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

UPDATED February 1, 2022

Please be advised of two TEMPORARY visitation orders:

1. **A local visitation order** for skilled nursing facilities (SNFs) (also available in larger font), effective January 1st through February 15, 2022; and

2. **A CDPH order** regarding visitation requirements in long-term care settings, effective January 7th-February 7th, 2022 (see also: PIN 22-04-ASC):

Key restrictions from these orders include:

- Indoor visitors must take a rapid antigen test at the time of the visit.
- Residents are restricted to two visitors per day indoors.
- Indoor visitors must wear a well-fitted mask that meets criteria specified within the order.
- Outdoor visitors must show proof of negative antigen test done within 1 day prior to visitation, or a negative PCR test done within 2 days prior to visitation; on-site testing on the day of visit also fulfills this requirement.

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; LTCFs), 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 01/13/2022 Version**

- Added extension for local visitation order.
- Updated visitation guidelines for RCFs, in alignment with PIN 22-04-ASC.
- 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. **Testing guidance**
3. **Vaccination and other infection prevention and control guidelines for COVID-19**
4. **Special considerations for memory care and behavioral units:**
5. **Resident cohorting and zoning**
6. **Transfer of patients with COVID-19 to LTC facilities**
7. **Visitation, communal dining, and activities**
8. **Additional resources**

### Positive case: reporting, isolation, and quarantine

**Reporting**

Reporting a suspected or confirmed 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\(^3\).

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

<table>
<thead>
<tr>
<th>SFDPH COVID-19 Disease Response Unit (CDRU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact: <a href="mailto:COVID.Outbreak@sfdph.org">COVID.Outbreak@sfdph.org</a> or (415) 554-2830</td>
</tr>
</tbody>
</table>

Notify SFDPH CDRU promptly if:

- 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.

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

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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.
1. **Isolate positive or symptomatic individual(s);** see Zoning section and **AFL 20-74**; for RCFs, see **PIN 21-12-ASC**. Please note that San Francisco uses the standard of being up-to-date on vaccination\(^4\), instead of fully vaccinated.

2. Identify and **quarantine close contact residents** in accordance with **AFL 20-53**.

3. **Notify** SFDPH CDRU per Reporting section above.

4. **Test** close contacts. Initiate testing response (see Testing section).

5. **Cohort residents** according to symptoms, vaccination status, and testing results, as outlined in **AFL 20-53** and **PIN 21-49-ASC**. **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. **Outbreak status, admissions** during surges: see **AFL 21-08** and **AFL 20-87** on crisis and contingency planning for staffing shortages and collaborating with SFDPH to resume admissions during outbreaks.

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

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

### Isolation and quarantine

For information on SF specific Isolation & Quarantine (I&Q), Directives can be found at: [https://www.sfdph.org/dph/alerts/coronavirus-health-directives.asp](https://www.sfdph.org/dph/alerts/coronavirus-health-directives.asp). For local resources and guidance on Isolation & Quarantine for LTC Facilities, contact [COVID.Outbreak@sfdph.org](mailto:COVID.Outbreak@sfdph.org).

**Resident considerations: isolation of residents who test positive**

Per **AFL 20-53**, residents who test positive and are symptomatic should be isolated (regardless of their vaccination status) until the following conditions are met:

- At least 10 days have passed since symptom onset; AND
- At least 24 hours have passed since resolution of fever without the use of fever-reducing medications; AND
- Any other symptoms have improved

- See **AFL 20-53** for more guidance regarding individuals who are severely immunocompromised (e.g., currently receiving chemotherapy, or recent organ transplant), or who had critical illness (e.g., required intensive care).

\(^4\) Per [San Francisco H.O. C19-07y](https://www.sfdph.org/dph/alerts/coronavirus-health-directives.asp), “Up-to-Date on Vaccination” means (i) two weeks after completing the full initial course of vaccination with a vaccine authorized to prevent COVID-19 by the FDA, including by way of an emergency use authorization, or by the World Health Organization (WHO) (also defined as being Fully Vaccinated) and (ii) one week after receiving a Booster once a person is Booster-Eligible. Until a person is Booster-Eligible, they are considered Up-to-Date on Vaccination two weeks after completing their full initial series of vaccination.
Residents who test positive and are asymptomatic throughout their infection should be isolated for at least 10 days following the date of their positive test.

Resident considerations: observation or quarantine of residents

Refer to AFL 20-53, AFL 20-74, and PIN 21-49-ASC for guidance on: new resident admissions or re-admissions; symptomatic residents regardless of vaccination status; and asymptomatic residents who are not up-to-date on vaccinations and close contacts of positive individuals.

- Similar to AFL 20-53, SNFs that are able to contact trace and have ≥90 percent staff and residents up-to-date on vaccination may allow residents who are up-to-date on vaccination to monitor symptoms but not quarantine after close contact. This does not apply to SNFs with less than 90 percent staff and residents up-to-date on vaccination, or those unable to contact trace.

- Note that AFL 20-53 refers to “fully vaccinated” residents and HCP, but San Francisco uses the standard of up-to-date on vaccination—not just fully vaccinated—for residents; HCP are required by CDPH to be up-to-date on vaccination.

Guidance on removing residents from isolation or quarantine:

Facilities should refer to AFL 20-74, AFL 21-44, and AFL 20-53. When additional clinical input is needed, facilities should consult their infection preventionists and medical providers, and if needed, SFDPH. Additional clinical input is recommended for:

- Symptomatic staff who test negative for COVID-19 and other viral infections; they should not work if symptomatic and consider repeat testing with clinician input.

- Symptomatic residents who test negative for COVID-19 and other viral infections. They should remain in quarantine for 14 days with improvement in symptoms for 48 hours and afebrile (without fever reducing medicines) for at least 24 hours prior to exiting quarantine.

RCFs should follow the guidance outlined in PIN 21-49-ASC regarding exit from isolation or quarantine, with up-to-date on vaccination replacing fully-vaccinated in guidance for residents and staff.

Resident outings (leaving and returning to the facility):

NOTE: The AFLs below refer to “fully vaccinated” residents and HCP, but San Francisco uses the standard of up-to-date on vaccination—not just fully vaccinated—for residents where noted below; HCP are required by CDPH to be up-to-date on vaccination.
SNF residents who are up-to-date on vaccination and leave the facility do not need to quarantine upon return if they have not had known close contact with a positive individual during their outing, per AFL 20-22. Facilities should consult AFL 20-53 for additional guidance regarding close contacts.

Testing and 14-day quarantine are recommended for residents who are NOT up-to-date on vaccination and are readmitted after hospitalization or who leave the SNF for more than 24 hours, per AFL 20-53 and AFL 20-87.

Testing and quarantine are also recommended for residents who leave the SNF for ambulatory care (e.g., emergency department, outpatient procedures, dialysis or other clinic visits) when there is suspected or confirmed COVID-19 transmission at the outside facility, per AFL 20-53 and AFL 20-87.

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 21-49-ASC.

Residents who are NOT up-to-date on vaccination with close contact outside the facility should quarantine in the “yellow” area for 14 days. See Testing section below, as well as AFL 20-87, AFL 20-53, AFL 20-22, PIN 21-49-ASC. 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.

Health care personnel (HCP) and staff considerations: isolation and quarantine (work restriction)

Figure 1 below outlines work restriction (isolation and quarantine) guidelines for HCP, per AFL 21-08.

Any HCP or Staff with a newly positive COVID-19 test, diagnosis of COVID-19, or COVID-19 symptoms must isolate, regardless of vaccination status, according to AFL 21-08.

Asymptomatic positive HCP working during their first 10 days of COVID-19 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 the HCP’s positive test.

Positive HCP who meet criteria to work should use a fit-tested N95, self-monitor symptoms for 10 days, and must stop working if they become symptomatic.

Refer to CDC guidance for more information on HCP with severe to critical illness or who are moderately to severely immunocompromised.

For HCP or staff with a close contact or high-risk exposure, follow San Francisco H.O. C19-07y, AFL 20-53 and AFL 21-08.

Facilities may consider more restrictive measures to prevent the spread of COVID when community case rates are moderate or high, such as testing.
staff who are up-to-date on vaccination who had a close community contact (see [CDC guidance](#)).

- All HCP and staff must monitor for 14 days. If symptoms develop, individuals must test and follow guidance immediately, as outlined in [H.O. C19-07, AFL 20-53](#) and [AFL 21-08](#).

**Figure 1: HCP work restriction (isolation and quarantine) guidance tables, from [AFL 21-08](#)**

### Work Restrictions for HCP with SARS-CoV-2 Infection (Isolation)

<table>
<thead>
<tr>
<th>Vaccination Status</th>
<th>Routine</th>
<th>Critical Staffing Shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boosted, OR Vaccinated but not booster-eligible</td>
<td>5 days* with negative diagnostic test† same day or within 24 hours prior to return OR 10 days without a viral test</td>
<td>&lt;5 days with most recent diagnostic test† result to prioritize staff placement‡</td>
</tr>
<tr>
<td>Unvaccinated, OR Those that are vaccinated and booster-eligible but have not yet received their booster dose</td>
<td>7 days* with negative diagnostic test† same day or within 24 hours prior to return OR 10 days without a viral test</td>
<td>5 days with most recent diagnostic test† result to prioritize staff placement‡</td>
</tr>
</tbody>
</table>

### Work Restrictions for Asymptomatic HCP with Exposures (Quarantine)

<table>
<thead>
<tr>
<th>Vaccination Status</th>
<th>Routine</th>
<th>Critical Staffing Shortage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boosted, OR Vaccinated but not booster-eligible</td>
<td>No work restriction with negative diagnostic test† upon identification and at 5-7 days</td>
<td>No work restriction with diagnostic test† upon identification and at 5-7 days</td>
</tr>
<tr>
<td>Unvaccinated§, OR Those that are vaccinated and booster-eligible but have not yet received their booster dose§</td>
<td>7 days with diagnostic test† upon identification and negative diagnostic test‡ within 48 hours prior to return</td>
<td>No work restriction with diagnostic test† upon identification and at 5-7 days</td>
</tr>
</tbody>
</table>

*Asymptomatic or mildly symptomatic with improving symptoms, and meeting negative test criteria; facilities should refer to [CDC guidance](#) for HCP with severe to critical illness or moderately to severely immunocompromised.

† Either an antigen test or nucleic acid amplification test (NAAT) can be used. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for discontinuation of isolation and return-to-work for SARS-CoV-2 infected HCP and for HCP who have recovered from SARS-CoV-2 infection in the prior 90 days; NAAT is also acceptable if done and negative within 48h of return.

‡ If most recent test is positive, then HCP may provide direct care only for patients/residents with confirmed SARS-CoV-2 infection, preferably in a cohort setting.

§ Includes persons with prior infection.

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**Testing guidance**

Symptomatic testing:

Regardless of vaccination status or prior positive test, all residents and/or staff who are symptomatic need to test immediately. Test results depend on how much virus is in the sample at the time of the test so consider retesting in 2 days, especially if antigen test results are negative but symptoms persist.

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, should not undergo surveillance testing unless symptomatic.

Residents:

- Per AFL 20-53; SNF residents who are not up to date with vaccinations need to test on admission unless tested 72 hours prior to admission, quarantine, and test again before exiting quarantine.

- SNFs should consider periodic (for example, weekly) diagnostic screening testing for residents who are not up-to-date and regularly leave the SNF for dialysis or other regular medical visits; 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” area, per AFL 20-53.

- All new RCF residents should be tested prior to moving into a facility per PIN 21-17.2-ASC.

HCPs/staff:

- HCP who are unvaccinated or not up-to-date on vaccinations in SNFs:
  - HCP who are unvaccinated or have not received their booster but are booster-eligible must undergo at least twice weekly SARS-CoV-2 diagnostic screening testing. Certain staff may require different cadence of testing, refer to AFL 21-34, AFL 21-28 and AFL 21-29.

- HCP with up-to-date vaccination in SNFs:
  - Diagnostic screening testing of asymptomatic employees with up-to-date vaccination is not required.
  - 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.

Response testing:
Updated CDC guidance continues to recommend immediate investigation as a potential outbreak when one (or more) COVID-19 positive individuals (resident or HCP) is identified in a facility.

- SNFs should refer to AFL 20-53 when applying response testing options in facilities that are able to contact trace AND have ≥90% HCP and residents up-to-date on vaccination.

- Note that AFL 20-53, PIN 21-53-ASC and PIN 21-32.1-ASC refer to “fully vaccinated” residents and HCP, but San Francisco uses the standard of up-to-date on vaccination—not just fully vaccinated—for LTCF residents; HCP are required by CDPH to be up-to-date on vaccination.

- Per PIN 22-04-ASC, independent living residents are only exempt from response testing if they do not receive assisted living services or use any of the communal facilities (e.g. dining, activities, transportation) at their facility.

- See CDC Interim guidance for HCP for guidance on high-risk exposures in the community for HCP (e.g., household contact).

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**Vaccination and other 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.

**Vaccination**

Up-to-date vaccination prevents severe illness and death due to COVID-19. In San Francisco, up-to-date vaccination is required for LTC Facilities workers and highly encouraged for all residents and visitors. For employees eligible for a booster, guidance is available here. The California Health Orders are summarized here.

Under San Francisco H.O. C19-07y, all booster-eligible health care workers must receive their booster by March 1, 2022. Those not yet eligible for boosters must comply no later than 15 days after the recommended timeframe for receiving the booster dose, or within 30 days of recovering from an acute COVID-19 infection.

The key requirements for SNFs are to:

- Ensure that all workers are up-to-date on vaccination or have submitted an approved exemption

- Ascertain vaccination status of all personnel who work onsite; refer to San Francisco H.O. C19-07y, State H.O. January 25th, 2022, and AFL 21-28 for approved vaccination documentation
• Require any exempt less-than-up-to-date or 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-ASC, and the Diagnostic Screening Testing section for cadence details); **AND**
  - Wear a well-fitted surgical mask or higher-level respirator at **all** times except while actively eating or drinking; **AND**
  - Provide a declination form to the LTC Facility with appropriate documentation for qualifying medical or religious exemptions.

• 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.

**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 COVID-19 symptoms upon entry, per AFL 20-22. Visitors should share contact information in case contact tracing is needed later.

• Always follow all recommended precautions to prevent COVID-19 regardless of screening, as even boosted staff, visitors, or residents may transmit asymptomatic infection.

**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:

• 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.**

**Recognize and respond rapidly to COVID-19 signs and symptoms in older adults**

• Monitor all residents daily for fever T>100.4 and COVID-19 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 can have no symptoms, subtle symptoms, or moderate to severe illness. Recognize atypical symptoms of COVID-19 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.

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 individuals who are up-to-date on vaccination, 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 individuals up-to-date on vaccination.
- Post visual cues prompting adequate ventilation. Breakroom signage can be found here.
- Consider placing portable air cleaners (HEPA or MERV13 air purifiers) in areas wherever masks are taken off indoors, especially break rooms or common areas with poor ventilation.
- Check with building maintenance or operations to avoid recirculating air and to identify the optimal filters that may be used in your HVAC system.

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/OSHA’s standards for aerosol transmissible diseases and emergency temporary standards.
- In addition, refer to SF Health Order C19-07y and CDPH Health Order December 22, 2021, as well as: PIN 21-38-ASC, PIN 20-23-ASC, AFL 20-74 (see chart) and CDC guidance.

Hand hygiene and disinfection

- 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.

- Clean all surfaces as per [CDC guidance](https://www.cdc.gov), as droplet transmission mitigates other concurrent respiratory infections.

**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 shedding of the individual, source control, ventilation, and susceptibility of others.

- Refer to [PIN 21-17-ASC](https://example.com), [PIN 21-49-ASC](https://example.com), and [AFL 20-22](https://example.com) regarding distancing during visitation and among residents during dining and communal activities, which considers vaccination status.
- Reduce seating in common areas to avoid overcrowding, especially break rooms.

### Special considerations for memory care and behavioral units:

Prioritize Memory Care units and Behavioral units (locked units) for early, active measures to prevent infection which can lead to rapid transmission.

- Per [PIN 21-19-ASC](https://example.com) consider opening windows for ventilation when feasible, safe, and secure or portable air cleaners per [CDPH guidance](https://www.cdph.ca.gov) on ventilation.
- To reduce risk of rapid transmission, use creative strategies to keep residents out of quarantine and isolation areas; games to remember handwashing; and other cues.
- For PPE with residents in Memory Care, refer to [AFL 20-74](https://example.com), [PIN 21-19-ASC](https://example.com).
- 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. Please consult [SFDPH’s LTCF team](https://www.sfdph.ca.gov) for cohorting options.

Visitation guidance may change depending on case rates, variants, and staffing; it is key to communicate with families about visitation updates.

### Resident cohorting and zoning

Cohorting is a strategy for controlling transmission by grouping residents into specific zones or pods, treated by assigned HCPs. The ability to quarantine exposed and isolate suspected/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](https://example.com) for more information. **Residents who are new admissions or re-admissions should be managed according to CDC guidance**, using [PIN 20-23-ASC](https://example.com), [PIN 22-04-ASC](https://example.com), [AFL 20-53](https://example.com), [AFL 20-74](https://example.com), [AFL 21-08](https://example.com) and [PIN 20-38-ASC](https://example.com).
Transfer of patients with COVID-19 to LTC facilities

- Per AFL 20-33, AFL 20-87, 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, as long as facilities can reasonably accommodate the resident.

- All new admissions, readmissions, or interfacility transfers diagnosed with COVID-19 must have the approval from SFDPH.

- For non-urgent issues: email COVID.Outbreak@sfdph.org. A checklist for a LTC Facility to accept a resident with suspected or known COVID-19 is available.

- For clinical questions and/or urgent needs: call the SFDPH COVID-19 Clinician Consultation Line at Communicable Disease Control at 415-554-2830,1,1,2,1,1.

Visitation, communal dining, and activities

Review the box at the top of this document regarding:

- A local visitation order for skilled nursing facilities (SNFs) (also available in larger font), effective January 1st through February 15, 2022; and

- A CDPH order regarding visitation requirements in long-term care settings, effective January 7th-February 7th, 2022 (see also: PIN 22-04-ASC).

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, adjusting limitations on communal activities and dining based on the status of COVID-19 infections in the facility and community; more restrictive state guidance may supersede local guidance unless explicated exempt. View local health orders for more information.

Visitation

Indoor visitation

- Vaccination status of all visitors seeking indoor visitation at the facilities outlined in the December 31st, 2021, CDPH health order must be verified. RCFs are required to follow these standards, per the December 31st, 2021 H.O., and should follow PIN 21-17-ASC and PIN 22-04-ASC. SNFs should refer to AFL 20-22, AFL 21-49 in addition to the H.O.s. In summary, for indoor visitation, up-to-date replaces fully-vaccinated requirements for LTCF residents, visitors, and staff:
  - Indoor visitors who are not up-to-date with vaccination 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 for essential visitation needs, including 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, AFL 21-49 for alternative visitation options and number of visitors.

- RCF residents may have visitors **regardless of the vaccination status of the resident**, if the visitor is up-to-date on vaccination AND provides proof of a negative COVID-19 test; the test must be from within one day prior to visitation if antigen, or within two days prior if PCR. Visitors who cannot meet these requirements may only visit the resident outdoors. Visitors who are not up-to-date on vaccination must wear a well-fitting face mask and maintain physical distancing. If the resident is not able to meet with visitors outdoors, please refer to PIN 22-04-ASC for further guidance.

  - 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, and CDPH Guidance for the Use of Face Coverings.
    - Follow physical distancing guidelines.
    - Facilities should also limit visitor movement in the facility, regardless of the visitor's vaccination status; for example, visitors should go directly to and from the resident's room or designated visitation area.
    - Visits for residents who share a room should be conducted outdoors, in a separate indoor communal 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 and should be offered unless the resident cannot leave the facility, or outdoor visitation is not possible.

- Per the [December 31st, 2021, CDPH order](https://www.cdph.ca.gov/), outdoor visitors must show proof of a negative antigen test done within 1 day prior to visitation, or a negative PCR test done within 2 days prior to visitation; on-site testing on the day of visit also fulfills this requirement.
o Outdoor visits between residents and visitors who are all up-to-date on vaccination may be conducted without face masks and include physical contact (e.g., hugs, holding hands) while in designated spaces for visitation that maintain 6-ft distancing among visitor groups; visits between residents and visitors, if any are unvaccinated or incompletely vaccinated, should be conducted with well-fitting face masks during the visit and maintain 6-ft physical distancing.

o Per PIN 22-04-ASC, Visitors who are not up-to-date on vaccination are eligible only for outdoor visitation if they can show documentation of a negative COVID-19 test where the specimen collection occurred within one (1) day of visitation for antigen tests, and within two (2) days of visitation for PCR tests or, and for which test results are available at the time of entry to the facility. Visitors who are not up-to-date on vaccination must wear a well-fitting face mask and maintain physical distancing.

Communal dining
Facilities should refer to AFL 20-22 and PIN 22-04-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:

o RCF residents and visitors:
  • RCF residents not in isolation or quarantine may participate in communal dining and dine with their visitors, regardless of the vaccination status of the resident, if the visitor is up-to-date on vaccination AND provides proof of a negative COVID-19 test; the test must be from within one day prior to visitation if antigen, or within two days prior if PCR. Visitors who cannot meet these requirements may only visit the resident outdoors. Visitors who are not up-to-date on vaccination must wear a well-fitting face mask and maintain physical distancing.

o SNF residents and visitors:
  • Residents who are up-to-date on vaccination and are not in isolation or quarantine may eat in the same room without physical distancing, and with their visitors who are up-to-date on vaccination. Visitors and residents must wear a well-fitting face mask except while actively eating or drinking.

If any residents who are not up-to-date on vaccination are dining in a communal area, all residents should use source control when not eating and unvaccinated residents should continue to remain at least 6 feet from others.

Communal 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. AFL 21-49, PIN 21-40-ASC include key points below:

o Residents who are up-to-date on vaccination and not in isolation or quarantine may participate in group activities in stable cohorts without face masks or physical distancing;
residents who are NOT up-to-date on vaccination are present, then all participants in the activity should wear a well-fitting face mask and unvaccinated residents should physically distance from others.

- 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.
- Singing, chanting, aerosol-generating aerobic activity are extremely high-risk for transmission and should be avoided indoors.
- Maintain required staffing ratios to improve safer activities, e.g., reinforcing distancing, masking when appropriate, hand hygiene, and checking for ventilation.

### 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)**

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

- **San Francisco Department of Public Health (SFDPH)**
  - [https://www.sfcdcp.org/covid19](https://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)
  o Provider Information Notices - Adult and Senior Care (ASC) Program: https://www.cdss.ca.gov/inforesources/community-care-licensing/policy/provider-information-notices/adult-senior-care