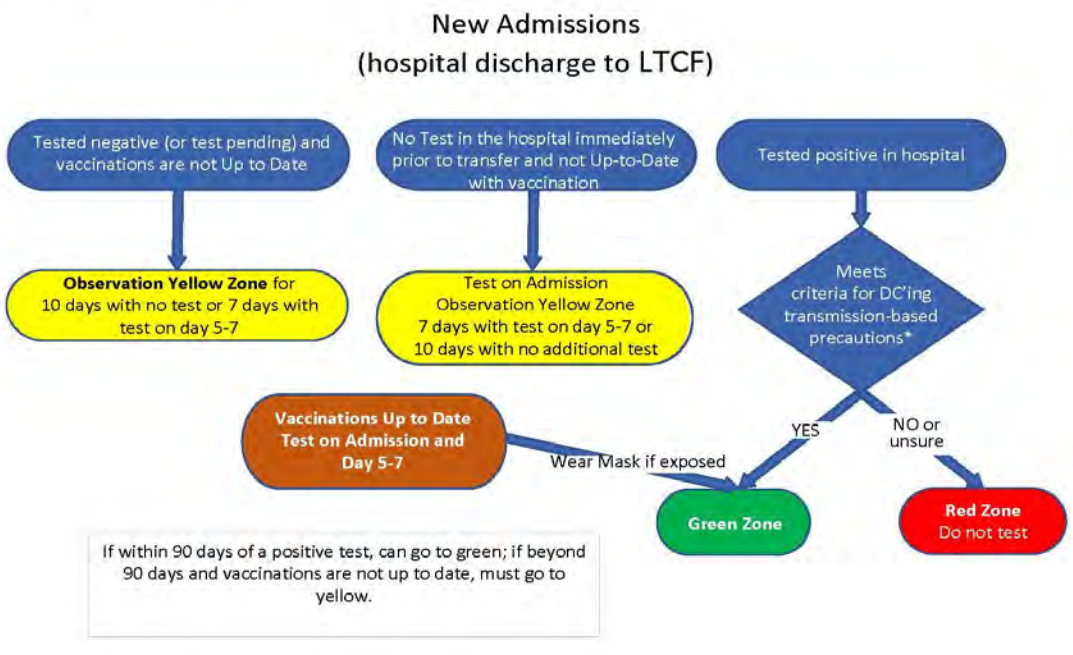
The effectiveness of the infection control measures implemented and the availability of a separate, unaffected building or unit to receive new admissions should be considered.

[AFL 20-87](#)

Please see the schematic below for guidance on admissions from acute care hospitals to skilled nursing facilities:



LTCF Admission Flows



Residents Who **Temporarily Leave** the Facility

Residents taking social excursions outside the facility should be educated about potential risks of public settings, particularly if vaccines are not up-to-date, or they are unvaccinated.

- They should be reminded to avoid crowds and poorly ventilated spaces.
- They should be encouraged and assisted with adherence to all recommended infection prevention and control measures, including masking, physical distancing, and hand hygiene.
- If they are visiting friends or family in their homes, they should follow the masking and physical distancing recommendations for visiting with others in private settings as described [How to Protect Yourself & Others | CDC](#)
- If any resident begins showing **symptoms** of COVID-19 upon their return to the facility regardless of their vaccination status, quarantine in a single room (if available) and test the resident.
- **SNF residents** that are not up-to-date with vaccination and leave the facility for < 24 hours and return to the facility should be tested at 2 days after their return and again 5-7 days after their return.
- Asymptomatic residents **with close contact** with someone with COVID-19, **regardless of vaccination status**, should have a series of two tests for COVID-19. In these situations, testing is recommended not earlier than 2 days after the exposure and, if negative, again 5–7 days after the exposure. [PIN 22-15](#)
- Residents who have left the facility for >24 hours **who were exposed** and are not **Up-to-Date with Vaccination**, should be **quarantined** in single rooms or a separate observation area ("yellow-observation") for at least 7 days from the date of exposure until results are known for testing obtained within 5-7 days after their admission.

[AFL 22-07](#) [PIN 22-15](#)



Managing Family, Visitors, and Volunteers

While it is safer for visitors not to enter the facility during an outbreak investigation, visitors must still be allowed in the facility. Visitors should be made aware of the potential risk of visiting during an outbreak investigation and adhere to the core principles of infection prevention. If residents or their representative would like to have a visit during an outbreak investigation, they should wear face coverings or masks during visits, regardless of vaccination status, and visits should ideally occur in the resident's room. Facilities may contact their local health authorities for guidance or direction on how to structure their visitation to reduce the risk of COVID-19 transmission during an outbreak investigation.

Any visitor entering the facility, regardless of their vaccination status, must adhere to the following:

- Facilities must: (1) verify visitors are fully vaccinated, or (2) for unvaccinated or incompletely vaccinated visitors, verify documentation of a negative SARS-CoV-2 test**
- LTCF's must verify visitors are fully vaccinated **or** have provided evidence of a negative SARS-CoV-2 test within one day of visitation for antigen tests, and within two days of visitation for PCR tests for indoor visitation. Visitors that are unvaccinated or incompletely vaccinated or are unable to show a negative SARS-CoV-2 test may only have an outdoor visit.

[AFL 22-07](#) [QSO-20-39](#) [PIN 22-07](#) [CDPH HOO Requirements for Visitors](#)

- All visitors must be screened for fever and COVID-19 symptoms and/or exposure within the prior 14 days to another person with COVID-19; if a visitor has COVID-19 symptoms or has been in close contact with a confirmed positive case, they must reschedule their visit, regardless of their vaccination status.
- All visitors must wear a well-fitting face mask with good filtration (N95, KF94, KN95, or surgical masks are preferred over cloth face coverings) and perform hand hygiene upon entry and in all common areas in the facility;
- If personal protective equipment (PPE) is required for contact with the resident due to quarantine or COVID-19 positive isolation status (including fully vaccinated visitors), it must be donned and doffed according to instruction by HCP.
- Facilities should limit visitor movement in the facility, regardless of the visitor's vaccination status; for example, visitors should not walk around the hallways of the facility and should go directly to and from the resident's room or designated visitation area.
- For visitors who visit for multiple consecutive days, proof of negative test is only required every third day.
- Unvaccinated or incompletely vaccinated visitors with history of COVID-19 within the prior 90 days may provide documentation of recovery from COVID-19 in lieu of testing.
- Either antigen or PCR testing is acceptable for testing.
- **Visitors who have tested positive for COVID-19 should not be permitted to visit or should be asked to leave if they are still within their isolation period (within 10 days of their positive test).**
- **Visitors who are unable to adhere to these core principles of COVID-19 infection prevention should not be permitted to visit.**

[QSO 20-39](#) [CDSS PIN 22-07](#)



- Visitors who are visiting a resident who is in critical condition, when death may be imminent, are exempt from the vaccination and testing requirements, however, must comply with all infection control and prevention requirements applicable for indoor visits.
- Safe, outdoor visitation may continue during an outbreak regardless visitor vaccination status. Outdoor visitation is preferred because it poses a lower risk of transmission due to increased space and airflow.
- If a resident is not able to leave their room or otherwise meet with visitors outdoors, the visitation may take place indoors even for visitors who cannot provide vaccine verification or a negative test; however, these visits cannot take place in common areas, or in the resident's room if the roommate is present. The visitor must wear a well-fitted mask with good filtration (N95, KF94, KN95, or surgical masks are preferred over cloth face coverings) and the resident must also wear a well-fitting face mask at all times and physically distance.
- Facilities must have a plan in place for tracking verified visitor vaccination status or documentation of a negative SARS-CoV-2 test.
- Visitors can access a digital copy of their COVID-19 vaccine record at <https://myvaccinerecord.cdph.ca.gov/>

Guidance on Physical Contact:

CDPH: [AFL 22-07](#)

- Outdoor visits between residents and all visitors who are fully vaccinated, must be conducted with face masks and may include physical contact (e.g., hugs, holding hands).
- Indoor visits must be conducted with both the resident and visitor wearing a well-fitting face mask. If both the resident and visitor are fully vaccinated, they do not need to physically distance and can include physical contact (e.g., hugs, holding hands) but must wear a well-fitting face mask while in the resident's room unless eating or drinking.
- Visits for residents who share a room should be conducted in a separate indoor space or with the roommate not present in the room (if possible), regardless of the roommate's vaccination status.
- Unvaccinated residents may also choose to have physical touch based on their preferences and needs, such as with support persons for individuals with disabilities and visitors participating in certain religious practices, including in end-of-life situations. In these situations, unvaccinated residents (or their representative) and their visitors should be advised of the risks of physical contact prior to the visit. Visitors should also physically distance from other residents and staff in the facility.

[QSO-20-39-NH](#)

CDSS: [CDSS PIN 22-07](#)

- Visitors and residents may have close contact (including touch, hugs, assisting with activities of daily living, etc.) while both the visitor and the resident perform hand hygiene before and after contact and are wearing a well fitted face mask with good filtration



Summary Table of Updated Visitation Guidance (03/01/2022)

Visitation Requirements for SNFs and CDSS licensed RCFEs and ARFs as of 03/01/2022

Indoor Visitation is always allowed for all residents regardless of the vaccination status of the resident or the location (green, yellow, red zone) of the resident if:

- The visitor is ***fully vaccinated**, or
- The visitor has a **negative SARS CoV-2 test**, or
- The visitor has had **SARS CoV-2 infection and recovered in the last 90 days**

Adequate documentation is required.

Outdoor Visitation only - For visitors who are unvaccinated, or do not have proof of a negative test (and have not had SARS CoV-2 infection and recovered in the last 90 days)

Note – if a resident is unable to leave their room to meet with visitors outdoors, or the resident is in critical condition, the visitation may take place indoors under strict infection control protocols

PPE requirements for visitors:

- **Visitors and residents always wear a well-fitting mask while visiting together**
- **Visitors must wear other PPE as directed by facility healthcare staff**
- **Visitors must physically distance from others**
- **Vaccinated residents and staff can have close contact if wearing a well fitted mask**

***Fully vaccinated only, they do not have to show evidence of the booster dose.**

Exemptions for Healthcare workers including Volunteers and Nursing Students:

- **Healthcare workers:** Facilities should follow [CDC guidelines](#) for limiting access to the facility to healthcare workers. Healthcare workers, including those from the local public health offices, should be permitted to come into the facility if they meet the CDC Guidelines for Healthcare Workers. Healthcare workers include employees, consultants, contractors, **volunteers**, and caregivers who provide care and services to residents on behalf of the facility, and **students** in the facility's nurse aide training programs or from affiliated academic institutions.
- **Students:** Students obtaining their clinical experience as part of an approved nurse assistant, vocational nurse, registered nurse, pharmacy, social work or other healthcare training program should be permitted to come into the facility if they meet the CDC Guidelines for Health Care workers. **Students** entering the facility routinely must participate in the facility wide screening testing. [AFL 20-22](#)

Assess Outbreak Control Measures

- If new cases are identified, facility leadership should review practices, obstacles to fully implementing control measures, and additional actions.
- ACPHD LTCF Outbreak surveillance for new cases will continue until two consecutive weeks of response-driven testing reveal no positive test results AND 14 days have elapsed since last report of new confirmed or probable cases. Certain exceptions may apply.

Community Transmission

- CDC's new COVID-19 Community Levels recommendations do not apply in healthcare settings, such as hospitals and nursing homes. Healthcare settings should continue to use community transmission rates and continue to follow CDC's infection prevention and control recommendations for healthcare settings. [Community Transmission Alameda County](#)



Additional Resources:

ACPHD

- [COVID-Influenza-like-Illness \(C-ILI\) Guidance](#)
- [Fit-Testing Resources](#)
- [COVID-19 Long Term Care Facility Webpage](#)
- <https://covid-19.acgov.org/isolation-quarantine>

CDC

- [Nursing Homes and Long-Term Care](#)
- [Infection Prevention Training](#)
- [PPE Burn Rate Calculator](#)
- Duration of Isolation and Precautions for Adults with COVID-19: [Ending Isolation](#)
- Interim Guidance: [Discontinuation of Transmission-Based Precautions](#)
- [Interim Guidance for Managing HCP with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](#)
- [PPE Donning and Doffing Sequence and Signs](#)
- [YouTube-How to Safely Take Off PPE](#)
- [YouTube-How to Safely Put On PPE](#)

CAHF

- [YouTube-Creating Airborne Infection Isolation Rooms \(AIIR\) for Long-Term Care](#) 6-21-21
- [YouTube-Understanding the Effects of Wildfire Smoke in the Long-Term Care setting](#) 6-21-21

CDSS

- [All COVID-19 ASC PINs by Topic](#)
- [PIN 21-32.1 Staff Testing and Masking Guidance](#) 8/11/21
- [PIN 21-23-ASC Quarantine and Isolation Guidance](#) 4/20/2021
- [PIN 21-17.2-ASC Visitation, Communal Dining, Group Activities, Non-essential Services, Outings, New Admissions and Entertainment](#) 5/14/2021
- [PIN-21-49-ASC Updated Guidance on Communal Dining, Group Activities, Entertainment, Non-essential Services and Transportation](#) supersedes in part PIN 21-17.2 11/17/22
- [PIN 22-07-ASC Updated Statewide Visitation Waiver, Testing and Vaccination Verification](#) 2/7/22
- [PIN-22-09-ASC Updated Guidance on Quarantine and Isolation for Facility Staff](#) 2/14/22
- [PIN 22-15-ASC Resident Cohorting, Isolation and Quarantine, Staffing and Use of Personal Protection Equipment](#) Supersedes PIN 21-12 (and 21-17.2, 21-49 and 20-38 in part) 5/13/22
- [PIN 21-16 Guidance on the Use of Antigen Tests](#)
- [PIN 21-30 CDPH Antigen Testing Program for CDSS Facilities](#)

CDPH

- [CDPH Guidance by Topic](#)
- [AFL 20-74 Recommendations PPE, Resident Placement/Movement, and Staffing in SNF's](#)
- [AFL 21-28](#) COVID-19 Testing, Vaccination Verification and PPE for HCP at SNF's
- [AFL 21-34](#) COVID-19 Vaccine Requirement for Healthcare Personnel (HCP)
- [AFL 21-08](#) Guidance on Quarantine and Isolation for Health Care Personnel (HCP) and Return to Work for HCP with COVID-19



- [AFL 22-07](#) Guidance for Limiting the Transmission of COVID-19 in Skilled Nursing Facilities
- [AFL 22-13](#) Coronavirus Disease 2019 (COVID-19) Mitigation Plan Recommendations for Testing of Health Care Personnel (HCP) and Residents at Skilled Nursing Facilities (SNF)
- [CDPH Skilled Nursing Facilities Infection Prevention Call FAQs](#)
- [Requirements for Visiting Nursing Homes - Flyer](#)
- [Antigen POC Test Reporting](#)
- [Recommendations for the Prevention and Control of Influenza](#)

California Health Officer Orders

- California State Public Health Officer Order 12/31/21, updated 2/27/22 [Requirements for Visitors in Acute Health Care and Long-Term Care Settings](#)
- California State Public Health Officer Order 2/22/22 [Health Care Worker Vaccine Requirement](#)

CalREDIE

- Please email CalREDIEHelp@cdph.ca.gov for assistance with reporting Antigen Test results.