Interim Guidance: Prevention and Management of COVID-19 in Long-Term Care Facilities

UPDATED July 23, 2021

The following guidance was developed by the San Francisco Department of Public Health (SFDPH) for use by local facilities and will be posted at www.sfcdcp.org. This interim guidance may change as knowledge, community transmission, access to vaccines, community practices, and state guidance change. Updated Health Orders, CDPH, and CDSS guidance will supersede the links in this document.

AUDIENCE: Administrators of Long-Term Care Facilities (LTC Facilities), which encompass the California Department of Social Services/Community Care Licensing Division and Department of Public Health Licensing and Certification Program Facilities in San Francisco. These include: Adult Residential Facilities (ARF), Residential Care Facilities for the Elderly (RCFE), Residential Care Facilities – Continuing Care, Social Rehabilitation Facilities, Residential Care Facilities for the Chronically Ill (RCFCI), and Skilled Nursing Facilities (SNF) that provide 24-hour skilled care on site.

Summary of Changes since 6/18/2021 Version

- Addition of the San Francisco Health Order C19-07 (updated 7/8/21) vaccine requirement in high-risk settings
- Makes clear the requirement of immediate reporting of suspected or confirmed COVID-19 cases to SFDPH (see Isolation and Quarantine section)
- Clarification on diagnostic screening testing, which requires all unvaccinated staff to continue weekly screening even if more than 70% of both staff AND residents are fully vaccinated

BACKGROUND: LTC facilities provide residential care to people who require varying levels of support. Because of the heterogeneity of residents, facilities, access to and uptake of prevention, treatment, and vaccination strategies, SFDPH is summarizing key components of infection prevention and mitigation of transmission, which will closely follow California DPH and DSS guidance.

LTC facilities are high-risk settings in which adequate ventilation, handwashing, appropriate PPE, and distancing are pillars for ongoing mitigation against COVID-19. Facilities are responsible for following updates by CDPH or CDSS in a timely manner and for updating Mitigation Plans required by their licensing bodies.

This document provides a summary guidance to LTC Facilities in the City & County of San Francisco on:

1. Positive Case: Reporting, Isolation, and Quarantine
2. General Infection Prevention and Control Guidelines for COVID-19
3. Testing Guidance
4. Resident Cohorting and Zoning
5. Transfer of Patients with COVID-19 to LTC Facilities
6. Visitation, Communal Dining and Activities
7. Additional Resources
Positive Case: Reporting, Isolation, and Quarantine

Reporting a Person Under Investigation (PUI), COVID-19 case, or outbreak\(^1\) is required under AFL 20-75 and AFL 20-53. Isolation refers to separation of a positive or suspected case from others. Quarantine refers to the observation period after last high-risk exposure\(^2\) or close contact\(^3\). For more information, SF Isolation & Quarantine (I&Q) Directives can be found at: https://www.sfdph.org/dph/alerts/coronavirus-health-directives.asp.

All facilities are required to notify SFDPH when a PUI or COVID-19 case is identified:

<table>
<thead>
<tr>
<th>SFDPH Communicable Disease Control (CD Control)</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="mailto:COVID.OMG.SNF@sfdph.org">COVID.OMG.SNF@sfdph.org</a> or (415) 554-2830 is available 7 days per week.</td>
</tr>
</tbody>
</table>

After hours, if needed, please call 415-554-3613 to reach the on-call physician.

Notify SFDPH Communicable Diseases (CD) Control within one hour of:

- Suspected or lab-confirmed positive SARS-CoV-2 test in residents or staff, or
- Three (3) or more residents or staff with new-onset respiratory symptoms within 72 hours of each other, or
- Residents with severe respiratory infection resulting in hospitalization or death.

Initiate the following steps when a resident or staff case is identified:

1. **Isolate positive individual(s);** see section on Zoning and AFL 20-74; for RCF, refer to PIN 21-12-ASC. Residents should not leave their room for meals and have their own bathroom if possible.

2. Identify and quarantine close contact residents, regardless of vaccination status for 14 days after last exposure.

3. Notify SFDPH CD Control as written above. For facilities facing I&Q challenges, SFDPH can help refer to I&Q sites as able.

4. Test close contacts – initiate testing response (see testing response section).

5. **Cohort residents** into Red/Yellow/Green with guidance from SFDPH according to symptoms and testing results. **Cohort staff** and plan for ongoing staffing needs: Keep all staff assigned to work only with positive (“red” area) or exposed/symptomatic/screening (“yellow” area) or negative/recovered (“green” area) residents during that shift (See Zoning section).

6. Communicate with SFDPH daily during the outbreak as requested.

7. Facilities in outbreak status must stop admissions for 28 days after most recent positive case.

8. **Monitor positive and exposed residents** with frequency described below. Notify their physician as soon as possible.

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\(^1\)An outbreak in a LTCF is one or more facility acquired COVID-19 cases in a resident. Thresholds for investigation by the DPH in a SNF is: one case of lab-confirmed positive COVID-19 in any resident or three or more residents/staff that are PUIs within 14 days (or otherwise epi-linked); In a RCF is: one case in the setting of two or more PUIs within 14 days.

\(^2\)A high-risk exposure is exposure to an aerosol generating procedure in a known COVID-19 individual without full PPE.

\(^3\)A close contact is defined as an individual that was within 6 feet of an infected person during their infectious period for more than 15 minutes over a 24-hour period.
Residents Considerations:

Quarantine: Three categories of residents in observation

1. Symptomatic residents (PUIs):
   - Should be separate from asymptomatic individuals as soon as possible.
   - Place symptomatic residents in a single-person room with the door closed and if possible, a private bathroom.
   - Residents should leave their rooms only for medically essential purposes, and those who must leave should wear a facemask unless they are unable to tolerate facemasks.
   - Symptomatic residents should be tested immediately with PCR or antigen; if positive then moved to the isolation area; if negative then observed for 14 days in quarantine with symptom checks at least twice a day; if antigen is negative in a symptomatic resident, then PCR should be sent within 24 hours.

2. Residents who are close contacts of positive residents or staff:
   - Roommates or close contacts of residents with confirmed or suspected COVID-19 infection should be considered exposed for 14 days from the last date of exposure, regardless of vaccination status.
   - Close contacts should be tested immediately, then every 3-7 days during the 14-day quarantine.
   - Asymptomatic close contacts of the same positive case may be roomed together in observation.

3. New admissions, if not fully vaccinated or if exposed prior to admission:
   - Unvaccinated residents who are newly admitted need to be tested upon admission and Day 12 to exit quarantine at Day 14 if they remain asymptomatic.
   - Fully vaccinated residents that may have been exposed to a positive case within 14 days prior to admission should complete quarantine as well per AFL 21-08.

Guidance on removing residents with suspected or known COVID-19 cases from isolation

- Symptomatic resident COVID-19 cases may be removed from isolation to enter the general resident population after 10 days since initial onset of COVID-19 symptoms, if symptoms are improving and if afebrile (without fever reducing medicines) for at least 24 hours, unless immunocompromised. Any individual with viral symptoms that test negative for COVID-19 should follow additional infection control policies at the facility.
- Asymptomatic residents that have tested positive for SARS-CoV-2 should complete 10 days of isolation from first day of positive testing, unless immunocompromised.
- All immunocompromised resident COVID-19 cases should complete 20 days of isolation per AFL 20-74 and can return to common areas after this time if symptoms are improving and if afebrile for 24 hours.
- Fully vaccinated asymptomatic residents who test positive should be isolated and observed for development of symptoms while additional evaluation is conducted in consultation with the local health department.
Guidance on removing residents from quarantine

- New admissions who are not yet fully vaccinated and in quarantine should have PCR on or prior to admission and Day 12 of quarantine to exit after Day 14, if negative. Facilities may use POC antigen testing every 3-4 days instead of PCR and should report results as per AFL 20-53.4 and PIN 21-28-ASC.

- Residents who are close contacts should quarantine for 14 days, regardless of vaccination status, and should be tested at Day 5-7 after exposure. If negative, they remain in quarantine for 14 days; if symptoms develop then test immediately and notify their physician. If positive, they should be moved to the “red” isolation area.

- Residents who need to transfer out of the facility during quarantine should confirm with the facility that they are able to complete quarantine at their destination site.

- For resources and guidance on Isolation and Quarantine: contact COVID.OMG.SNF@sfdph.org

Staff Considerations:

Health Care Personnel (HCP) and Staff with a COVID-19 positive test or symptoms

Any HCP or Staff with a newly positive COVID-19 test, diagnosis of COVID-19, or COVID-19 symptoms must isolate, according to SF H.O. C19-07. See Box 1 for “Return to Work” criteria.

- For anyone with COVID-19 symptoms, see “Prevent staff from working while ill” and Box 1 below.

- HCP and staff who test positive and are symptomatic should be excluded from work, regardless of their vaccination status.

- Unvaccinated or partially vaccinated HCP and staff who test positive and are asymptomatic should be excluded from work to isolate for 10 days from the date of their positive test and continue to monitor for symptoms for 14 days. If they develop symptoms at any point, they enter the symptoms-based criteria for discontinuing isolation and must continue to isolate from 10 days of symptoms onset.

- Fully vaccinated HCP and staff who tested positive and are asymptomatic should be excluded from work for 10 days from the first positive test and continue to monitor for symptoms for 14 days.
  - If HCP shortages are present, HCP who test positive and are asymptomatic can continue to work following CDC guidance on mitigating staffing shortages, as long as they are caring only for residents with confirmed COVID-19, preferably in a cohorting setting. Asymptomatic positive HCP’s must maintain separation from other HCPs, including having a separate breakroom and restroom, and must wear a well-fitted mask for source control at all times while at the facility. Asymptomatic positive HCP may not care for residents who have not tested COVID-19 positive until at least 10 days from the date of their positive test, per AFL 20-53.

HCP high-risk exposures or close contacts

For HCP or staff with a close contact or high-risk exposure, follow the I&Q Directives and H.O. C19-07, AFL 20-53 and AFL 21-08. In the situation of a high-risk exposure or close contact:

- Asymptomatic vaccinated HCP do not need to work restrict following their exposure;
immunocompromised asymptomatic vaccinated HCP should consider work-restriction.

- Asymptomatic unvaccinated HCP must work-restrict for **14 days** from the date of last exposure **with or without testing**.
  - During critical staffing shortages, asymptomatic unvaccinated HCP are not prohibited from returning after **Day 7** from the date of last exposure if they have received a **negative PCR test result from a specimen collected after Day 5**.
- All must monitor for 14 days and if they develop symptoms, must enter work-restriction and follow isolation requirements as outlined in Box 1 or as I&Q Directives require.

**Staff working in quarantine or isolation areas**

- **Use full PPE** for any resident interaction in “red or yellow” areas
- **Unvaccinated staff** must work-restrict for 14 days if they’ve had a close contact² or high-risk exposure¹ (see definitions, a high-risk exposure is only if full PPE was not worn)
- **Fully vaccinated staff** do not need to work-restrict if they’ve had a close contact or high-risk exposure; they may continue to work and should self-monitor symptoms for 14 days.
- **Staff working in “red or yellow” areas** should not work in any other areas during that day, have their own breakroom and bathroom, and use full PPE regardless of vaccination status.

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**General Infection Prevention and Control Guidelines for COVID-19**

Preventing transmission from the community and staff to residents is essential. Using mitigation tools, such as vaccination, screening, ventilation, personal protective equipment, cohorting and testing, is crucial for infection prevention and control, among other methods discussed throughout this guidance.

1. **Vaccination**

Vaccination is one of the most effective tools for reducing the spread of COVID-19 infection. To reduce mortality and transmission of COVID-19, **all facilities must encourage vaccination among LTC facility residents and staff**. The following San Francisco Health Order C19-07 (July 8, 2021) (SF H.O. 19-07) supersedes CDSS PIN 21-14-ASC and state or federal guidance, which includes:

- **No later than September 15, 2021, High-Risk Settings (including LTC Facilities) will be required to**:
  - Ascertain vaccination status of all personnel who work onsite and ensure that all personnel are fully vaccinated unless exempt as defined in C19-07 Section 6b,
  - Require any unvaccinated exempt staff to:
    - Continue surveillance testing at least weekly; AND
    - Wear a well-fitted mask at all times at the workplace, except for limited periods while actively eating or drinking; AND
    - Provide a declination form to the LTCF with appropriate documentation for qualifying medical or religious exemptions.
  - The facility must:
    - Provide any unvaccinated exempt staff a well-fitted non-vented N95 on request and strongly encourage them to wear it at all times when working with patients or residents
Keep records of resident and employee vaccination status and provide these to the SFDPH within one business day of the request.

2. **Screen and monitor everyone for symptoms**

- All visitors, staff, vendors, residents returning from outings, and other individuals (except for 911 responders) should be screened for fever and symptoms per state and local guidance. Visitors should share contact information, in case contact tracing is needed later.

- Everyone should practice hand hygiene and wear properly-fitting face coverings to enter the building; **AFL 20-22** and **PIN 21-17-ASC** address face coverings for visitors, **AFL 20-74**, **PIN 21-19-ASC** (memory care and face coverings,) and **PIN 21-12-ASC** (face coverings, PPE).

Prevent staff from working while ill

COVID-19 infections often start from household or community-acquired illness among staff, who then transmit to others at facilities. Refer to San Francisco's Isolation and Quarantine directives, as well as the CDC’s Updated Healthcare Infection Prevention and Control in Response to COVID-19 Vaccination and CDC Return to Work criteria for healthcare personnel:

- Publicize and implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill employees to stay home. Facility HR should be aware of resources for positive or symptomatic staff, e.g. isolation and quarantine, food, cleaning supplies.

- **Symptomatic staff, regardless of vaccination status should notify their supervisor and NOT report to work. See Box 1 for “Return to Work Criteria.”**

- **Follow the San Francisco Isolation and Quarantine directives and the additional guidance outlined below for high-risk exposures and close contacts, including in outbreak settings.**

<table>
<thead>
<tr>
<th><strong>Box 1. Return to Work Criteria for LTC Facility Staff with confirmed or suspected SARS-CoV-2</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>HCP with mild to moderate illness who are not severely immunocompromised:</strong></td>
</tr>
<tr>
<td>• At least 10 days have passed <em>since symptoms first appeared</em> and</td>
</tr>
<tr>
<td>• At least 24 hours have passed <em>since last fever</em> (without the use of fever-reducing medications) and</td>
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<tr>
<td>• Symptoms are improving</td>
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<tr>
<td><strong>HCP who were asymptomatic throughout their infection and are not severely immunocompromised:</strong></td>
</tr>
<tr>
<td>• At least 10 days have passed since the date of their first positive viral diagnostic test.</td>
</tr>
<tr>
<td><strong>HCP with severe to critical illness or who are severely immunocompromised:</strong></td>
</tr>
<tr>
<td>• At least 10 days (and up to 20 days) have passed <em>since symptoms first appeared</em> and</td>
</tr>
<tr>
<td>• At least 24 hours have passed <em>since last fever</em> (without the use of fever-reducing medications) and</td>
</tr>
<tr>
<td>• Symptoms are improving</td>
</tr>
<tr>
<td>• Consider consultation with infection control experts</td>
</tr>
</tbody>
</table>
Recognize and respond rapidly to COVID-19 signs and symptoms in older adults

- Monitor all residents daily for fever $T>100.0$ and symptoms; residents in quarantine or observation should be monitored twice a day (or once a shift) and residents with confirmed or suspected COVID-19 infection should be monitored twice a shift or every 4 hours.

- People with COVID-19 have a wide range of symptoms, from mild to severe illness. Recognize atypical symptoms of COVID19 seen among older individuals, because these can often predict worsening and hospitalization: changes mental status (e.g., lethargy, confusion, agitation, or behavior change), poor oral intake, and/or falls or weakness.

- Facilities should train staff to recognize the signs and symptoms above, and to contact the resident’s medical provider as soon as they suspect typical or atypical symptoms of illness.

- Special Considerations for Memory Care and Behavioral Units:
  - Prioritize Memory Care units and behavioral units (locked units) for early, aggressive measures to prevent infection. These units can be challenging for infection control because PPE and cleaning supplies may need to be locked up, and ambulatory residents can sometimes be difficult to redirect. An outbreak on such a unit has the potential for rapid transmission.
  - In addition to universal masking/face coverings, hand hygiene and social distancing for both staff and residents. Consider the following per PIN 21-19-ASC
    - Supervised hand hygiene for residents.
    - Opening windows for ventilation when feasible, safe, and secure.
    - Cohort specific staff to the memory unit or behavioral unit alone.
    - Frequent Infection Control team spot checks for adherence on the unit.
    - Cordon off an area of the memory unit to use as an COVID-19 isolation/cohort area.
    - Creative strategies to keep ambulatory residents out of the rooms of residents under cohorted in non-exposed and exposed groups (e.g., “bus stop” or “bookshelf” ideas) isolation.

3. Ventilation

Viral transmission is primarily airborne through small viral particles in tiny droplets, and occasionally contact when droplets land on mucous membranes. The HIGHEST RISK of transmission is wherever masks are taken off indoors, even among fully vaccinated individuals, due to less than perfect effectiveness of vaccines, variants, and host factors. With lower risk of transmission outdoors, facilities should:

- Maximize fresh air circulation in the facility. Follow SFPDH guidance.
- Avoid overcrowding, even among fully vaccinated individuals
- Post visual cues prompting adequate ventilation. Breakroom signage can be found here.

4. Personal Protective Equipment

Provide specific training on transmission-based precautions and appropriate use of PPE.

- Ensure that all staff have been fit-tested for N95 respirators. When fit-testing staff, reinforce
procedures to prevent the spread of infection and staff exposure/shortages. Fit-testing is valid for one year; skilled nursing facilities should renew fit-testing annually.

- Please refer to SF Health Order C19-07 and:
  - For RCFs, PIN 21-12-ASC, PIN 21-17.2-ASC, PIN 20-23-ASC.
  - For SNFs, see AFL 20-74, AFL 20.22, and CDC guidance.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>COVID Positive Residents (Red Area)</th>
<th>Symptomatic, Suspected COVID, Awaiting Test Results (Yellow PUI, Single Room if Available)</th>
<th>COVID Exposed Residents (Yellow-Exposed)</th>
<th>Newly Admitted Residents Under Observation (Yellow-Observation)</th>
<th>Residents with No Known Exposure or COVID Recovered (Green Area)</th>
</tr>
</thead>
<tbody>
<tr>
<td>N95 respirator</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes, if not fully vaccinated; if fully vaccinated, facemask sufficient</td>
</tr>
<tr>
<td>Eye Protection</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No, but advise if risk of droplet exposure to mucous membranes</td>
</tr>
<tr>
<td>Gowns</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>As needed per Enhanced Standard precautions</td>
</tr>
<tr>
<td></td>
<td>-Extended use permitted in supply crisis, except for residents with known multidrug resistant organism. Maintain clean areas on unit where gowns are worn such as nurses' station.</td>
<td>-Extended use NOT recommended. 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.</td>
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<td>As needed per Enhanced Standard precautions</td>
</tr>
<tr>
<td>Gloves with hand hygiene before donning and doffing</td>
<td>Yes, upon room entry and between residents (if multi-occupancy room)</td>
<td>Yes, upon room entry and between residents (if multi-occupancy room)</td>
<td>Yes, upon room entry and between residents (if multi-occupancy room)</td>
<td>Yes, upon room entry and between residents (if multi-occupancy room)</td>
<td>As needed per Enhanced Standard precautions</td>
</tr>
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5. **Hand Hygiene and Disinfection**

**Hand Hygiene:**

- Maintain hand hygiene for residents and staff, especially when entering the building, entering/exiting meal areas or break rooms, exiting bathrooms, and before/after communal activities. Ideally, soap and water are best for hand hygiene. Maintain running warm water, soap, and paper towels for handwashing; avoid hand-driers that blow air to avoid spreading aerosols.

- The use of 60-95% alcohol-based sanitizer dispensers outside resident rooms and other resident care and common areas (e.g., outside dining hall, upon entering common activity room, in therapy gym, elevator landings) can substitute for handwashing if sinks are not available.

- Post signs encouraging hand hygiene and cough etiquette; visual cues improve adherence. A hand hygiene sign with multiple translations is available for download here.
Disinfection

- Clean all surfaces at least daily or more often as per CDC guidance, especially “high-touch” surfaces (every 2 hours if SNF). Use EPA-registered, healthcare-grade disinfectants that are effective against COVID-19; staff should know drying times.
- Work with staff to identify high-touch surfaces such as door handles, bed rails, and bathroom fixtures, mobile medical equipment, and other shared resident care equipment. Commonly overlooked items include bed alarms, PPE carts, light switches, and med carts.

6. Distancing

In general, maintaining 6 feet reduces the risk of droplet transmission and reduces overcrowding. Greater distances may be safer, depending on the aerosol-generating activity, rate of shedding of the individual, source control, and susceptibility of others.

- Refer to PIN 21-17.2-ASC and AFL 20-22 re: distancing during visitation and among residents during dining and communal activities, which considers vaccination status.

Testing Guidance

State guidance is rapidly changing in response to case rates, vaccination status, and CDC recommendations. Please refer to AFL 22-08, AFL 20-53 and PIN 21-28-ASC, PIN 20-23-ASC for testing guidance, as well as SF H.O. C19-07. Any updates to the Health Orders, AFLs and PINs will supersede this guidance.

- Diagnostic Screening testing: for asymptomatic residents and/or staff without close contact or high-risk exposure to a positive case:
  - New/re-admissions: Fully vaccinated SNF residents without known close contact to a positive case within the last 14 days do not need admission testing or quarantine; all new RCF residents should be tested prior to moving into a facility, ideally with PCR and ordered by the primary care provider.
  - If SNF resident is returning after >24-hour outing, consider that resident a new admission to the LTC facility. RCF residents may go back to their original area even if >24-hour outing, if no known exposures to a positive case while away from the facility.
  - LTC facility staff: per AFL 20-53 and PIN 21-28-ASC, if at least 70% of facility staff AND at least 70% of residents are fully-vaccinated, then fully-vaccinated, asymptomatic LTCF staff can stop weekly surveillance testing. If fewer than 70% staff or 70% of residents are fully vaccinated, then all staff must continue asymptomatic diagnostic screening testing.
    - LTC facilities must calculate this daily and if less than 70% for either staff or residents then all staff must resume weekly testing for two weeks until one (1) week after reaching 70% for both categories again.
    - LTC facilities may consider continued diagnostic screening testing and work restriction for fully vaccinated staff with underlying immunocompromising conditions (e.g. organ transplantation, cancer treatment, prednisone 20mg daily for more than two weeks)
  - If LTC facility residents or staff are asymptomatic and previously tested positive within the last 90 days, they should not undergo surveillance testing unless symptomatic.
• **Response testing:** As soon as possible after one (or more) COVID-19 positive individuals (residents or staff) is identified in a facility, serial retesting of all residents and HCP who test negative upon prior testing rounds (regardless of vaccination status) should be performed every 3 to 7 days until no new cases are identified among residents in sequential rounds of testing over 14 days. The facility may then resume their previous routine screening testing schedule for HCP.
  
  - For RCFs, CCRC independent living residents may be excluded from response testing unless they have been in communal settings with other residents, regardless of vaccination status.
  
  - If LTC facility residents or staff are asymptomatic and previously tested positive within the last 90 days, they should not undergo surveillance testing unless symptomatic.

• **Symptomatic testing:** Regardless of vaccination status or prior positive test, all residents and/or staff who are symptomatic need to test immediately.
  
  - Facilities using antigen testing should follow SFDPH guidance (twice a week testing)
  
  - Facilities using PCR or other molecular testing should refer to AFL 20-53 or PIN 20-23-ASC; if turnaround time is longer then 48hrs, then consider antigen testing twice a week.

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**Resident Cohorting and Zoning**

Cohorting is a strategy for controlling transmission in which you group residents into specific units or pods treated by assigned staff or HCPs. Consider designating entire units or pods within the facility, and cohort staff to care separately for known, suspected, or non-exposed COVID-19 residents during their shift. The ability to separately house suspected and confirmed individuals will vary by facility, and this decision can be made on case-by-case basis in consultation with SFDPH. See AFL 20-74 for more information.

**Only residents with the same respiratory pathogen may be housed in the same room. For example, when feasible, a resident with COVID-19 should not be housed in the same room as a resident with influenza or an undiagnosed respiratory infection.**

<table>
<thead>
<tr>
<th>California Department of Public Health, Healthcare-Associated Infections Program COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recommendation</strong></td>
</tr>
<tr>
<td>Resident placement and movement considerations</td>
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</tbody>
</table>

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Bed Placement of Residents

Facilities should designate three main areas for (1) COVID-19 positive, (2) residents under quarantine or observation, and (3) COVID-19 negative or other residents. Under this consideration, if there is a shortage of private rooms:

- **Residents with confirmed COVID-19** may room together in a designated unit/area for residents with lab-confirmed COVID-19 infection.

- **Residents with suspected COVID-19 and test results pending** should be isolated in a private room with their own bathroom. If that is not possible, please discuss I&Q referral with SFDPH to minimize exposure to susceptible patients and staff.

- **Asymptomatic roommates of positive residents** should be considered close contacts and exposed to COVID-19. *Avoid placing exposed residents in a new room with residents who do not have known exposure to COVID-19.* They should be roomed as described below, in order of desirability.

1. *(Preferred) Move exposed roommate to a private room, preferably with a private bathroom.*

2. *(Alternative) Move the resident with known COVID-19 out of the room where the exposure occurred. Keep the exposed roommate in the original room without a new roommate.*

3. If bed capacity, staffing availability, or other constraints prevent the first 2 placement options, it is reasonable to keep the roommate in the same room as the suspect/known COVID-19 case. This is preferable to having the roommate share a room with residents who do not have known exposures to COVID-19. If this is the case, to mitigate potential ongoing risks of transmission to the roommate:
   - Place resident beds as far apart as possible. Instruct mobile residents to socially distance (stay 6 feet away) from their roommate while in the room.
   - Place a surgical mask on the resident with suspected or known COVID-19 resident, if tolerated.
   - Open windows for ventilation if safety, security, and weather allow.
   - Enhance/increase frequency of daily environmental cleaning of the room, focusing on shared bathroom and high-touch surfaces. Try to designate one bathroom for use by sick residents.
   - Sick residents should take their meals in their rooms when possible, avoid common areas, and if they must enter common areas, they should wash hands before entering.

- **Residents who are new admissions/re-admissions** should be managed according to CDC guidance, using PIN 20-23-ASC and AFL 20-74, AFL 21-08.2:
  - **If fully-vaccinated AND no history of close contact** to positive individual or exposure within the last 14 days, residents may be admitted to the “green” area without quarantine, per AFL 21-08 and PIN 20-38-ASC.
  - **If COVID-19 status is unknown** or there is no history of COVID-19 and not yet fully-vaccinated: resident should be quarantined in a single-person room or in a designated observation area “yellow” area so the resident can be monitored for signs of COVID-19 for 14 days. Residents should be tested on admission and at Day 12, and may exit quarantine after 14 days if both tests are negative and the resident remains asymptomatic.
  - **If residents are COVID-19 positive AND have completed 10- or 20-day isolation confirmed by SFDPH Medical Branch COVID-19 transfer coordinator:** residents may be admitted into the “green” or “green-recovered red” area.
• **Considerations for residents in Memory Care or Behavioral Units**
  - The benefits of transferring a resident with known or suspected COVID-19 infection from a Memory Care or Behavioral Unit to a designated COVID-19 or quarantine unit must be weighed with the risks of such transfers, especially if significant exposure has already occurred for other residents and staff in the locked unit. Such a transfer may have adverse effects, including potential falls, and can be extremely distressing and disorienting for the resident.
  - Transfers should be carefully planned to minimize exposure when moving through the building. The ability of the receiving COVID-19 or observation unit to keep the resident from wandering after transfer should also be considered.
  - Please consult SFDPH I&Q referral for assistance with placement.

### Transfer of Patients with COVID-19 to LTC Facilities

- Per CDPH, patients with COVID-19 may be transferred to LTC facilities if they are clinically stable, even if they still require isolation/transmission-based precautions. CDSS also permits transfers per [PIN 20-38](https://example.com).

- All new admissions/readmissions who have been diagnosed with COVID-19 or a positive test must have the approval of transfer and new admission/readmission from SFDPH Hospital Unit’s COVID-19 transfer coordinator per [AFL 20-33](https://example.com) at DPH.DOC.Hospitalunit@sfdph.org

- [A checklist for LTC Facility to accept a resident with suspected or known COVID-19](https://example.com) is posted here.

### Visitation, Communal Dining and Activities

Socialization and meaningful connection are important to mental and physical health, especially among LTC facility residents; visitation guidance is rapidly shifting for LTC facilities. Facilities should continue to offer options to connect with loved ones virtually ([www.sfcdcp.org/safersocial](https://www.sfcdcp.org/safersocial)). Please note that outdoor is safer than indoor visitation, whenever possible. **California State guidance on visitation is rapidly changing as rates of vaccination increase and testing is widely available. Facilities are now directed to adhere to California state policies and regulations.**

**Visitation**

[AFL 20-22](https://example.com) and [PIN 21-17-ASC](https://example.com) encompass visitation definitions, requirements, and recommendations for outdoor and indoor visitation, as well as resident communal dining and communal activities. In all circumstances, facilities must update prevention and mitigation activities to reduce the risk of COVID-19 transmission and maintain a mitigation plan per state guidance.

- Outdoor visitation is lower risk and should be an option whenever possible; this may include car and window visitation. Indoor communal visitation is preferable to in-room visitation if facilities are able to accommodate and equitably maintain visitations for all residents.

- Visitors are not required to show proof of vaccination or testing; however, they must adhere to the facility’s requirements for infection prevention, contact information, and should report any symptoms that arise within 14 days of their last contact with the facility.
• Residents may choose to have varying levels of physical contact with visitors if the resident is fully-vaccinated, depending on AFL 20.22 or PIN 21-17-ASC.
• SNF residents who return within 24 hours of an overnight outing and who have not had close contact with positive cases may return to their facility area; however, if returning from an outing >24hrs, the resident should be considered a new admission.
• RCF residents who have not had close contact with positive cases may return to their facility area regardless of duration of outing; see PIN 21.17-ASC.
• LTC facility residents with close contact or high-risk exposure during an outing need to quarantine upon return to the facility for 14 days after last exposure, regardless of vaccination status.
• Residents in CCRCs who live independently are generally exempt from testing and visitation requirements if they have not been in communal settings with other CCRC residents. Exceptions to being exempt from testing requirements include residents who are symptomatic, exposed to a person who is positive, moving into the facility, or returning from being treated in the hospital.

Communal Dining

Communal dining applies to residents of a LTC facility and does not yet include visitors. Facilities should refer to AFL 20-22 and PIN 21-17-ASC or any versions that supersede them. Highlighting:
• Residents may participate in all communal dining and activities regardless of vaccination status (unless they are in isolation or quarantine).
• Residents should maintain face coverings except when eating or drinking. If all staff and all residents are fully vaccinated, it may be possible to remove face coverings in the dining area. However, if vaccination status is unclear for any residents, then everyone should keep face coverings on unless eating or drinking.
• Cohort diners into consistent groups to minimize exposure, in case someone later tests positive.
• Residents should perform hand hygiene upon entering the dining room and before leaving, regardless of vaccination status.
• Maintain adequate ventilation with fresh air before, during, and after meals as safety, security, and air quality/weather allow.
• Staff considerations:
  o Continue to reinforce excellent hand hygiene and mask use before, during, and after meal service.
  o Indoor spaces without windows or with poor ventilation where masks are taken off (e.g. break rooms, conference rooms) are highest risk for transmission, we strongly encourage using a portable air cleaner if electrical and operational load allow.

Communal Activities

Residents may engage in small group activities. Consider prioritizing activities that meet the following safety guidelines AND support the quality of life of the frailest, most isolated residents who are least able to access other sources of support and activity.
• Any activities that can be done outdoors safely should be done outdoors.
• Staff are responsible to ensure social distancing, masking, and hand hygiene are performed correctly. Maintain required staffing ratios to ensure safety.
• If patients or non-vaccinated staff can enter the area during the staff activity, then all staff should use appropriate face coverings and distance, per AFL 20-22 and H.O. 19-07.
• The space should be adequately ventilated, for example, by opening windows or doors as safety, security, and weather allow; keep areas well-ventilated for 1-2hrs after use.
• The space should be cleaned thoroughly between groups.
• Singing, chanting, aerosol-generating aerobic activity are extremely high-risk for transmission and should be avoided indoors.
• Residents may participate in all communal dining and activities regardless of vaccination status if not in isolation or quarantine to prevent discriminatory actions; if vaccination status is unknown, everyone present should use face coverings.

Additional Resources

Stay informed. Information is changing rapidly. Updated CDC, local and state COVID-19 activity and recommendations can be found at:

• **Centers for Disease Control and Prevention (CDC)**
  o Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes
  o Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination
  o Return to work criteria for healthcare personnel (updated guidance)

• **CMS COVID-19 Long-Term Care Facility Guidance (revised)**

• **San Francisco Department of Public Health (SFDPH)**
  o [www.sfcdcp.org/covid19](http://www.sfcdcp.org/covid19)

• **California Department of Public Health (CDPH)**
  o All Facilities Letters: [https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL.aspx](https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL.aspx)

• **California Department of Social Services (CDSS)**