Alameda County Health Care Services Agency
Public Health Department
www.acphd.org

Colleen Chawla, Director
Kimi Watkins-Tartt, Director
Nicholas Moss, MD, Health Officer

Public Health Department: Main Line (510) 267-8000
COVID-19 Information: (510) 268-2101
COVID-19 Vaccine Appointments: (510) 268-4829

Long Term Care Facility COVID-19 Outbreak Control Recommendations

Updated 2/23/2023

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 2/23/2023 in red.

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Definitions for Skilled Nursing or Residential Care Facilities

Confirmed COVID-19 Outbreak LTCF:

- ≥1 facility-acquired[1] COVID-19 case in a resident.
- ≥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

Other Reportable Events:

- ≥1 probable[2] 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 (loss of taste or smell) 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 among HCP: having the potential to share the same indoor space for 15 minutes or longer while working in the facility during the 14 days prior to the onset of symptoms or positive test (for example, worked on the same unit during the same shift). AFL 23-09 Order of the State Public Health Officer Beyond Blueprint (ca.gov)

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.

Boosted: A person is considered "boosted" if they have received one or more booster doses of any of the available boosters.

Up-to-date: 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

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; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. These HCP may include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the health care facility, and persons (e.g., clerical, dietary, environmental services, laundry, security, maintenance, engineering and facilities management, administrative, billing, and volunteer personnel) not directly involved in patient care but potentially exposed to infectious agents that can be transmitted among from HCP and patients. CDC

[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] https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-09.aspx

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

Response Testing: Response testing is serial testing performed following an exposure that has occurred in high-risk residential congregate settings or high-risk/high-density workplaces. The goal of response testing is to identify asymptomatic infections in people in high-risk settings and/or during outbreaks to prevent further spread of COVID-19. CDPH Healthcare & Testing Guidance

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 COVID-19 Line List Template for all **new** cases (residents, healthcare personnel, 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.

❑ 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.

❑ Recent data suggest COVID-19 vaccine effectiveness at preventing infection or severe illness wanes over time, especially for certain groups of people, such as people ages 65 years and older and people who are immunocompromised. This is why staying up-to-date with booster doses is important.

- All LTCF workers are required to complete a primary vaccination series and get at least one booster dose when eligible. Adult Care Facilities and Direct Care Worker Vaccine Requirement AFL 21-34
- Encourage all workers to be up-to-date with vaccinations including additional booster doses when eligible. https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html#adults
- 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
- All Long-Term Care Facilities must maintain records of worker vaccination or exemption status. PIN 22-05.2

❑ Resources:

- Why Residents Should Get the Bivalent Booster (AHCA NCAL)
- Handout: Why Residents Should Get the Bivalent Booster (AHCA NCAL)

❑ **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. Flu vaccines and COVID-19 vaccines can be given at the same time if both vaccines are due.

Treatments

❑ **Effective treatment** for residents with mild to moderate COVID-19 is available and **should be offered**

if they meet clinical criteria for treatment based on EUAs. CDPH HEALTH ADVISORY: Reminder to Lower Barriers to Prescribing COVID-19 Therapeutics

- ❑ 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's should assess residents who may be eligible for treatment (high risk with symptoms) **daily** 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. If you need any assistance with accessing treatment, contact your assigned nurse investigator or LTCFoutbreak@acgov.org.
- ❑ 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)
- ❑ Coronavirus Disease 2019 (COVID-19) Treatment Resources for Skilled Nursing Facilities (SNFs)
- ❑ NIH COVID-19 Treatment Guidelines

Know Your Treatment Options for COVID-19

Treatment must be started early, so don't delay testing.

If you test positive for COVID-19 and have symptoms, talk to your healthcare provider right away about treatment. The table below explains 3 different options for COVID-19 treatment.

Treatments are not a substitute for vaccination. Vaccination remains the safest, most effective way to protect yourself from COVID-19.

	Paxlovid	Molnupiravir	Remdesivir
Who is eligible?	• Ages 12+ • Persons with even mild symptoms who are **not hospitalized** but are at risk for serious illness.	• Ages 18+ • Persons with even mild symptoms who are **not hospitalized** but are at risk for serious illness.	• Adults and children over 28 days of age and over 3 kg (7 lbs.) • Persons with even mild symptoms who are **not hospitalized** but are at risk for serious illness.
When must it be started?	Within **5 days** from start of symptoms	Within **5 days** from start of symptoms	Within **7 days** from start of symptoms
How is it given?	**Pills** taken orally for 5 days	**Pills** taken orally for 5 days	Once daily **Intravenous Infusion (IV)** for 3 days
Where can it be given?	**Home**	**Home**	**Healthcare facility/ infusion center**

For more information, visit:
https://www.fda.gov/consumers/consumer-updates/know-your-treatment-options-covid-19

ALAMEDA COUNTY HEALTH CARE SERVICES AGENCY
PUBLIC HEALTH DEPARTMENT

12/29/22

Surveillance of HCP and Residents

- ❑ Measure temperature and **oxygen saturation** and assess for symptoms of suspected COVID-19 every

shift among all residents.

- **Residents in Isolation 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.

❑ Institute symptom monitoring. See COVID-19 Screening Guidance for Businesses and Organizations & COVID-19 Self-Assessment Screening Guidance for Personnel

- Exclude from entrance any HCP 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.
- Instruct HCP to report symptoms of COVID-19, a positive COVID-19 or Flu test, and close contact with someone with COVID-19 infection to a point of contact designated by the facility.
  - See "Managing HCP Illness & Exposure" section for details on handling ill HCP.

❑ Monitor and investigate HCP 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 **symptomatic** residents or HCP for FLU especially when there is a cluster of symptomatic individuals. Consider additional respiratory viruses, such as RSV. See appendix C

❑ If indicated, consider testing for MDRO's such as Carbapenem Resistant Organisms.
Caring for Patients with CRO in LTCFs Carbapenem-resistant Enterobacterales (CRE) - CDPH

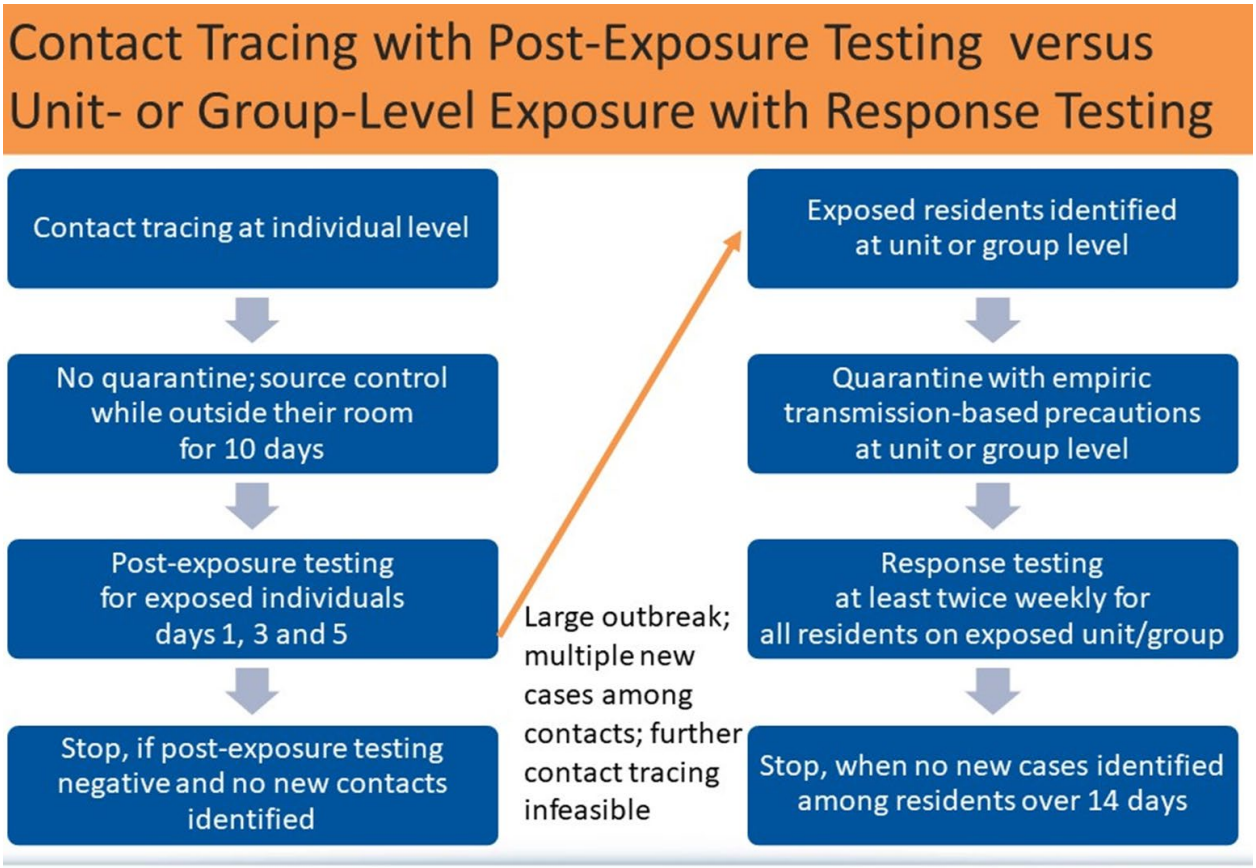
❑ Maintain the ability to ramp up testing by having available supplies or testing vendor in place in the

event of outbreaks or should screening testing be required again at a future date.

- ❑ Follow infection control precautions when collecting nasopharyngeal (NP) and other swabs:
  - Patient should be in a single room with door closed.
  - Minimum number of HCP 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.

Testing: Using Contact Tracing for Response Testing

- ❑ There are two response testing approaches to consider for preventing further spread in a facility, **Contact Tracing** or **Facility Wide or Group Level Testing** (Facility Wide or Group Level Response Testing).



1. **Before using the contact tracing approach, consider:**
   a. Do you have the expertise, resources, and ability to identify all close contacts immediately

(including communal dining, break rooms, activity rooms, therapy rooms)? If not, you should consider testing all Healthcare Personnel (HCP) and residents using the **facility-wide** or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach.

b. Is community transmission high? CDC COVID Data Tracker
c. Is the case a resident or HCP? (resident case may be an indicator of facility spread and inability to identify all potential contacts, consider using **facility wide** testing)
d. What is the size of the facility and census? (may be more difficult to contact trace if 50 beds or more, consider using **facility wide** testing)
e. Does the initial positive case have a clear link to exposure outside of the facility (e.g., family, friends)?
f. Identify all contacts during the infectious period (two days before symptom onset or two days before positive test result if no symptoms) to determine exposure. Can all potential contacts be identified?
g. Does the facility HCP that tested positive have resident contact or have contact with other facility HCP who provide care or have contact with residents?

2. If your facility is unable to do contact tracing based on this criterion, proceed to facility-wide (or unit based) testing.

❑ **Quarantine and Testing Guidance for Exposed Residents identified during Contact Tracing:**

- All residents and HCP who have been identified as close contacts, regardless of vaccination status, should be tested promptly and, if negative, again at 3 days and at 5 days after the exposure. **If unable to test on days 1, 3 and 5, proceed to Facility Wide or Group Level Testing**
- Residents do not need to quarantine but should wear a well-fitted mask or surgical mask (recommended) for 10 days. They should not participate in communal dining.
- Exposed **symptomatic** SNF residents or those **unable to wear masks**, should be placed on transmission-based precautions until the diagnosis of current SARS-CoV-2 infection or other respiratory illness is excluded.
- Asymptomatic residents identified as close contacts through individual contact tracing should not participate in communal dining and generally remain in their current room while undergoing testing as described above but they do not need to be cared for by HCP using the full personal protective equipment (PPE) recommended for the care of a resident with COVID-19.
- Consider quarantine while undergoing testing**.**
- Post-exposure testing is not generally recommended for HCP or residents who have had SARS-CoV-2 infection in the last 30 days if they remain asymptomatic

AFL 22-13 CDC CMS QSO 20-38-revised PIN 22-15.1 CDC

❑ If testing of close contacts reveals additional facility HCP or residents with COVID-19 infection, contact tracing should be continued to identify residents with close contact or facility HCP with higher-risk exposures to the newly identified individual(s) with COVID-19 infection for further testing.

❑ **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.** If the nurse investigator determines that the outbreak has not been controlled effectively with the contact tracing approach, you may be asked to begin facility-wide testing.

Testing: Facility Wide or Group Level Response Testing

- ❑ As soon as possible after one (or more) COVID-19 positive individuals (resident or facility healthcare personnel) 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 healthcare personnel (HCP), regardless of vaccination status. **Serial retesting should continue to be performed until no new cases are identified in sequential rounds of testing every 3-7 days covering a 14-day period.**
  AFL 22-13 PIN 22-16
- ❑ **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 30 days if they remain asymptomatic.
  - If HCP 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 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 31-90 days after the date of initial symptom onset, if an alternative etiology cannot be identified, then retesting using antigen test 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.
  - HCP should ideally be included in the overall facility testing. As an alternative, they can be tested by their healthcare 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

Using Antigen testing for Response Testing

Antigen tests provide timely results for purposes of immediately cohorting residents, providing treatment and isolating healthcare personnel (HCP). It is the preferred testing method.

- ❑ If using a **rapid antigen** test for Facility Wide Response testing of residents and HCP, **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.hsag.com/globalassets/covid-19/cdph_faqsipwebinars.pdf
- ❑ **Symptomatic individuals who test negative** should be isolated and receive a PCR test or repeat the

Ag Test in 48 hours even if symptoms have resolved.

Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic | CDC

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 Order of the State Public Health Officer: Revision of Mandatory Reporting of Covid-19 Results by Health Care Providers
- ❑ **Please email CalREDIEHelp@cdph.ca.gov for assistance with reporting Antigen Test results.**

Resident Placement, Movement Restrictions & Transferring Residents

Plan for and create a distinct Isolation area to be ready as soon as you have a positive case. AFL 23-12

- ❑ **Isolation Area (dedicated area, formerly Red Zone):** COVID-19 Positive
  - COVID-19 positive for duration of Isolation period, regardless of their vaccination status
  - May be a designated floor, unit, wing, or group of rooms at the end of a hallway that is physically separate and includes ventilation measures to prevent transmission to other residents outside of the Isolation Area
  - Dedicated staffing who does not provide care for residents in other areas (HCP are assigned to only care for COVID-19 patients during their shift) may be preferred during a large outbreak
  - Regardless of dedicated staffing, ensure all HCP strictly adhere to:
    - Masking for source control
    - Hand hygiene and changing PPE between residents
- ❑ **Quarantine:** Use transmission-based precautions.
  - **Any resident with symptoms of COVID-19,** single room if possible while awaiting test results. Otherwise, quarantine in place.
  - During facility-wide Response testing, all 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.
  - Consider quarantine for close contacts (exposed) if:
    - Resident is unable to be tested or wear source control as recommended for the 10 days following their exposure
    - Resident is moderately to severely immunocompromised
    - Resident is residing on a unit with others who are moderately to severely immunocompromised
    - Resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions or if there is widespread outbreak (eg positive cases after 2nd round of testing)
    - New admissions with a known exposure in the last 2 weeks

    CDC AFL-22-13 PIN 22-15.1
  - **Discontinuation of Quarantine:**
    - Residents can come out of quarantine on Day 7 if they do not develop symptoms
    - Residents who are not tested can come out of quarantine after Day 10 following the

exposure (Day 0) if they do not develop symptoms.
- When discontinuing quarantine or isolation, residents should remain on Enhanced Standard Precautions if they have another indication (e.g., colonized with multidrug resistant organism or have an active C. difficile infection, etc.)

CDC PIN 22-15.1

- ❑ DO NOT MOVE probable or suspected-cases from their rooms unless they are COVID-19 positive. 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. Call your assigned ACPHD outbreak nurse for additional instructions on moving patients between zones.
- ❑ Instruct healthcare personnel (HCP) 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 HCP or residents. AFL 22-07
- ❑ Regardless of vaccination status, residents in quarantine and **Isolation** 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 the Isolation area/rooms, 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 the Isolation Area 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 Isolation Area should be turned off and portable fans circulating “dirty air” should not be used.
- ❑ If there are two ceiling vents in the Isolation Area 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 Isolation Area 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

Recommendation for Transmission Based Precautions During Outbreak Response	COVID Positive Residents (Isolation Area)	Symptomatic, Suspected COVID, Awaiting Test Results Exposed during facility-wide or group-level response testing.	No known exposure, COVID recovered, exposed asymptomatic
N95 Respirator	Yes	Yes	No (optional)
Facemask	No; N95 respirator required	No; N95 respirator required	Yes, for source control
Eye Protection During direct patient care	Yes	Yes	No, except for aerosol generating procedure
Gowns Maintain clean areas where gowns are not worn, such as a main workstation. Extended use NOT permitted	Yes	Yes	As needed per Enhanced Standard Precautions (e.g., likely exposure to blood and body fluids)
Gloves with hand hygiene before donning and after donning gloves	Yes, upon room entry and between providing care for residents (if more than one resident in a room).	Yes, upon room entry and between providing care for residents (if more than one resident in a room).	Yes, upon room entry and between providing care for residents (if more than one resident in a room).

- ❑ Follow PPE (Personal Protective 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

❑ During Outbreak Response, residents who leave their rooms should 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, gown, and eye protection. https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

❑ 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 during Outbreak Response and ensure appropriate cleaning and disinfection after each use if reusable face shields or goggles are used. CDC Eye Protection Strategies

❑ Ensure HCP that care for residents with COVID-19 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. Cal/OSHA enforces CCR, Title 8, Section 5144 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 Protective Equipment (PPE), 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 (e.g., 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 healthcare personnel (HCP) 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, Enhanced Standard, Droplet, and Contact precautions and enhanced, 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 Instructions for putting on and removing PPE YouTube Donning and Doffing PPE for Staff Wearing an N95 Respirator

❑ **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 HCP), 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.
- ❑ **Ensure all HCP practice source control measures and social distancing in the break room and other common areas** (e.g., 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~~ isolation rooms (e.g., having clinical HCP 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 Isolation)

- ❑ 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

Important! 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. If residents with a cough cannot tolerate or remember to keep on the mask, or physical distancing is not possible, please contact the resident's health care provider or the local health department for direction, including if additional isolation is necessary. PIN 23-02

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 in Resource-Limited Settings
- ❑ 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 healthcare personnel to use.

Managing HCP 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 PIN 22-09 CDC's updated risk assessment framework
- ❑ HCP who has had close contact with someone with SARS-CoV-2 in the **community** (e.g., household contacts) should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. See below for work restrictions.
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html CDPH Guidance on Isolation and 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.

- HCP returning to work between days 5-9 after meeting routine criteria should wear a fit-tested N95 for source control through at least day 10 from symptoms onset or positive test (for HCP who remain asymptomatic throughout their infection).
- 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 restroom and breakroom, take meal breaks outdoors or in a well-ventilated area, away from other HCP or residents when removing their N95)
  - If breakrooms are shared, N95 should not be removed.
  - wear a N95 respirator for source control at all times while in the facility until at least 10 days from symptoms onset or positive test.
- These HCP are restricted from contact with severely immunocompromised patients.

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

Vaccination Status	Routine work restriction	Critical staffing shortage
All HCP, regardless of vaccination status	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‡

*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. Post-exposure testing is not generally recommended for HCP who have had a SARS-CoV2 infection in the last 30 days if they remain asymptomatic.

‡ **If most recent test is positive, then HCP should provide direct care only for patients/residents with confirmed SARS-CoV-2 infection, preferably in Isolation**. This may not apply for staff types or in settings where practically infeasible or where doing so would disrupt safe nurse to patient ratios, and for staff who do not have direct patient/resident care roles.

AFL 21-08 PIN 22-09 CDC HCP High Risk Exposure Guidance

❑ **Instructions for HCP who were exposed for COVID-19**

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

Vaccination status	Routine work restriction	Critical staffing shortage
All HCP, regardless of vaccination status	No work restrictions 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 restrictions with negative diagnostic test† upon identification (but not earlier than 24 hours after exposure) and if negative, test at days 3 and 5

† Either an antigen test or nucleic acid amplification test (NAAT) can be used.

- Exposed HCP who are working during their post-exposure testing period should also wear a N95 respirator for source control at all times while in the facility until they have a negative test result on day 5.

AFL 21-08 PIN 22-09 CDC HCP Risk Assessment Guidance

- ❑ 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.
- ❑ Please provide Isolation and Quarantine information to healthcare personnel (HCP) 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.
- ❑ Plan for worker absences. Do not require a healthcare provider's note for employees who are sick to validate their illness.
- ❑ Facilities should avoid 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.
- ❑ 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 Isolation, 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 **without putting existing residents at risk**.
  - 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 Isolation area 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. Does the facility have a (full-time if SNF) trained Infection Preventionist?

2. 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 if performing facility-wide response testing.
2. Can the facility isolate, and quarantine residents as described in these recommendations?
3. Are all healthcare personnel (HCP) trained on the use of infection prevention measures (hand hygiene, PPE use, cleaning/disinfecting) and can HCP maintain hand hygiene (handwashing), proper use of PPE and cleaning/disinfecting protocols, optimally validated by adherence monitoring?
4. Are HCP from all shifts fit-tested to the respirator model(s) currently available for use in the facility?
5. Does the facility have adequate supplies of PPE to meet the needs of current patients and future patients for a minimum of 2 weeks?
6. Does the facility have sufficient staffing to meet the safety requirements of all residents and no operational problems?

*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 22-31

❑ Testing guidance for **newly admitted and readmitted residents**:

- Newly admitted residents and residents who have left the facility for >24 hours, **regardless of vaccination status**, should have a series of three viral **tests** for SARS-COV-2 infection; **immediately** upon admission and, if negative, again **at 3 days and 5 days** after their admission.
- **Quarantine is not required** for newly admitted and readmitted residents, **regardless of vaccination status**.
- **Newly admitted residents should wear source control for 10 days on admission.**
- Testing and quarantine are **not required** for hospitalized residents who tested positive for COVID-19 and met criteria for discontinuation of isolation and precautions prior to SNF admission or readmission and are within 30 days of their infection.

AFL 22-13 PIN 23-02

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
- Residents who leave the facility > 24 hours should be treated as a new admission.
- If any resident begins showing **symptoms** of COVID-19 upon their return to the facility regardless of their vaccination status, place in a single room (if available) and test the resident.
- Asymptomatic residents **with close contact** with someone with COVID-19, **regardless of vaccination status**, should be tested promptly (day 1) and, if negative, again at 3 days and at 5 days after the exposure. (Consider quarantine if transmission is high)

AFL 22-07 PIN 23-02 AFL 22-13
CDC - Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic

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.

While an outbreak investigation is occurring, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Also, visitors should physically distance themselves from other residents and healthcare personnel (HCP), when possible.

While not required, we encourage facilities in counties with high levels of community transmission to offer testing to visitors, if feasible. If facilities do not offer testing, they should encourage visitors to be tested on their own before coming to the facility.

QSO 20-39

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

- All visitors must be educated to screen themselves prior to entry and be made aware of recommended actions to prevent transmission to others if they have COVID-19 symptoms and/or exposure within the prior 14 days to another person with COVID-19.They must also be made aware of recommended actions to prevent transmission to others. **During an outbreak, designate a facility staff member to conduct initial screening**; if a visitor has COVID-19 symptoms in the last 24 hours or has been in close contact with a confirmed positive case or someone with symptoms, 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.
- **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 PIN 22-28.1 AFL 22-07

- ❑ **Outdoor visitation is preferred** and must be allowed because it poses a lower risk of transmission due to increased space and airflow. Masks are not required outside but can be encouraged.
- ❑ Visitors can access a digital copy of their COVID-19 vaccine record at https://myvaccinerecord.cdph.ca.gov/
- ❑ **Guidance on Physical Contact:**
  - Outdoor visits between residents and all visitors do not need to be conducted with face masks and may include physical contact (e.g., hugs, holding hands). When providing outdoor visitation facilities should facilitate visits on the facility premises (e.g., visits on lawns, patios, and other outdoor areas, drive-by visits, or visit through a window) with physical distancing between visitor-resident groups
  - Indoor visits must be conducted with both the resident and visitor wearing a well-fitting face mask. 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.
  - Visitors should also physically distance from other residents and healthcare personnel in the facility. 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.

  QSO-20-39-NH PIN 22-28.1 AFL 22-07

Summary Table of Visitation Guidance

Visitation Requirements for SNFs and CDSS licensed RCFEs and ARFs
Visitation is always allowed for all residents regardless of the vaccination status of the resident or the location of the resident
PPE requirements for visitors: • **Visitors and residents always wear a well-fitting mask while visiting indoors together** • **Visitors must wear other PPE as directed by facility healthcare personnel (HCP)** • **Visitors must physically distance from others** • **Vaccinated residents and HCP can have close contact if wearing a well fitted mask**

- ❑ **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. Heath care 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.

  AFL 22-07

Assess Outbreak Control Measures

- ❑ If new cases are identified, facility leadership should review practices, obstacles to fully implementing control measures, and additional actions.

- ❑ **If using the Contact Tracing** approach to response testing, ACPHD LTCF Outbreak surveillance for new cases will continue until there are no new positives when testing close contacts on day 1, 3 and 5 plus 5 additional days of surveillance.
- ❑ **If using the Facility-wide or Unit based** approach to response testing, ACPHD LTCF Outbreak surveillance for new cases will continue until two consecutive weeks testing every 3-7 days reveal no positive test results for healthcare personnel and residents 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 AFL 23-10 (updated guidance)
- Fit-Testing Resources
- COVID-19 Long Term Care Facility Webpage
- https://covid-19.acgov.org/isolation-quarantine

CDC

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- Interim Guidance for Managing HCP with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- 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
- PPE Donning and Doffing Sequence and Signs

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

- Provider Information Notices (PINs)
- PIN 21-16 Guidance on the Use of Antigen Tests
- PIN 21-30 CDPH Antigen Testing Program for CDSS Facilities
- 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 22-05.2 UPDATED ADULT AND SENIOR CARE FACILITY WORKER 9/26/22
- PIN 22-28.1 BEST PRACTICES FOR VISITATION RELATED TO CORONAVIRUS 11/29/23 Supersedes PIN 22-28 and 22-07-ASC
- PIN 22-28 BEST PRACTICES FOR VISITATION RELATED TO CORONAVIRUS 9/26/22

CDPH

- CDPH Guidance by Topic
- AFL 23-12 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

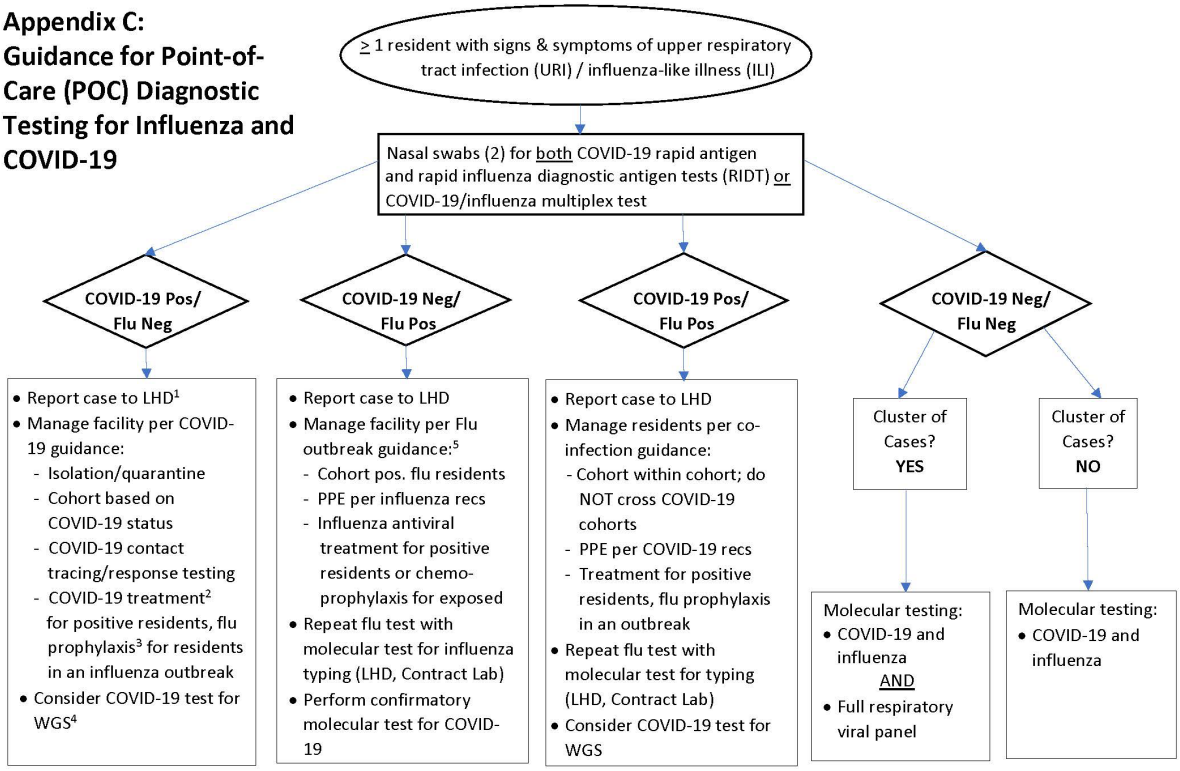
California Health Officer Orders

- California State Public Health Officer Order 2/22/22 Health Care Worker Vaccine Requirement

CalREDIE

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

Appendix C: Guidance for Point-of-Care (POC) Diagnostic Testing for Influenza and COVID-19



[1] **LHD**: local health department [2] Treatment options for COVID-19 may include antiviral drugs or monoclonal antibody [3] Oseltamivir for influenza post exposure chemoprophylaxis; there is no COVID-19 post exposure prophylaxis currently available [4] **WGS**: whole genome sequencing
[5] CDPH Influenza Prevention and Management Guidance for SNF (www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/SNF_DetectAndControlOutbreaks.aspx)

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