



Skilled Nursing Facility COVID-19 Outbreak Control Recommendations

Updated 10/13/2023

These recommendations supplement the California Department of Public Health (CDPH) All-Facilities Letters [All Facilities Letters \(ca.gov\)](#), CDC and CMS Guidance. They include additional precautions and actions to control a suspected or confirmed outbreak.

Please see <https://covid-19.acgov.org/covid19-assets/docs/hoo/23-2-mandatory-masking.pdf> requiring Staff to wear high-quality, well-fitting masks whenever they are in patient care areas or in contact with SNF patients regardless of the Staff member’s COVID-19 vaccination status.

Please see <https://covid-19.acgov.org/covid19-assets/docs/hoo/23-03-mandatory-masking-staff-in-healthcare-facilities.pdf> This Order will go into effect on November 1, 2023, and end on April 30, 2024, unless the Health Officer adjusts the dates based on virus surveillance data.

Note: All changes to this document as of 10/03/2023 in red.

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Definitions for Skilled Nursing Facilities

Confirmed COVID-19 Outbreak SNF:

- ≥1 facility-acquired¹ 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.

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

[AFL 23-09](#)

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 have been within 6 ft for 15 minutes or longer while working in the facility during the 7 days prior to the onset of symptoms; for example, worked on the same unit during the same shift, and no more likely sources of exposure identified outside the facility.

<https://preparedness.cste.org/wp-content/uploads/2020/11/HCP-Outbreak-Definition.pdf>

Up to Date: A person who has 1 dose of the updated COVID-19 vaccine.

<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html>

HCP with Higher Risk Close Contact: HCP with prolonged close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection and

- HCP was **not wearing a respirator** (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or face mask); OR
- HCP was **not wearing eye protection** if the person with SARS-CoV-2 infection was not wearing a cloth mask or face mask; OR
- HCP was not wearing all recommended PPE during an aerosol-generating procedure.

[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,

¹ Facility-acquired COVID-19 infection in a long-term care resident refers to SARS-CoV-2 infections that originated in the facility. It does not refer to the following:

- Residents who were known to have SARS-CoV-2 infection on admission to the facility
- Residents who tested positive on day 1, 3 or 5 after new admission.

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>



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](#)

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

1. **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 a **confirmed outbreak or reportable event** to the Alameda County Public Health Department
 - Alameda County utilizes the Shared/School Portal for Outbreak Tracing (SPOT) to gather information about congregate setting COVID-19 cases. [How to Report an Outbreak](#)
 - The [LTCF-SPOT User Guide](#) is available with detailed instructions. For any questions or concerns regarding SPOT, please contact LTCFdata@acgov.org.
 - For any other questions or concerns contact ACPHD at (510) 268-2785 or email LTCFoutbreak@acgov.org Mon-Fri 8:30 am to 5:00 pm. Always begin isolation and quarantine of any confirmed/suspected cases immediately.
 - 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.
- Submit a map/floor plan of your facility to ACPHD **upon request**.
- Skilled Nursing Facilities** (SNFs) should report cases and outbreaks to Licensing and Certification East Bay District Office: (510) 620-3900.
- Providers (physicians) 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 encrypted email to the assigned outbreak investigator 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 [Disease Reporting and Control](#)

Outbreak Control Recommendations

Communication

- In addition to notifying ACPHD and Licensing & Certification, the following should be aware of a new outbreak:
 - 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

Facilities should notify HCP, residents, and families promptly about identification of SARS-CoV-2 infections in the facility and maintain ongoing, weekly 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](#) [Cover Your Cough](#)

HCP Surveillance

- Institute symptom monitoring. See [Sample Employee COVID-19 Health Questionnaire](#)
- 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.

Testing

- Maintain plans to** conduct testing at your facility. [CDPH Healthcare & Testing Guidance](#)
- Implement Antigen testing for fast results to Isolate effectively and evaluate for timely COVID-19 treatments. Antigen testing should be conducted 2-3 times per week.**
- See guidelines and resources for Antigen Testing:
- [CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#)
- 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](#)
- [Recommendations for the Prevention and Control of Influenza in California Skilled Nursing Facilities \(SNFs\) for the 2022-2023 Season during the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#)
- 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. [PPE Donning and Doffing Sequence and Signs](#)
 - 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.



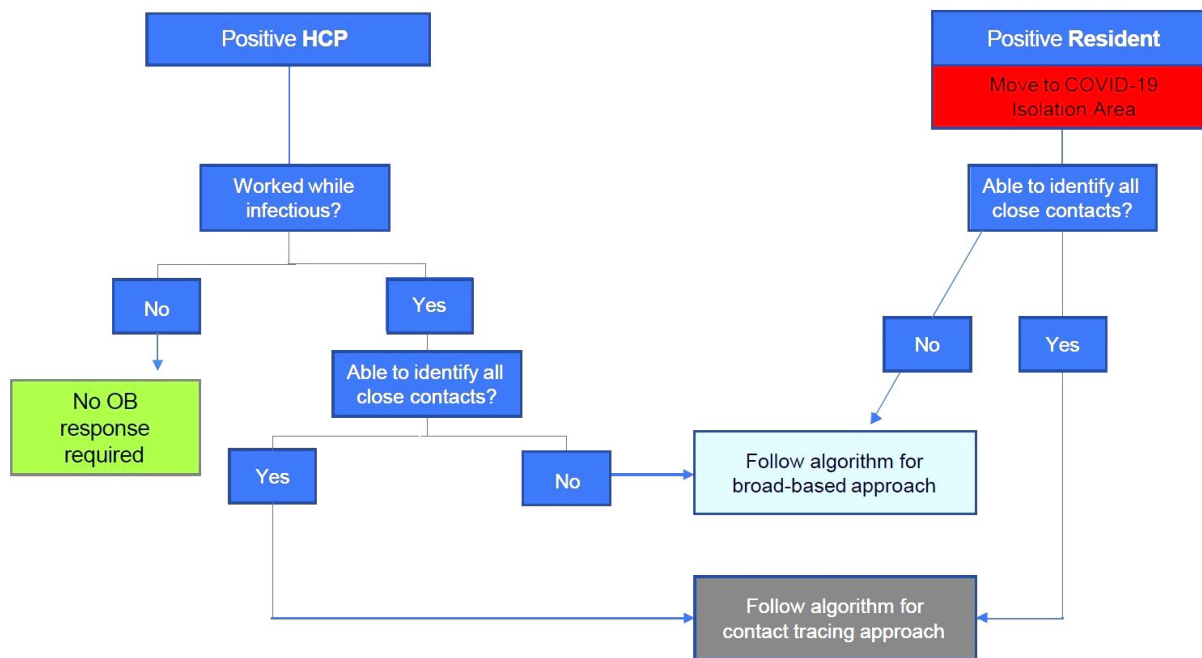
- [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 \(COVID-19\)](#)

- ❑ Please check with your testing laboratory to confirm the most appropriate specimen, transport medium, etc. for collection.
- ❑ Maintain the ability to ramp up testing by having available supplies or testing vendor in place in the event of outbreaks. See [COVID-19 Surge Readiness: Best Practices for SNFs](#)

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](#)).

CHOOSING AN OUTBREAK RESPONSE METHOD FOR LONG-TERM CARE FACILITIES



1. Before using the contact tracing approach, consider:

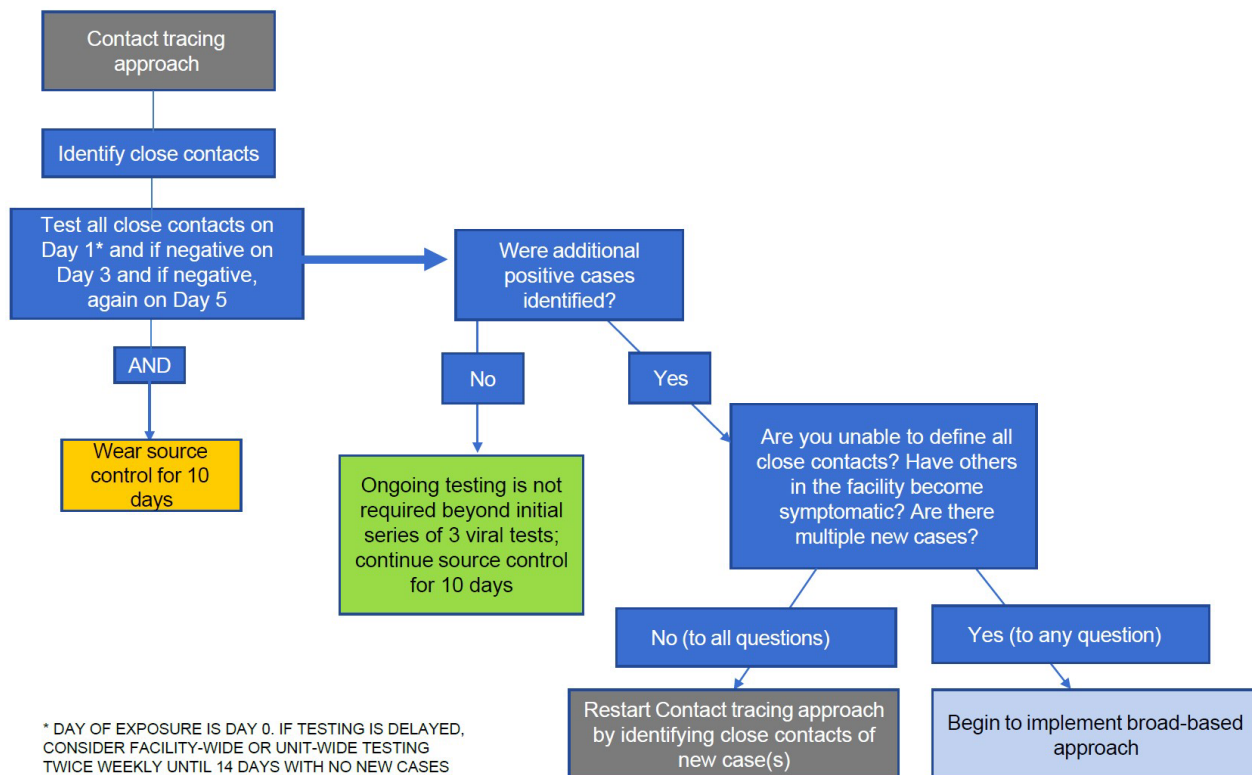
- Do you have the expertise, resources, and ability to identify all close contacts immediately (including communal dining, break rooms, activity rooms, therapy rooms)? If not, you should consider testing all Healthcare Personnel (HCP) and residents using the **facility-wide** or **group-level** (e.g., unit, floor, or other specific area(s) of the facility) approach.
- Is the case a resident or HCP? A resident case may be an indicator of facility spread and inability to identify all potential contacts, consider using **facility wide** testing.
- Does the initial positive case have a clear link to exposure outside of the facility (e.g., family, friends)? If so, contact tracing approach may be feasible.
- 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? If so, contact tracing approach may be feasible.
- 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? If so, consider using **facility wide** testing.

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

IMPLEMENTING A CONTACT-TRACING-BASED APPROACH TO OUTBREAK RESPONSE FOR LONG-TERM CARE FACILITIES



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.
- 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.
- Testing should be considered for those who have recovered in the prior 31-90 days; however, an



antigen test instead of a nucleic acid amplification test (NAAT) is recommended. [CDC](https://www.cdc.gov)

- If testing of close contacts reveals additional HCP or residents with COVID-19 infection, contact tracing should be continued to identify residents with close contact or 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.

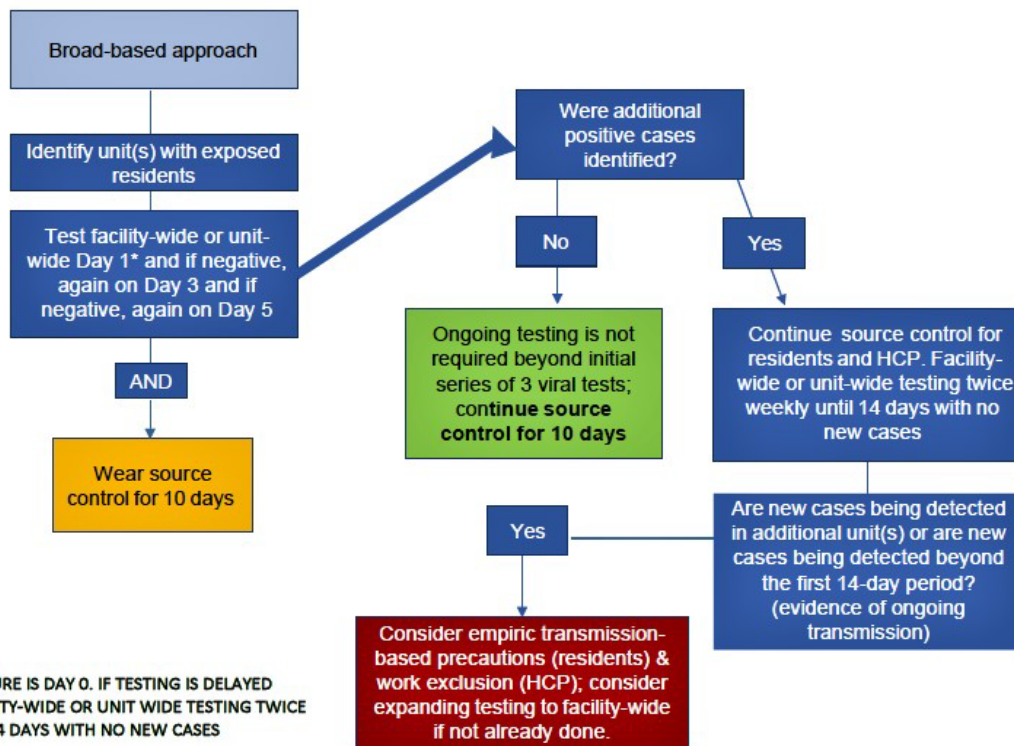
Testing: Facility Wide or Group Level Response Testing

- As soon as possible after one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility, perform **testing on the affected unit(s) or facility-wide immediately 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 on day 1 (where day of exposure is day 0), day 3, and day 5. If no additional cases are identified, no further testing is indicated. Masks should be worn as source control for 10 days after their exposure.**
- If additional cases are identified testing should continue on affected unit(s) or facility-wide every 3-7 days until there are no new cases for 14 days.**
- 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 testing for residents and HCP, test twice a week.
- Response testing should continue until no new cases are identified on or after 14 days of testing every 3-4 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 or resident test positive, identify contacts during the infectious period (two days before symptom onset or two days before positive test result if no symptoms) to identify close contacts and 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.
 - **Symptomatic individuals who test negative** should be isolated and receive a PCR test or repeat the antigen test 48 hours after the first negative test, even if symptoms have resolved. **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 isolate residents and HCP who test positive.
 - 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](https://www.alamedahealthcare.com)



Officer Order No. 20-19

IMPLEMENTING A UNIT-BASED OR FACILITY-WIDE OR BROAD-BASED APPROACH TO OUTBREAK RESPONSE FOR LONG-TERM CARE FACILITIES



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.

- ❑ **Isolation Area (dedicated area):** COVID-19 Positive – Use Transmission Based Precautions
 - COVID-19 positive residents for the duration of the Isolation period, regardless of their vaccination status
 - MDRO colonization status and/or presence of other communicable disease should also be taken into consideration during the cohorting process.
 - 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. **Provide signage to remind individuals that they are entering the Isolation Area. Assess airflow in the Isolation area and resident rooms. Strategically place portable air cleaners throughout the Isolation area and in resident rooms.**
 - Dedicated staffing who do 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. **If unable to dedicate HCP, educate and encourage a workflow process that allows HCP to perform routine care working from non-isolated to COVID-19 isolated residents (e.g., resident assessments, med pass, etc.).**
 - All HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to **Standard Precautions** and use a NIOSH-approved particulate respirator with N95 filter or



higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) and perform hand hygiene and change PPE between residents. [CDC](#)

- Symptomatic residents - Isolate in Single room, if possible, otherwise Isolate in current room - Use Transmission-based Precautions for duration of testing** (including N95 respirator, gown, gloves, and eye protection) – **Do not move to Isolation Area unless COVID-19 positive.**

- **Additionally, it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory infections based on symptoms alone. Consider testing for pathogens other than COVID-19 and initiating appropriate infection prevention precautions for symptomatic older adults.**

- Consider Transmission based precautions for exposed residents (close contacts) if:**

- Resident is on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions or if there is widespread outbreak (e.g., positive cases after 2nd round of testing).
- 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.
- New admissions with a known exposure in the last 2 weeks.

[CDC AFL 23-12](#)

- Discontinuation of transmission-based precautions for asymptomatic exposed (close contacts) residents**

- on Day 7 if exposed residents do not develop symptoms and testing is negative.
- on Day 10 for Residents who are not tested 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)

[CDC](#)

- DO NOT MOVE** probable or suspected cases to the **Isolation Area** 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.

- 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., if the outbreak has not been controlled effectively.

- Regardless of vaccination status, residents on Transmission-based precautions/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 Transmission based precautions.

- All Residents who 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 ACPHD [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.

Transmission-Based Precautions and Other Infection Control Measures

[COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category](#)

Recommendation for Transmission Based Precautions During Outbreak Response	COVID Positive Residents (Isolation Area)	Exposed (if using facility-wide or group-level response testing), Symptomatic, Suspected COVID, Awaiting Test Results	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	Yes, upon room entry and between providing care for residents (if more than one resident in a room).	As needed per Enhanced Standard Precautions (e.g., likely exposure to blood and body fluids)

Standard Precautions – PPE use

- Wear gloves when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, nonintact skin, or potentially contaminated intact skin (e.g., of a patient incontinent of stool or urine) could occur.
- Wear a gown, that is appropriate to the task, to protect skin and prevent soiling or contamination of clothing during procedures and patient-care activities when contact with blood, body fluids, secretions, or excretions is anticipated.
- Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed to protect the mucous membranes of the eyes, nose and mouth during procedures and patient-care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions.

[CDC Standard Precautions](#)

Create and maintain policies and step by step procedures addressing the following:

- What PPE is required in which situations (e.g., residents with confirmed or suspected COVID-19, residents placed in empiric transmission-based precautions)
- Recommended sequence for safely donning and doffing PPE.
- How to clean, decontaminate, and maintain any reusable PPE after and between uses as allowed by the manufacturer’s instructions for use; and
- Written schedule for hand hygiene, PPE, environmental cleaning, and other IPC audits

Post clear and visible signage for PPE donning and doffing and appropriate infection prevention



precautions where Isolation/Transmission-based precautions are in use. [CDC Instructions for putting on and removing PPE](#)

- Verify all HCP can demonstrate competency in proper PPE donning and doffing procedures, and document competency assessments.
 - [YouTube Donning and Doffing PPE for Staff Wearing an N95 Respirator](#)
- HCP should perform hand hygiene before and after donning and doffing personal protective equipment (PPE). HCP must understand the need to change gloves and gowns and perform hand hygiene between all residents, regardless of known COVID-19 or other infectious disease status. [AFL 23-12](#)
- Conduct ongoing monitoring of compliance with hand hygiene and PPE procedures and provide on-the-spot correction as needed.** [Monitoring Adherence to Health Care Practices that Prevent Infection](#)
- Ensure all HCP are familiar with Standard, Enhanced Standard, Droplet, and Contact precautions, as well as eye and respiratory protection, and document training activities.
- 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. [CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#)
- When using eye protection during Outbreak Response, ensure appropriate cleaning and disinfection after each use if reusable face shields or goggles are used. [APIC Eye Protection Fact Sheet - Guidance](#)
- 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 the 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. [N95 Respiratory Resources](#)
- Source Control** protects others and is the use of well-fitting 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](#)
- 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. [Respiratory Protection Standard AFL 21-08 CDC](#)
- Healthcare personnel, both paid and unpaid, should be allowed to bring their own highly protective masks (such as N95 respirators) if the mask does not violate the facility's safety and health requirements. They should not be asked to remove their more protective source control device (a well-fitting N95 respirator, for example) for a less protective device (such as a procedure mask) unless the mask or respirator is visibly soiled, damaged, or hard to breathe through. [CDC](#)
- Educate HCP on hand hygiene, respiratory hygiene, cough etiquette, and document training activities.



(Consider using powder or liquid-based product that simulates the spread of germs that can be viewed with the use of ultra-violet light. This can teach how quickly and broadly germs can be spread in a short period of time.)

- 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 a 2-week supply of PPE at minimum, preferably 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 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.
- Instruct healthcare personnel (HCP) on the importance of using separate equipment, cleaning, and disinfecting the equipment between residents.
- 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.

Surveillance of Residents

- Consult medical director or clinical team for best practice for monitoring Residents in Isolation.**
 - Consider checking residents in Isolation every 4 hours at minimum, all others every 8 hours at minimum.
 - 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.
 - **Note that residents living with dementia may not be able to verbalize their COVID symptoms.**
 - Identification of these symptoms should prompt isolation and testing for COVID-19

Treatments

- Effective treatment** for residents with mild to moderate COVID-19 is available and **should be offered**. [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>
- Symptomatic individuals who test negative** should receive a PCR test or repeat the antigen test 48 hours after the first negative test. It is important that residents are identified within the 5 day-window for starting treatment. **While awaiting test results, move only if the resident can go into a private room.**
- During an outbreak, LTCF's should assess residents who may be eligible for treatment (high risk with symptoms) **daily** and ensure providers are notified immediately. Treatments often have a short timeline to initiate (**5 days for oral anti-virals and 7 days for IV treatment**). 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.**
- Resources:
 - [Access to treatment LTCF](#)
 - [AFL-23-29 COVID-19 Treatment Resources for Skilled Nursing Facilities \(SNFs\)](#)



- [CDPH COVID-19 Treatment Resources for Healthcare Providers](#)

- ❑ [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	Remdesivir	Molnupiravir
Who is eligible?	<ul style="list-style-type: none"> • Ages 12+ • Persons with even mild symptoms who are not hospitalized but are at risk for serious illness. 	<ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Ages 18+ • 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 7 days from start of symptoms	Within 5 days from start of symptoms
How is it given?	Pills taken orally for 5 days	Once daily Intravenous Infusion (IV) for 3 days	Pills taken orally for 5 days
Where can it be given?	Home	Healthcare facility/ infusion center	Home

For more information, visit:

<https://www.fda.gov/consumers/consumer-updates/know-your-treatment-options-covid-19>



- ❑ **Remdesivir Patient Access Program - Manufacturer Provides Payment Assistance**

Gilead Sciences, the manufacturer of [remdesivir \(Veklury\)](#), has an [Advancing Access Program](#) for assisting patients who are prescribed remdesivir and cannot afford the co-pay or cost. Eligible commercially insured patients can access the co-pay coupon program, and un- or underinsured patients may be able to get free product through the patient assistance program. You can call the Advancing Access program at 1-800-226-20576 for details of eligibility and how to use the programs.

<https://www.vekluryhcp.com/access/>

Managing HCP Illness & Exposure

- ❑ Skilled Nursing Facilities should use the CDC Risk Assessment Framework to determine exposure risk for HCP with potential exposure to patients, residents, visitors, or other HCPs with COVID-19.

[AFL 21-08 CDC's updated risk assessment framework](#)

- ❑ 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>

- For HCP with an ongoing household exposure who are unable to isolate from the COVID-19 positive case, testing should begin during the exposure and extend for 5 days after the COVID-19 positive case isolation time frame ends.
- Monitor and investigate HCP absenteeism due to any suspected COVID-19 symptoms.
- 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.
- Plan for worker absences. Do not require a healthcare provider's note for employees who are sick to validate their illness.
- Please provide Isolation information to healthcare personnel (HCP) who test COVID-19 positive. Instructions are also available for HCP who were exposed to someone with COVID-19. 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.
- 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 arrives 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.
- Instructions for HCP who test positive for COVID-19:**
 - 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 due to critical staffing shortage should:
 - provide direct care only for patients/residents with confirmed SARS-CoV-2 infection, preferably in Isolation.
 - 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.
- Always wear a N95 respirator for source control 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 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.

[†] 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.

[AFL 21-08 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.
- 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.

[AFL 21-08 CDC HCP Risk Assessment Guidance](#)

☐ Travel Guidance: [CDC Travel](#)

Facility Admissions, Re-admissions and Residents Who Temporarily Leave the Facility

☐ 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 the 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 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?

Testing guidance for **newly admitted, readmitted residents** and residents who temporarily leave the facility.

- 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.
- **If a new admission tests positive and was not in empiric transmission-based precautions during the infectious period, initiate outbreak response (Contact Tracing or Broad-based testing)**
- Newly admitted residents should wear source control for 10 days on 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.
- Testing and Isolation 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.
- Residents who leave the facility > 24 hours should be treated as a new admission. [CDC](https://www.cdc.gov)
- Residents who leave the facility < 24hours



- 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](#)
- **Upon return to the facility, screen and monitor residents for signs and symptoms of COVID-19.**
- 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 transmission-based precautions if transmission is high)
- 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.

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. **The visit should occur in a manner that does not place other residents at risk.** If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.

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 not required, we encourage facilities in counties with high levels of community transmission to offer testing to visitors, if feasible.

[QSO 20-39](#)

□ Any visitor entering the facility, regardless of their vaccination status, should 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 **should** reschedule their visit, regardless of their vaccination status.
- All visitors should 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. Facilities may choose to require visitors to wear masks while in the facility during an outbreak.
- If personal protective equipment (PPE) is required for contact with the resident due to transmission-based precautions or COVID-19 positive isolation status (including fully vaccinated visitors), it should be donned and doffed by the visitor according to instruction by HCP. The resident should wear a well-fitting mask, if tolerated.



- 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 are unable to adhere to these core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave.

[QSO 20-39](#)

- ❑ **Outdoor visitation is preferred** and **should** be allowed because it poses a lower risk of transmission due to increased space and airflow. Masks outside can be encouraged. When providing outdoor visitation, facilities should facilitate visits on the facility premises (e.g., visits on lawns, patios, and other outdoor areas)

Recommendations for Visitors with Confirmed COVID-19, Compatible Symptoms, or Recent Exposure

Criteria	Actions*
Confirmed COVID-19 or compatible symptoms	<ul style="list-style-type: none"> • Defer non-urgent, in-person visitation until the healthcare criteria to end isolation is met (10 days from test date or onset date which is known to be day 0). This time period is longer than what is recommended in the community.
Close contact with someone with COVID-19 or were in another situation that put them at higher risk for transmission	<ul style="list-style-type: none"> • Defer non-urgent, in-person visitation until 10 days after their close contact if they are unable to wear source control. No delay if source control is worn unless symptoms develop, in which case the resident should be placed in isolation.

* Visits that occur in Skilled Nursing Facilities (SNFs) specifically, must align with the guidance and core principles of COVID-19 infection prevention outlined in QSO-20-39.

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.
- ❑ **CMS requires nursing homes to educate residents and staff on the risks and benefits of the vaccines, offer to administer the vaccine. Facilities should educate and encourage visitors to become vaccinated and stay up-to-date with vaccinations.**
- ❑ **The facility must report COVID-19 vaccine status of residents and staff, each dose of vaccine received, COVID-19 vaccination adverse events and therapeutics administered to residents for treatment of COVID-19. As already required at §483.80(g)(2), this data also must be reported to CDC's NHSN. [COVID-19 Nursing Home Data](#) [COVID-19 Health Care Staff Vaccination Requirements - Final Rule](#)**
- ❑ **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.
 - Encourage all workers to be up-to-date with vaccinations.



- Residents and HCP are considered **up-to-date** if they have 1 dose of updated COVID-19 vaccine. [CDC Stay Up to Date with COVID-19 Vaccines](#)

Resources:

- [#GETVACCINATED AHCA Toolkit](#)

- 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. **Egg allergy necessitates no additional safety measures for influenza vaccination beyond those recommended for any recipient of any vaccine, regardless of severity of previous reaction to egg.**

Resources:

- [HCP Influenza Vaccination Summary Reporting FAQs](#)
- [CDPH Influenza Vaccination Resources](#)
- [Prevention and Control of Seasonal Influenza with Vaccines: Recommendations ACIP](#)

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 Isolation rooms/areas.**
 - 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 the Isolation Area should be turned off and portable fans circulating "dirty air" should not be used.
 - See [illustration](#)

- 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](#)
- [Best Practices for Ventilation of Isolation Areas to Reduce COVID-19 Transmission Risk in Skilled Nursing Facilities, Long-Term Care Facilities](#)
- [Temporary airborne infection isolation for airborne infectious diseases \(AirIDs\)](#)

Environmental Cleaning

- 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. Ensure staff have access to EPA-registered disinfectant wipes in break rooms.

Best Practices for Cleaning in Healthcare Facilities	Additional Guidance for Ongoing Success
Use disinfectants that kill SARS-CoV-2	<ul style="list-style-type: none"> Use EPA List N for a complete list of disinfectants
Clean reusable items between use	<ul style="list-style-type: none"> Dispose of single-use items after use
Work from clean to dirty to avoid spreading dirt and microorganisms	<ul style="list-style-type: none"> Clean low-touch surfaces before high-touch surfaces Clean resident zones (beds, sitting areas) before resident toilets Clean high-touch surfaces outside the resident zone before the high-touch surfaces inside the resident zone
Clean general resident areas not under transmission-based precautions before those areas under transmission-based precautions.	<ul style="list-style-type: none"> Ensure appropriate PPE is worn
Proceed from high surfaces to low surfaces to prevent dirt and microorganisms from dripping or falling and contaminating already cleaned areas	<ul style="list-style-type: none"> Clean bed rails before bed legs Clean environmental surfaces before cleaning floors Clean floors last to allow collection of dirt and microorganisms that may have fallen
Proceed in a systematic manner to avoid missing surfaces	<ul style="list-style-type: none"> Clean clockwise, or left to right, etc.
Perform management of laundry, food service utensils, and medical waste in accordance with state law and regulations and facility policy.	<ul style="list-style-type: none"> Ensure policies in place for staff to reference

Resources:

- [Best Practices for Environmental Cleaning in Healthcare Facilities](#)
- [EPA List N](#)

Educate Environmental Services staff on proper hand hygiene, PPE donning & doffing procedures & appropriate cleaning and disinfectant contact times. Document training.

Regular monitoring of and feedback of results to staff can maintain or improve adherence to environmental cleaning practices. Use these tools weekly during outbreaks to identify gaps and opportunities for improvement. Monitoring may be performed in any type of patient care location.

- [CDPH EVS Adherence Monitoring Fluorescent Marker Assessment Tool](#)
- [CDPH Adherence Monitoring Environmental Cleaning and Disinfection Tool](#)



- 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. EVS staff should refrain from entering a newly vacated room without all the recommended PPE.
 - <https://www.cdc.gov/hai/prevent/resource-limited/cleaning-procedures.html>
 - [Environmental Cleaning in Resource-Limited Settings](#)
 - [Air changes/hour \(ACH\) and time required for airborne-contaminant removal by efficiency](#)
- Terminal Cleaning Recommendations for Residents who were in Transmission-Based Precautions - *New Section***
 - Prior to entering the room, determine if the vacated resident was on transmission-based precautions to determine appropriate PPE usage and amount of time required to wait before entering room. Once the recommended time has passed, individuals may enter the room and clean as described below:
 - HCP, including environmental services personnel, should refrain from entering the vacated room of a SARS-CoV-2 (or other airborne pathogen) positive resident until sufficient time has elapsed for enough air changes to remove potentially infectious particles. Refer to [CDC's Air Contaminant Removal Table for additional guidance](#). After this time has elapsed, the room should undergo appropriate cleaning and surface disinfection before it is returned to routine use.
 - Remove soiled/used personal care items (e.g., cups, dishes) for reprocessing or disposal.
 - Remove facility-provided linens for reprocessing or disposal. See [CDC's linen and laundry management](#)
 - Inspect window treatments and if soiled, clean blinds on-site, and remove curtains for laundering.
 - Clean and disinfect all reusable (noncritical) resident care equipment.
 - Using the general best practices, clean and disinfect the room systematically from clean to dirty, top to bottom, including all low-touch and high-touch surfaces, other surfaces that may not be accessible when the room/area was occupied (e.g., patient mattress, bedframe, tops of shelves, vents), and floors.
 - All non-dedicated, non-disposable medical equipment used for that resident should be cleaned and disinfected according to manufacturer's instructions and facility policies before use on another resident.

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
 - **There are no new cases when testing on day 1, 3, and 5 plus 5 additional days of surveillance.**
 - or
 - Two consecutive weeks (14 days) of testing every 3-4 days reveal no positive test results for residents.



Additional Resources:

ACPHD

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

CMS

- [QSO 20-39 Nursing Home Visitation - COVID-19](#)

CDC

- [Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 \(COVID-19\) Pandemic](#)
- [Infection Prevention Training](#)
- [CDC Burn Rate Calculator](#)
- [PPE Donning and Doffing Sequence and Signs](#)

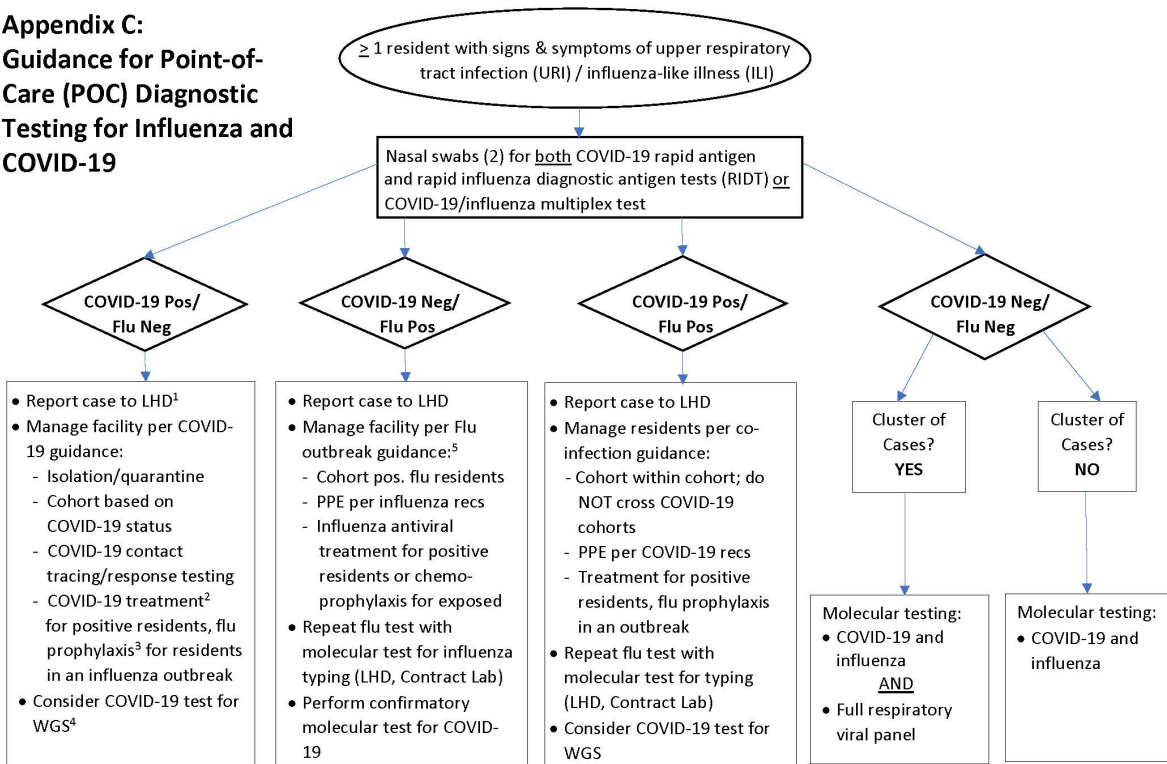
CAHF

- [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

CDPH

- [COVID-19 Surge Readiness: Best Practices for Skilled Nursing Facilities](#)
- [CDPH Guidance by Topic](#)
- [AFL 23-12 Recommendations PPE, Resident Placement/Movement, and Staffing in SNF's](#)
- [AFL 21-08 Guidance on Quarantine and Isolation for Health Care Personnel \(HCP\) and Return to Work for HCP with COVID-19](#)
- [CDPH Skilled Nursing Facilities Infection Prevention Call FAQs](#)
- [Recommendations for the Prevention and Control of Influenza](#)

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](http://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/SNF_DetectAndControlOutbreaks.aspx)

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