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

UPDATED November 24, 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 State and City Health Orders, CDPH, and CDSS guidance will supersede this document. Facilities are responsible for following updates by CDPH or CDSS in a timely manner and for updating Mitigation Plans required by their licensing bodies.

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 the 08/30/21 Version

- Updated communal dining guidance for visitation, per AFL 20-22.9 and PIN 21-49.
- Updated recommendations for visitors to include considering testing within 72 hours before travel or gathering with others regardless of vaccination status.
- Continue immediate reporting of suspected or confirmed COVID-19 cases to SFDPH.

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 CDPH and CDSS guidance.

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

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**SFDPH COVID-19 Disease Response Unit (CDRU)**

COVID.LTCF@sfdph.org or (415) 554-2830 is available 7 days per week. After hours, if needed, please call (415) 554-3613 to reach the on-call physician. Notify SFDPH CDRU within one hour of:

- Suspected or lab-confirmed positive SARS-CoV-2 test in residents or staff, or
- Three 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.

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

1. **Isolate positive individual(s):** see Zoning section and AFL 20-74.1; for RCFs, see PIN 21-12-ASC. Residents should not leave their room for meals and should 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 CDRU as written above. For facilities facing I&Q challenges, SFDPH may help refer to I&Q sites.
4. **Test** close contacts – initiate testing response (see Testing section).
5. **Cohort residents** into Red/Yellow/Green areas 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).

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\(^{1}\)An outbreak in a LTCF is one or more facility acquired COVID-19 cases in a resident. Thresholds for additional investigation and mandatory reporting to the health department are noted in AFL 20-75.

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

\(^{3}\)A close contact is an individual that was within 6 feet of an COVID-19 infected person for > 15 mins in a 24-hour period.
6. Facilities in outbreak status must stop admissions. Following approval from the SFDPH CDRU, admissions may resume if facilities demonstrate sufficient infection control measures and complete 14 days of negative response testing per AFL 20-87.1.

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

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

**Resident Considerations**

**Quarantine: Three categories of residents in observation**

1. **Symptomatic residents (PIUs):**
   - 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. Those who must leave should wear a facemask, as tolerated.
   - Symptomatic residents should be tested immediately with PCR or antigen; if positive then moved to the “red” 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 and placed in quarantine for 14 days from the last date of exposure, regardless of vaccination status, while they undergo serial testing (see Testing Section).
     - Asymptomatic close contacts of the same positive case may be roomed together in observation.

3. **New resident admissions or re-admissions:**
   - Unvaccinated and incompletely vaccinated residents who are newly admitted or transferred need to be tested upon admission (unless testing was completed within 72 hours prior to transfer) and at the end of quarantine to exit quarantine after Day 14 if they remain asymptomatic, AFL 20-53.5. For readmissions see AFL 20-87.1.
   - Unvaccinated or incompletely vaccinated residents who leave the facility for <24 hours and return to the facility should be tested 5-7 days after their return; unvaccinated and incompletely vaccinated residents who leave the facility for >24 hours should be quarantined in the yellow-observation area for 14 days and tested prior to return to their usual room in green-unexposed/recovered area, per AFL 20-22.9.

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4 Unvaccinated and incompletely vaccinated refers to those that have not completed the COVID-19 vaccine series. In general, people are considered fully vaccinated: 2 weeks after their second dose in a 2-dose series or 2 weeks after a single-dose vaccine.
SNFs should consider periodic (for example, weekly) diagnostic screening testing for unvaccinated and partially vaccinated residents who regularly leave the SNF for dialysis; in the absence of suspected or confirmed COVID-19 transmission at the dialysis center, residents who leave the facility for dialysis do not need to be quarantined in a "yellow-observation" or "yellow-exposed" area, per AFL 20-53.5.

RCF residents may go back to their original area even if >24-hour outing, if they did not have a close contact while away from the facility, per PIN 21-17-ASC.

- Fully vaccinated residents with history of close contact within 14 days prior to admission should complete quarantine and testing as well per AFL 21-08.5, AFL 20-22.9.
- Fully vaccinated new admissions or readmissions without a history of close contact in the prior 14 days are not required to quarantine per AFL 20-22.9, AFL 21-08.5. If the hospital of discharge has known COVID-19 transmission, it may be decided to have new residents undergo quarantine in consultation with SFDPH.
- Testing and quarantine are not required for hospitalized residents who tested positive for COVID-19 and met criteria for discontinuation of isolation and precautions prior to SNF admission or readmission. See AFL 20-87.1, AFL 21-08.5, AFL 20-53.5.

Guidance on removing residents from quarantine

- New admissions who are not yet fully vaccinated and in quarantine should have a negative PCR on or 72 hours prior to admission and retested prior to exit (Day 14), per AFL 20-53.5.
- Residents who had close contact outside the facility should quarantine in the “yellow-observation” area for 14 days, regardless of vaccination status, and should be tested immediately, at Day 5-7 after exposure and at the end of quarantine (AFL 20-87.1, AFL 20-22.9, PIN 21-17.2-ASC and CDPH Testing Guidance). 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 were exposed due to a positive case within the facility should immediately follow the Resident Placement section and Response testing section below.
- 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.
- RCFs should see PIN 21-17.2-ASC and PIN 21-12-ASC for recommendations on removing residents from quarantine.
- For resources and guidance on Isolation & Quarantine, contact COVID.LTCF@sfdph.org.
Symptomatic residents with COVID-19 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, per AFL 20-80.

Asymptomatic residents that have tested positive for COVID-19 should complete 10 days of isolation from first day of positive testing, unless immunocompromised.

- Severely immunocompromised resident COVID-19 cases or cases that required ICU level care could extend up to 20 days of isolation per AFL 20-53.5 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.

RCFs should follow the guidance outlined in PIN 21-12-ASC and PIN 20-23-ASC.

**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.
  
  - HCP and staff who test positive and are symptomatic should be excluded from work to isolate for 10 days from the date of symptoms onset, regardless of their vaccination status. For anyone with COVID-19 symptoms, see “Prevent staff from working while ill” and Box 1 below.

- 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. 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. If there was a known close contact continue to monitor for symptoms for 14 days, see below.

- Fully vaccinated HCP and staff who tested positive and are asymptomatic should be excluded from work for 10 days from the first positive test.
  
  - 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 N-95 mask for source control at all times. 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 20-53.5.

**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 20-53.5 and AFL 21-08.3. 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.
  - **When community transmission is high and given new variants in our community, facilities may consider more restrictive measures to prevent the spread of COVID-19, such as testing asymptomatic vaccinated staff with close community contact.** See SF’s Isolation and Quarantine Guidance for more information: [https://www.sfdph.org/dph/COVID-19/Isolation-and-Quarantine.asp](https://www.sfdph.org/dph/COVID-19/Isolation-and-Quarantine.asp).
- 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; If symptoms develop, individuals must follow isolation requirements immediately, as outlined in Box 1 or as I&Q Directives.

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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, vaccination is required for LTC Facilities employees. For employees eligible for a booster, guidance is available here. The California Health Orders are summarized here.

The key requirements for SNFs are to:
o Ensure that all workers are fully vaccinated\(^5\) or have submitted an approved exemption.

o Ascertain vaccination status of all personnel who work onsite; refer to CDPH Health Order August 5, 2021, and AFL 21-28 for approved vaccination documentation.

o Require any exempt unvaccinated staff to:
  • Test for COVID-19 at least twice weekly in long-term care settings OR at least once weekly in high-risk congregate settings (see AFL 21-28, AFL 21-29 and PIN 21-32.1-ASC, and the Diagnostic Screening Testing section for cadence details); AND
  • Wear a surgical mask or higher-level respirator at all times in patient or resident accessible areas at the workplace, except for limited periods while actively eating or drinking; AND
  • Provide a declination form to the LTC Facility with appropriate documentation for qualifying medical or religious exemptions.

o The facility must:
  • Provide all exempt unvaccinated staff a well-fitted non-vented N95 in settings where residents have access or care is provided and/or an FDA-cleared surgical masks in any setting that does not require a respirator.
  • Keep records of resident and employee vaccination status or exemption and provide these to health authorities within one business day of the request.

2. Screen and monitor everyone for symptoms

o 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.

Prevent staff from working while ill

o 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 below for “Return to Work Criteria.”

\(^5\)Fully Vaccinated (referred to as vaccinated) means individual have completed the full series of vaccination for COVID-19: In general, people are considered fully vaccinated: 2 weeks after their second dose in a 2-dose series, such as the Pfizer or Moderna vaccines, or 2 weeks after a single-dose vaccine, such as Johnson & Johnson’s Janssen vaccine (CDC).
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.

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 COVID-19 seen among older individuals, because these can often predict worsening and hospitalization: changes in 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.

### BOX 1. Return to Work Criteria for LTC Facility Staff with confirmed or suspected SARS-CoV-2

<table>
<thead>
<tr>
<th>HCP with mild to moderate illness who are not severely immunocompromised:</th>
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<tbody>
<tr>
<td>- At least 10 days have passed since symptoms first appeared, and</td>
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<tr>
<td>- At least 24 hours have passed since last fever (without the use of fever-reducing medications), and</td>
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<tr>
<td>- Symptoms are improving.</td>
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<tr>
<th>HCP who were asymptomatic throughout their infection and are not severely immunocompromised:</th>
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<tr>
<td>- At least 10 days have passed since the date of their first positive viral diagnostic test.</td>
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<tr>
<th>HCP with severe to critical illness or who are severely immunocompromised:</th>
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<tbody>
<tr>
<td>- At least 10 days (and up to 20 days) have passed since symptoms first appeared, and</td>
</tr>
<tr>
<td>- At least 24 hours have passed since last fever (without the use of fever-reducing medications), and</td>
</tr>
<tr>
<td>- Symptoms are improving.</td>
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<tr>
<td>- Consider consultation with infection control experts.</td>
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### 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 CDPH 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.**

- Everyone should practice hand hygiene and wear properly fitting face coverings to enter the building. **Facilities must strictly adhere to CDPH Masking Guidance and continue to adhere to Cal/OSHAs standards for aerosol transmissible diseases and emergency temporary standards.**

- In addition, refer to SF Health Order C19-07y and CDPH Health Order July 26, 2021, as well as: PIN 21-38-ASC (supersedes PIN 21-12-ASC and PIN 21-17.2 on masking), PIN 20-23-ASC, AFL 20-74.1 and CDC guidance.

- For residents in Memory Care refer to AFL 20-74.1, PIN 21-19-ASC.

<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>
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<tbody>
<tr>
<td>Recommendation</td>
</tr>
<tr>
<td>N95 respirator</td>
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<tr>
<td>Eye Protection</td>
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- **Gowns**
  - Extended use permitted in supply crisis, except for residents with known multidrug resistant organism - Maintain clean areas on unit where gowns are not worn such as nurses’ station
  - 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.
  - 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.
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  - 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.

- **Gloves with hand hygiene before donning and doffing gloves**
  - Yes, upon room entry and between residents (if multi-occupancy room)
  - Yes, upon room entry and between residents (if multi-occupancy room)
  - Yes, upon room entry and between residents (if multi-occupancy room)
  - Yes, upon room entry and between residents (if multi-occupancy room)

5. Hand Hygiene and Disinfection

**Hand Hygiene**
San Francisco Department of Public Health

Guidance

- 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. Physical 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 viral shedding of the individual, source control, and susceptibility of others.

- Refer to PIN 21-17.2-ASC, PIN 21-49-ASC, and AFL 20-22.9 re: distancing during visitation and among residents during dining and communal activities, which considers vaccination status.

7. 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.
- Cording off an area of the memory unit to use as a COVID-19 isolation/cohort area.
- Creative strategies to keep ambulatory residents out of the rooms of residents under cohoorted in non-exposed and exposed groups isolation.

## Testing Guidance

State guidance is rapidly changing in response to case rates, vaccination status, and CDC recommendations. Please refer to [CDPH Health Orders July 26, 2021](#) and [August 5th, 2021, AFL 21-28, AFL 21-29, AFL 20-53.5](#), [PIN 21-32.1-ASC, PIN 20-23-ASC](#) for testing guidance, as well as [SF H.O. C19-07y](#). Any updates to the Health Orders, AFLs and PINs will supersede this guidance.

1. **Symptomatic testing:** Regardless of vaccination status or prior positive test, all residents and/or staff who are symptomatic need to test immediately.

2. **Diagnostic Screening testing:** For asymptomatic residents and/or staff without close contact or high-risk exposure to a positive case. In all instances, LTC Facility resident/staff that are asymptomatic and previously tested positive within the last 90 days, they should not undergo surveillance testing unless symptomatic.

### Residents:

- 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.
- Fully vaccinated SNF residents who leave the facility for non-essential purposes (e.g., to go out to a restaurant or visit family in their home) do not need to quarantine upon return per, [AFL 21-08.5](#).
- Unvaccinated SNF residents who leave the facility for <24 hours and return to the facility should be tested 5-7 days after their return; unvaccinated and incompletely vaccinated residents who leave the facility for >24 hours should be quarantined in the yellow-observation area for 14 days and tested prior to return to their usual room in green-unexposed/recovered area.
- 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.
- All 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.

**HCPs/staff:**

- **Unvaccinated HCP in SNFs:**
  - HCP who are unvaccinated or incompletely vaccinated must undergo at least twice weekly SARS-CoV-2 diagnostic screening testing. Certain staff may require different cadence of testing, refer to AFL 21-28 and AFL 21-29.

- **Vaccinated HCP in SNFs:**
  - Diagnostic screening testing of asymptomatic fully vaccinated employees is not required if >70% of both residents and staff is met. See AFL 20-53.5 for vaccinated HCP diagnostic screening testing considerations.
  - Facilities may consider diagnostic screening testing in individuals with underlying immunocompromising conditions (e.g., organ transplantation, cancer treatment), which might impact the level of protection provided by COVID-19 vaccine.

**2. Response testing:** As soon as possible after one or more COVID-19 positive individuals (resident/staff) is identified in a facility, serial retesting of all residents and HCPs 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.
- See the Isolation and Quarantine section for testing following close contact exposures in the community for high-risk setting staff.

### 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. 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 20-74.1 for more information.
Bed Placement of Residents

- 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.

- Residents who are new admissions/re-admissions should be managed according to CDC guidance, using PIN 20-23-ASC and AFL 20-53.5, AFL 20-74.1, AFL 21-08.5:
  
  - 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 21-08.5 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.

- 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 both/all residents in the room, 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.

   **Special 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.
Per AFL 20-33.2 and PIN 20-38, patients with COVID-19 may be transferred to LTC facilities if they are clinically stable, even if they still require isolation/transmission-based precautions.

All new admissions, readmissions, or interfacility transfers diagnosed with COVID-19 must have the approval from SFDPH Hospital Unit’s COVID-19 transfer coordinator at DPH.DOC.Hospitalunit@sfdph.org.

A checklist for LTC Facility to accept a resident with suspected or known COVID-19 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. LTC Facilities should consider, in consultation with their local health department, reimplementing limitations on communal activities and dining based on the status of COVID-19 infections in the facility.

**Communal Dining**

Facilities should refer to AFL 20-22.9, PIN 21-49-ASC, and PIN 21-17.2-ASC, or any versions that supersede them. If there are differing requirements between the most current CDC, CDPH, CDSS, CDDS, and local public health department guidance or health orders, licensees should follow the strictest requirements. The following highlights key messages on communal dining:

- **RCF residents and visitors:**
  - RCF residents not in isolation or quarantine may participate in communal dining and dine with their visitors, regardless of their vaccination status. Visitors must wear a well-fitting face mask except while actively eating or drinking.

- **SNF residents and visitors:**
  - Fully vaccinated residents who are not in isolation or quarantine may eat in the same room without physical distancing, and with their fully vaccinated visitors. Visitors and residents must wear a well-fitting face mask except while actively eating or drinking.
  - If any unvaccinated residents are dining in a communal area all residents should use source control when not eating and unvaccinated patients/residents should continue to remain at least 6 feet from others (e.g., limited number of people at each table and with at least six feet between each person).

- **Recommendations for all LTC Facilities:**
  - Consider testing within 72 hours before travel or gathering with others regardless of vaccination status, as you may have an asymptomatic infection.
  - Residents should perform hand hygiene upon entering the dining room and before leaving, regardless of vaccination status. Staff should continue to reinforce excellent hand hygiene and mask use before, during, and after meal service.
• Maintain adequate ventilation with fresh air before, during, and after meals as safety, security, and air quality/weather allow.

• 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.

Visitation
Indoor Visitation

o **Vaccination status of all visitors seeking indoor visitation at the facilities outlined in the August 26, 2021 H.O. must be verified.** RCFs are required to follow these standards, per the August 26, 2021 H.O. and should follow PIN 21-17.2-ASC and PIN 21-40-ASC. SNFs should refer to AFL 20-22.9 in addition to the H.O.s. In summary, for indoor visitation:
  • CDPH requires LTC Facilities to develop and implement processes for verifying the vaccination status of all visitors seeking indoor visitation.
  • **Indoor visitors who are unvaccinated or incompletely vaccinated** must show documentation of a negative SARS-CoV-2 test where the specimen collection occurred within 72 hours before each visit and for which the test results are available at the time of entry to the facility.
  • **Visitors who are visiting a resident in critical condition,** when death may be imminent, are exempt from the vaccination and testing requirements, however, must comply with all infection control and prevention requirements applicable for indoor visits.
  • **Visitors who are unable to adhere to the core principles of COVID-19 infection prevention or who have tested positive for COVID-19 should not be permitted** to visit or should be asked to leave. See AFL 20-22.9 for alternative visitation options and number of visitors.

  o **All visitors entering the facility, regardless of their vaccination status, must:**
    • Be screened for fever and COVID-19 symptoms and/or exposure within the prior 14 days to another person with COVID-19; if a visitor has COVID-19 symptoms or has been in close contact with a confirmed positive case, they must reschedule their visit, regardless of their vaccination status.
    • Wear a well-fitting face mask and perform hand hygiene upon entry and in all common areas in the facility. For visitor masking requirements, see PIN 21-38-ASC, AFL 20-22.9, and CDPH Guidance for the Use of Face Coverings.
      • Well-fitting face masks are required for visitation in resident rooms regardless of vaccination status. Don and doff PPE according to instruction by HCP, if required for contact with the resident due to quarantine or COVID-19 isolation status.
    • Follow physical distancing guidelines and maintain at least 6 feet distance from other visitors from different households, as well as from facility staff and other residents. If both the resident and visitor are fully vaccinated, they do not need to physically
distance and can include physical contact (e.g., hugs, holding hands), but must wear a well-fitting face mask while in the resident’s room; otherwise, unvaccinated or incompletely vaccinated visitors and residents must wear well-fitting face masks and maintain 6-ft physical distancing during their visit.

- Facilities should also 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. Indoor communal visitation is preferable to in-room visitation if facilities can accommodate and equitably maintain visitations for all residents. Visits for residents who share a room should be conducted in a separate indoor space or when the roommate is not present in the room, regardless of the roommate’s vaccination status.

**Outdoor visitation**

- Outdoor visits pose a lower risk of transmission due to increased space and airflow; therefore, outdoor visitation is preferred and should be offered unless the resident cannot leave the facility, or outdoor visitation is not possible due to precipitation, outdoor temperatures, or poor air quality.

- Outdoor visits between fully vaccinated residents and fully vaccinated visitors may be conducted without face masks and include physical contact (e.g., hugs, holding hands) while in designated spaces for visitation that maintain 6 feet distancing between the visitor and facility staff and other residents they are not visiting; otherwise, visits between residents or visitors that are unvaccinated or incompletely vaccinated should be conducted with well-fitting face masks during the visit and maintain 6 feet physical distancing.

**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.

- **Fully vaccinated residents who are not in isolation or quarantine may participate in group/social activities together without face masks or physical distancing; if any unvaccinated residents are present, then all participants in the activity should wear a well-fitting face mask and unvaccinated residents should physically distance from others.**

- **Communal activities where participants do not use source control and physical distancing should be carefully planned and monitored so that vaccination status of all participants can be verified and ensured throughout the activity.**

- **Staff are responsible to ensure social distancing, masking, and hand hygiene are performed correctly. Maintain required staffing ratios to ensure safety.**

- **The space should be adequately ventilated, for example, by opening windows or doors as safety, security, and weather allow; keep areas well-ventilated for 1-2 hours 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.
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)**

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

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

- **State and Local Reporting and Vaccination Requirements for Health Care and Congregate Setting**

- **California Department of Public Health (CDPH)**
  - 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)**