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

UPDATED January 7, 2022

NEW Temporary visitation order for Skilled Nursing Facilities (SNFs)
The Health Officer has issued a new short-term letter order aimed at protecting the residents of SNFs by imposing restrictions on visitation effective January 1-31st, 2022. Key restrictions under this temporary Order include:

- Indoor visitors must take a rapid COVID-19 test at the time of the visit.
- Residents are restricted to two visitors per day indoors.
- Indoor visitors must wear a mask that meets criteria specified within the order.

Readers may access the full order [here](https://www.sfcdcp.org) (or a [larger-font version](https://www.sfcdcp.org)).

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](http://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 11/24/2021 Version**

- Included **statewide mandate for health care workers to be up-to-date on vaccination.**
- Updated isolation/quarantine guidelines for residents based on up-to-date vaccination.
- Consolidated guidance for readability and to account for changing CDC and CDPH guidance.
- Continue immediate reporting of suspected or confirmed COVID-19 cases to SFDPH.

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1 Per San Francisco Health Order C19-07y (December 29, 2021), “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 eligible for a Booster. Until a person is eligible for a Booster, they are considered Up-to-Date on Vaccination two weeks after completing their full initial series of vaccination.
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. General 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\(^2\) 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\(^3\) or close contact\(^4\).

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>
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<tbody>
<tr>
<td>Contact: <a href="mailto:COVID.Outbreak@sfdph.org">COVID.Outbreak@sfdph.org</a> or (415) 554-2830</td>
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<tr>
<td>Notify SFDPH CDRU promptly if:</td>
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<td>• Suspected or lab-confirmed positive SARS-CoV-2 test in residents or staff, or</td>
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<tr>
<td>• Three or more residents or staff with new-onset respiratory symptoms within 72 hours of each other, or</td>
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<tr>
<td>• Residents with severe respiratory infection resulting in hospitalization or death.</td>
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\(^2\)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.

\(^3\)A high-risk exposure is an exposure to aerosol generating procedures in a known COVID-19 individual without full PPE.

\(^4\)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.
Initiate the following steps when a resident or staff case is identified:

1. Isolate positive or symptomatic individual(s); see Zoning section and AFL 20-74; for RCFs, see PIN 21-12-ASC.
2. Identify and quarantine close contact residents in accordance with AFL 20-53.
3. Notify SFDPH CD RU 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 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. For resources and guidance on Isolation & Quarantine for LTC Facilities, contact COVID.Outbreak@sfdph.org. RCFs should see PIN 21-49-ASC and PIN 21-12-ASC for recommendations on removing residents from quarantine.

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).

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.

- Per 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 and close contacts to monitor symptoms but not quarantine. 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.

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:

- Asymptomatic residents that have tested positive for COVID-19 with prior infection within 90 days, regardless of vaccination status. These residents should stay isolated in own room, if possible, while they are evaluated for additional clinical input. They should remain in isolation for 10 days unless their medical provider and SFDPH determine isolation is not needed.

- 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 21-12-ASC and PIN 20-23-ASC.

Resident outings (leaving and returning to the facility):

- SNF residents who are fully vaccinated and leave the facility for 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 unvaccinated or partially vaccinated residents readmitted after hospitalization or who leave the SNF for more than 24 hours, per AFL 20-53 and AFL 20-87.

- Testing and 14-day 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.

Unvaccinated residents who had 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 and SF’s Isolation and Quarantine Directives.

- Asymptomatic positive HCP 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.
- Positive HCP who meet criteria to work should monitor symptoms once a shift for 10 days and stop working and isolate 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 the I&Q Directives and H.O. C19-07, 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 the I&Q Directives and 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
State guidance is rapidly changing in response to case rates, vaccination status, and CDC recommendations. For testing guidance, please refer to CDPH Health Orders December 22nd, 2021, July 26th, 2021, and August 5th, 2021; AFL 21-34, AFL 21-28, AFL 21-29, and AFL 20-53; PIN 21-53-ASC, PIN 21-32-ASC, and PIN 20-23-ASC; and local H.O. C19-07y. Any updates to the Health Orders, AFLs and PINs will supersede this guidance.

Symptomatic testing:

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

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 fully vaccinated need to test on admission unless tested 72 hours prior to admission, and again before exiting quarantine.
- SNFs should consider periodic (for example, weekly) diagnostic screening testing for unvaccinated residents who 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:

Under the December 22nd, 2021, CDPH Health Order, as well as AFL 21-34, AFL 21-29, AFL 20-28, AFL 20-53, and PIN 21-53-ASC, all booster-eligible health care workers must receive their booster by February 1, 2022. Those not yet eligible for boosters must be in compliance no later than 15 days after the recommended timeframe for receiving the booster dose.

- 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. See AFL 20-53 for diagnostic screening testing considerations for HCP who are up-to-date on vaccination.
  - 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, which advises different responses for facilities with ≥90% HCP and residents up-to-date on vaccination from those with <90% HCP and residents up-to-date on vaccination.
For RCFs, CCRC independent living residents may be excluded from response testing unless they have been in communal settings with other residents, per PIN 21-40.

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

### 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.

**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, up-to-date 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:

- 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 CDPH Health Order December 22, 2021, 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 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.

- 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 other recommended precautions to prevent COVID-19 regardless of screening, due to the potential that a resident or visitor has an 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 have a wide range of symptoms, from none 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](#).

**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 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](#) 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, PIN 21-49-ASC, and AFL 20-22 regarding distancing during visitation and among residents during dining and communal activities, which considers vaccination status.

**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](#) consider opening windows for ventilation when feasible, safe, and secure or portable air cleaners per CDPH guidance 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, PIN 21-19-ASC.

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 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 for more information. Residents who are new admissions or re-admissions should be managed according to CDC guidance, using PIN 20-23-ASC, AFL 20-53, AFL 20-74, AFL 21-08 and PIN 20-38-ASC.

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 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

Review the box at the top of this document regarding the temporary health order (also viewable in larger font), on SNF visitor restrictions through January 31st, 2022.

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.
Communal dining
Facilities should refer to AFL 20-22, and PIN 21-49-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

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 21-40-ASC. SNFs should refer to AFL 20-22, AFL 21-49 in addition to the H.O.s. In summary, for 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 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.

- 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

o 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.

o Visitors who remain outdoors during the entire visit do not need to show proof of vaccination or testing per CDPH but should be screened for symptoms.

o 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-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.

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 Currently, fully vaccinated residents who are not in isolation or quarantine may participate in group activities in stable cohorts 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.

o 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.

o Singing, chanting, aerosol-generating aerobic activity are extremely high-risk for transmission and should be avoided indoors.

o Maintain required staffing ratios to improve safer activities, e.g., reinforcing distancing, masking when appropriate, hand hygiene, and checking for ventilation.
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)**