



Long Term Care Facility COVID-19 Outbreak Control Recommendations

Contact Name:

Date:

Phone:

Name of Facility:

Fax/Email:

Complete Address:

These recommendations supplement the California Department of Public Health (CDPH) All-Facilities Letters (<https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL20.aspx>) and California Department of Social Services (CDSS) Provider Information Network (<https://www.cdss.ca.gov/inforesources/community-care-licensing/policy/provider-information-notices>), and include additional precautions and actions to control a suspected or confirmed outbreak.

Case Definitions for Skilled Nursing or Residential Care Facilities

Confirmed COVID-19 Outbreak: ≥ 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; OR at least two of the following symptoms: fever (measured or subjective), chills, rigors, myalgia, headache, sore throat, new olfactory and taste disorder(s)

Reporting Requirements

- Report **initial confirmed outbreak or reportable event** to the Alameda County Public Health Department (ACPHD) at (510) 764-7639, Mon-Fri 8:30 am to 5 pm. After hours and on weekends, call Alameda County Fire Dispatch at (925) 422-7595 and ask to speak to the Public Health Duty Officer on call.
- For repeat outbreaks, please report to (510) 764-7639 or email LTCFOutbreak@acgov.org. Reports made on weekends will be responded to on Monday. Begin implementing these Outbreak Control Recommendations immediately.
- Skilled Nursing Facilities (SNFs) should report outbreak to Licensing and Certification East Bay District Office: (510) 620-3900.
- Residential Care Facilities (RCFE and ARF) should report to Community Care Licensing and Certification Regional Office: (510) 286-4201 and CCLASCPOaklandRO@dss.ca.gov.
- Complete a [Confidential Morbidity Report-LTCF-SNF-RCFE \(CMR\) form](#) for all residents that test positive. Completed forms should be sent by secure email your assigned nurse. If you have not yet been assigned to a nurse send forms to LTCFOutbreak@acgov.org.
- If an LTCF medical provider serves as the ordering provider for testing staff, complete a standard

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>



CMR form for all staff that test positive: <https://covid-19.acgov.org/covid19-assets/docs/healthcare-guidance/cmr-d-reporting.pdf>. Completed forms should be sent by secure email to covidreport@acgov.org or by fax to 510-273-3744.

- Complete [line list](#) daily for all **new** cases and submit to ACPHD by secure email to LTCFOutbreak@acgov.org until instructed otherwise by ACPHD. ACPHD's Line List Template can be downloaded at <https://covid-19.acgov.org/clinical-guidance.page?#LongTerm> under Skilled Nursing & Residential Care Facilities → Materials.
- Submit a map/floor plan of your facility to ACPHD within 24 hours of reporting the outbreak

Outbreak Control Recommendations

Communication

In addition to notifying ACPHD and Licensing & Certification, notify:

- Infection preventionist and Director of Nursing
- Facility administrator
- Medical director
- Health Services Director
- HCP and care givers who work at the facility
- Primary care provider of residents who:
 - Test positive for COVID-19
 - Are a close contact (e.g., roommate) of a resident who tested positive for COVID-19
 - Reside on a unit where an outbreak is occurring
- Residents, family, and visitors

Distribute an outbreak communication letter to all residents and their families.

Post signs at facility entrance. Post visual alerts instructing residents and staff to report symptoms of COVID-19 to a designated person.

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 more frequently with vitals signs including oxygen saturation (e.g. twice a shift).** 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.

Maintain Standard precautions while performing all surveillance activities. See CDC guidance for [Using Personal Protective Equipment](#).

Institute symptom monitoring and temperature checks of all staff at the facility entrance or within main reception area. See [Screening Guidance for Employers](#) & [Self-Assessment Guidance for Workers](#).

- 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



	<p>& runny nose, new olfactory and taste disorder(s), nausea, vomiting or diarrhea.</p> <ul style="list-style-type: none"> • See “Managing Ill Staff & Exposure” section for details on handling ill staff.
	<p>Monitor and report staff absenteeism due to any suspected COVID-19 symptoms.</p>
<p>Diagnostic Testing</p>	
	<p>Develop and implement plans to conduct testing at your facility. See guidelines for testing residents and health care personnel in LTCF:</p> <ul style="list-style-type: none"> • Testing Guidelines for Nursing Homes (CDC) • Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes (CDC) • Health Officer Order 20-18 (ACPHD)
	<p>Follow infection control precautions when collecting nasopharyngeal (NP) and other swabs:</p> <ul style="list-style-type: none"> • Patient should be in a single room with door closed • Minimum number of staff should be in room • Wear N-95 respirator (or equivalent), eye protection (face shield or goggles), disposable gown and gloves. • Perform hand hygiene immediately before donning and immediately after doffing • Don and doff in the correct sequence to avoid self-contamination. • For further guidance on proper specimen collection, see CDC guidelines for methods of specimen collection <ul style="list-style-type: none"> ○ 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.
	<p>Consider testing for additional respiratory viruses, for example, influenza A and B during flu season.</p>
<p>Response-Driven Testing</p>	
	<p>As soon as possible after a COVID-19 positive case is identified in a facility, “response-driven” serial retesting of all residents and HCP who tested negative upon initial baseline testing or during routine surveillance testing should be performed every 7 days until no new cases are identified in two sequential rounds of testing; the facility may then resume their regular surveillance testing schedule.</p> <ul style="list-style-type: none"> • Once a resident or HCP tests positive, no additional testing is needed for that individual for 90 days. • 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. See AFL 20-87 (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-87.aspx) • Specimen collection from residents should be performed by facility care staff or contracted service and testing should be performed by the facility’s usual laboratory provider with a preferred turnaround time of 48 hours or less for results. • 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.



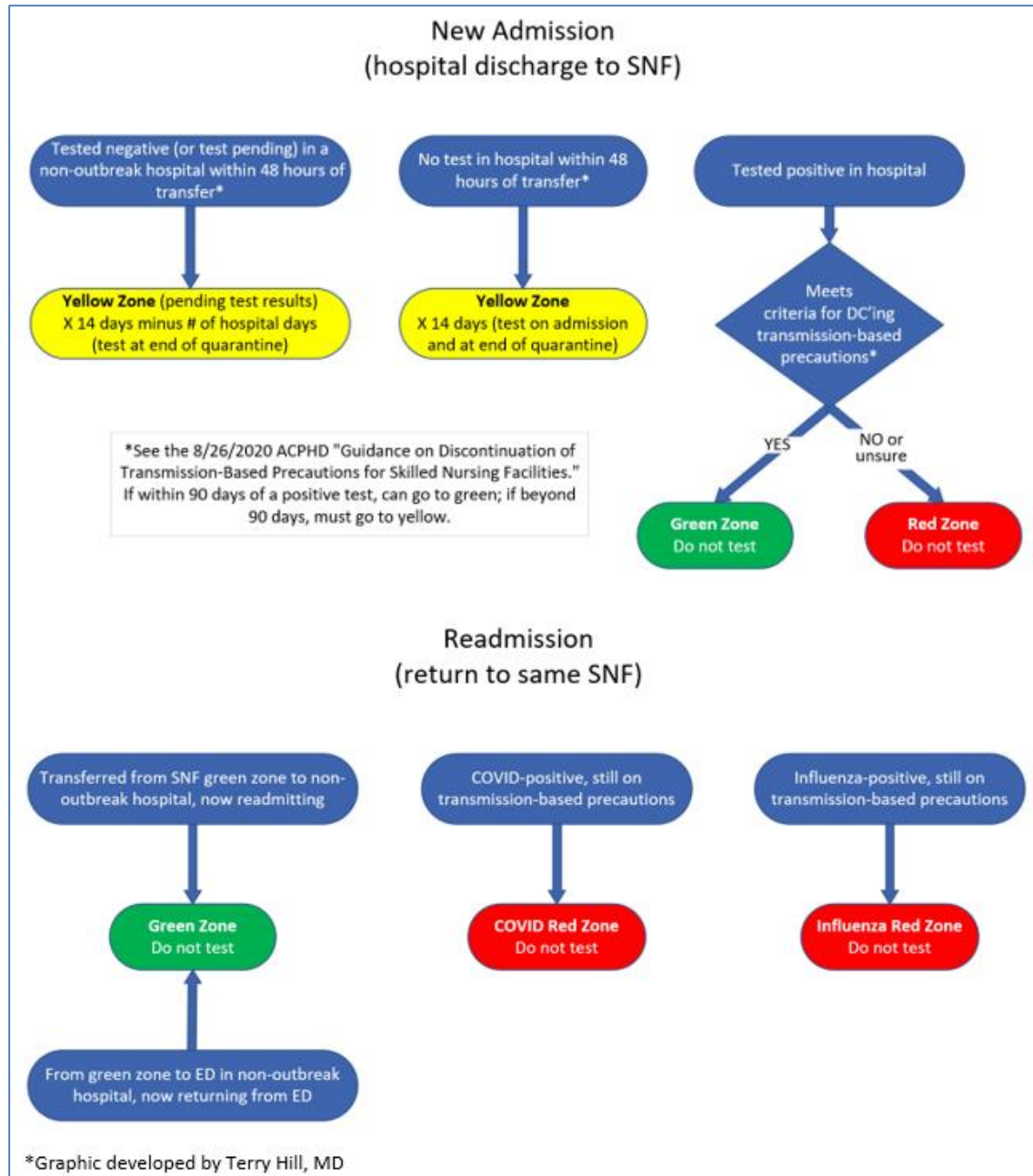
	<ul style="list-style-type: none"> All testing must be ordered by a clinician who will be responsible for informing the patient and arranging for appropriate clinical follow-up.
	<p>If using a rapid antigen test for response-driven testing of asymptomatic residents and staff during an outbreak, a positive result may be useful in confirming infection in an individual, but negative results may be confirmed using RT-PCR. Consult with your assigned LTCF Outbreak Team nurse for more information.</p> <p>See Considerations for Use of SARS-CoV-2 Antigen Testing in Nursing Homes and Considerations for Interpreting Antigen Test Results in Nursing Homes for more information. (https://www.cdc.gov/coronavirus/2019-ncov/downloads/hcp/nursing-home-testing-algorithm-508.pdf)</p>
	RCFEs experiencing an outbreak may consult with ACPHD to consider a more targeted testing strategy. This might include focusing testing within an affected unit or building.
	ACPHD offers assistance to coordinate testing but has limited ability to support testing in facilities; contact the Public Health Nurse assigned to your facility outbreak and/or email LTCFOutbreak@acgov.org with requests for assistance.
	Do <u>not</u> send specimens directly to the Alameda County Public Health Laboratory without approval.

Resident Placement, Movement Restrictions & Transferring Residents

	<p>Create three distinct, cohort areas. These could be a separate wing, unit, or rooms at the end of the hallway:</p> <ol style="list-style-type: none"> Red zone: COVID-19 (+) Green zone: COVID-19 (-) or recovered Yellow zone: COVID-19 unknown. Includes an observation unit of residents <ul style="list-style-type: none"> newly admitted or those with known exposures to COVID or recently returned from a hospital with a known outbreak or Suspect or probable cases pending lab results
	DO NOT MOVE probable or suspected cases from their rooms within the Green or Yellow zones unless they receive a laboratory confirmed COVID-19 (+) test. Call your assigned ACPHD outbreak nurse for instructions on moving patients between zones.
	Instruct staff on the importance of using separate equipment and fully changing PPE whenever going from one resident to the next to provide care,
	Suspend group activities and close communal dining areas. Suspend salon, podiatry, and other non-essential personal care services.
	Residents should stay and be served meals in their rooms.
	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 suspected or confirmed COVID-19 case, you must also include symptoms, signs, date of illness onset, laboratory test results, and infection control precautions.



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



Transmission-Based Precautions and Other Infection Control Measures



Follow PPE guidance as outlined in the [CDPH COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category](#) (<https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-74-Attachment-01.pdf>). See the schematic below:

California Department of Public Health, Healthcare-Associated Infections Program
 COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category

Recommendation	COVID Positive Residents (Red Area)	Symptomatic, Suspected COVID, Awaiting Test Results (Yellow, Single Room if Available)***	COVID Exposed or Residents from Hospital with confirmed outbreak (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	No
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
Gowns	Yes <input type="checkbox"/> Extended use** permitted in supply crisis, except for residents with known multidrug resistant organism (MDRO). <input type="checkbox"/> Maintain clean areas on unit where gowns are not worn such as nurses' station.	Yes <input type="checkbox"/> Extended use** NOT recommended. <input type="checkbox"/> When gowns in short supply, may reserve gown use for when indicated for high contact activity per Enhanced Standard precautions, or may dedicate gown for each resident and keep in room.	Yes <input type="checkbox"/> Extended use** NOT recommended. <input type="checkbox"/> When gowns in short supply, may reserve gown use for when indicated for high contact activity per Enhanced Standard precautions, or may dedicate gown for each resident and keep in room.	Yes <input type="checkbox"/> Extended use** NOT recommended. <input type="checkbox"/> When gowns in short supply, may reserve gown use for when indicated for high contact activity per Enhanced Standard precautions, or may dedicate gown for each resident and keep in room.	As needed per Enhanced Standard precautions
Gloves with hand hygiene before donning and after doffing	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

*Extended use may be implemented for facemask (source control), N95 respirator, and eye protection (goggles or faceshield) during supply shortage. Extended use refers to the practice of wearing the same facemask/N95 respirator/goggles/faceshield for repeated close contact encounters with different residents, without removing between patient encounters, typically in a cohort setting. When practicing extended use of N95 respirators, the maximum recommended extended use period is 8–12 hours. Respirators should not be worn for multiple work shifts and should not be reused after extended use. Respirators should be removed and carefully stored in a clean paper bag before activities such as meals, restroom breaks, and other breaks and then re-donned and worn through the remainder of the shift. The respirator must be discarded if at any time it becomes contaminated or does not fit or function correctly.

** Extended use and reuse of gowns can transmit MDRO and should be avoided if possible (i.e., these are crisis strategies). Extended use of gowns refers to the practice of wearing the same the same gown by the same HCP when interacting with more than one resident known to be infected with the same infectious disease when these residents are housed in the same location, only if residents do not have other diagnoses transmitted by contact (e.g., C. difficile, C. auris). If the gown becomes visibly soiled, it must be removed and discarded. When extended use of gowns is practiced, e.g., on a dedicated COVID-19 positive “Red” unit, gowns should not be worn in clean areas on unit, e.g., nurses’ station, clean supply room, breakrooms, etc

***Although residents that are symptomatic with suspected COVID pending test results, COVID exposed residents, and newly admitted residents under observation would be placed in the Yellow status, these residents should be cohorted based on their designation and not placed with residents on Yellow status for different reasons.

All staff, residents who must leave their rooms, and essential visitors at facilities should always cover their nose and mouth with a surgical mask while in the facility. If surgical masks are not available, a clean and dry cloth mask or other cloth covering shall suffice. If cloth coverings are



	used, they should be laundered after each shift before reuse.
	Use a fit-tested N-95 respirator or equivalent when performing Aerosol Generating Procedures.
	HCP should perform hand hygiene before and after donning and doffing personal protective equipment (PPE). Ideally, PPE should be discarded after every contact with every resident if supplies allow. However, with critical shortages of PPE, consider extended use and re-use practices.
	See Cal/OSHA Interim Guidance on COVID-19 for Health Care Facilities: Severe Respirator Supply Shortages (https://www.dir.ca.gov/dosh/coronavirus/Cal-OSHA-Guidance-for-respirator-shortages.pdf) and Optimizing Personal Protective Equipment (PPE) Supplies (https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html).
	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.
	Educate HCP on hand hygiene, respiratory hygiene, cough etiquette, and document training activities.
	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.
	Conduct ongoing monitoring of compliance with hand hygiene and PPE procedures, and provide on-the-spot correction as needed.
	Ensure an adequate supply of 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 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. 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 or break areas if possible; otherwise, consider staggering the use of break 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, hooyer 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 or who are severely immunocompromised**, 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 20 days have passed since symptoms first appeared.

This 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).

Except for rare situations, a test-based strategy is NOT recommended to determine when to discontinue Transmission-Based Precautions.

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

Transmission-based precautions and use of an N-95 respirator may be discontinued after Day 14 of quarantine. (Day 0 is the last day the resident was either exposed to a person with COVID-19 or admitted/readmitted to the facility)

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, have an active *C. difficile* infection).

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.

Educate Environmental Services staff on proper PPE donning & doffing procedures & appropriate contact times for cleaning solutions. 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

	Instruct HCP to not report to work if they have any symptoms compatible with COVID-19. HCP must report symptoms to their supervisor.
	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.
	Exclude HCP with confirmed COVID-19 infection, with or without symptoms. You MUST issue work exclusion letters to all staff who test COVID-19 (+). Use the letter sent to you with these outbreak control recommendations provided by your assigned LTCF Outbreak Nurse.
	Exclude HCP with symptoms consistent with COVID-19. Exclude until at least 24 hours have passed since recovery (defined as resolution of fever without the use of fever-reducing medications), <i>and</i> improvement in symptoms (e.g., cough, shortness of breath) <i>and</i> at least 10 days have passed since symptoms first appeared.
	For return-to-work criteria for employees, follow current guidance under “Criteria for Returning to Work after Isolation or Quarantine” on our website: https://covid-19.acgov.org/covid19-assets/docs/isolation-quarantine/criteria-release-from-iso-or-quar-and-return-to-work-eng-2020.07.28.pdf . Please note that recommendations for quarantine for HCP has not changed from the standard 14 days except in the context of critical staffing shortages.
	Do NOT require a negative test or doctor’s note for return to work.
	When a COVID-19 positive HCP returns to work they should restrict contact with severely immunocompromised patients until 14 days after illness onset. This 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).
	If staffing shortages arise, consult with ACPHD about mitigation strategies. In limited situations facilities may be authorized to have asymptomatic (never symptomatic) HCP with confirmed COVID-19 return to work before full Return to Work Criteria are met. <ul style="list-style-type: none"> • These HCP should provide direct care only for residents with confirmed COVID-19, preferably in a cohort setting. These HCP are restricted from contact with severely immunocompromised patients. A separate break room & bathroom should be provided as well.
	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: <ul style="list-style-type: none"> • 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



	<p>working at a facility that is currently experiencing an outbreak.</p> <ul style="list-style-type: none"> Encourage HCP tested routinely at another facility to share these results with all other employers.
	<p>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.</p>

Closure, Admissions and Re-admissions

	<p>Consult with medical director and ACPHD to determine if the facility should close to new admissions during a suspected or confirmed COVID-19 outbreak. If required, the duration of closure to new admissions will be determined for each situation individually. The effectiveness of the control measures implemented and the availability of a separate, unaffected building or unit to receive new admissions may be considered. ACPHD will provide clear reopening criteria to ensure that the facility can reopen as soon as possible once the outbreak is controlled. AFL 20-87 (ca.gov)</p>
	<p>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. <u>A negative test result is not required for admission.</u></p>
	<p>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 <u>without putting existing residents at risk.</u></p>
	<p>Assess residents being newly admitted for symptoms compatible with COVID-19. Follow recommendations above for resident placement and movement restrictions and infection control precautions.</p>
	<p>All new admissions or readmissions (from a hospital with a confirmed outbreak) should be quarantined for a period of 14 days in the Yellow zone. If the resident was not tested for COVID-19 in the 48 hours prior to admission then test upon admission, and quarantine for 14 days, and test again on day 14. If negative, release from quarantine. See CDPH AFL 20-87 for more information.</p>
	<p>For new or returning residents who were hospitalized for COVID-19 and are clinically ready for discharge from the hospital, implement Transmission-based precautions including an N-95 respirator (or equivalent) 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.</p>

Managing Family, Visitors, and Volunteers in a COVID-19 Outbreak



	<p>Facilities must suspend all indoor, in-room, and communal space visitation when a the facility is experiencing a COVID-19 outbreak and conducting response-driven testing.</p> <ul style="list-style-type: none"> • Safe, outdoor visitation may continue during an outbreak. • Visitors must wear masks and adhere to physical distancing of at least 6 feet
	<p>During outbreaks, limit indoor visitation to end-of-life situations or when a visitor is essential to the resident’s well-being and care.</p> <ul style="list-style-type: none"> • Visitor may only go the resident’s room and not to other areas of the facility. • Visitor must wear facemask while in the facility • Visitors must perform hand hygiene when entering the facility and when leaving the resident’s room.
	<p>Facilities may resume indoor, in-room, and communal space visitation when the facility has identified no new positive COVID-19 cases after two sequential rounds of response driven testing over a 14-day period.</p>
	<p>Screen visitors upon entry and exclude visitors who have:</p> <ul style="list-style-type: none"> • Signs and symptoms consistent with COVID-19 • In the last 14 days, had close contact with someone with confirmed COVID-19.
	<p>Restrict / exclude volunteers.</p>
Assess Outbreak Control Measures	
<p>If new cases continue to be identified, facility leadership and ACPHD should review practices, obstacles to fully implementing control measures, and additional actions.</p>	
<p>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 suspected cases. Certain exceptions may apply.</p>	

Additional resources:

- ACPHD [COVID-Influenza-like-Illness \(C-ILI\) Guidance](#)
- CDPH COVID-19 webpage: <https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/ncov2019.aspx>
- CDC guidance for long-term care facilities preparing for COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spread-in-long-term-care-facilities.html>
- CDC infection control training modules: <https://www.cdc.gov/longtermcare/>
- CDC PPE Burn rate calculator: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html>
- ACPHD Long Term Care Facility COVID-19 webpage: <http://www.acphd.org/2019-ncov/providers/skilled-nursing-residential-care-facilities.aspx>
- CDC Duration of Isolation and Precautions for Adults with COVID-19: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html>
- CDC Discontinuation of Transmission-Based Precautions and Disposition of Patients of COVID-19 in Healthcare Settings (Interim Guidance): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html>