California Department of Public Health (CDPH)
Center for Health Care Quality
Skilled Nursing Facilities Infection Prevention Call

Frequently Asked Questions

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A. COVID-19 Vaccine Requirements

Healthcare Worker Vaccine Requirement Guidance	
State Public Health Officer Order: Health Care Worker Vaccine Requirement (Originally issued 8/5/21; Amended 12/22/21, 2/22/22, and 9/13/22) Frequently Asked Questions	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/FAQ-Health-Care-Worker-Vaccine-Requirement.aspx
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CMS QSO 23-02-ALL: Revised Guidance for Staff Vaccination Requirements (10/26/22)	https://www.cms.gov/files/document/qs0-23-02-all.pdf
CMS QSO-21-19-NH: Interim Final Rule—COVID-19 Vaccine Immunization Requirements for Residents and Staff (5/11/21)	https://www.cms.gov/files/document/qso-21-19-nh.pdf
CDC Interim Clinical Considerations for COVID-19 Vaccines	https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html
CDC: Stay Up to Date with COVID-19 Vaccines Including Boosters	https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html#when-you-can-get-booster
CDPH EZIZ: One-Stop Shop for Immunization Training and Resources—Resources for Long-Term Care Facilities • LTCF COVID-19 Vaccine Toolkit • Bivalent COVID-19 Booster Dose FAQs • COVID-19 Vaccine Timing by Age	https://eziz.org/resources-for-longterm-care-facilities/ https://eziz.org/assets/docs/COVID19/LTCFToolkit.pdf https://eziz.org/assets/docs/COVID19/BivalentBoosterFAQ.pdf https://eziz.org/assets/docs/COVID19/IMM-1396.pdf

Refer to the above links and the CDPH Bivalent COVID-19 Booster Dose FAQs for the most updated answers to vaccine questions (https://eziz.org/assets/docs/COVID19/BivalentBoosterFAQ.pdf).

1. **Q: Do the clinical reasons for the medical exemption need to be listed in the provider's medical exemption letter?**
   A: Yes. HCP must have a religious or medical exemption recorded and saved on file to continue to work if they have not completed the required primary series plus one booster with their vaccines. Per CMS QSO 23-02-ALL: Revised Guidance for Staff Vaccination Requirements (10/26/22), Attachment A, the clinical reason is required to be documented in the medical exemption letter (https://www.cms.gov/files/document/qs0-23-02-all.pdf). Nursing homes should have a process for tracking HCP vaccination or exemption status to ensure they are complying with the California State Public Health Officer Order: Health Care Worker Vaccine Requirement (updated 9/13/22).
2. **Q: Is the Federal Retail Pharmacy Program for COVID-19 vaccination still available for nursing homes, and do participating pharmacies offer boosters at nursing homes?**
   A: The Pharmacy Program still exists (https://www.cdc.gov/vaccines/covid-19/retail-pharmacy-program/index.html); however, it is not the same as it was when the vaccine was first being distributed in December 2020 and early 2021. To identify a local participating pharmacy, it is recommended you download the CDPH Long-Term Care Facility (LTCF) COVID-19 Vaccine Toolkit

(https://eziz.org/assets/docs/COVID19/LTCFToolkit.pdf). A list of participating LTCF pharmacies in California can be found in Appendix B. Nursing homes can reach out directly to the pharmacy of their choice to inquire if they can provide the vaccine to your staff and residents. Note that while some pharmacies are serving only contracted facilities, others are willing to serve other LTCFs.

3. **Q: Do we need to get consents every time we administer the COVID-19 booster to residents since there may be ongoing recommendations for additional doses?**
   A: There are no federal or California state requirements for informed consent specifically relating to immunization. The use of a consent form is not required for an EUA vaccine. Vaccine providers may opt to use a consent form at their discretion. Persons receiving immunization should receive the "EUA Fact Sheet for Recipients" (https://www.cdc.gov/vaccines/covid-19/eua/index.html). Immunization providers may also want to provide additional informational resources from CDC's website, "Building Confidence in COVID-19 Vaccines" (https://www.cdc.gov/vaccines/covid-19/vaccinate-with-confidence.html). CDC also indicates that "explaining the risks and benefits of any treatment to a patient—in a way that they understand—is the standard of care." Regarding the issue of getting new consent forms every time, CDC guidance indicates that providers should consult with their legal counsel on whether or not prior consent forms are sufficient. Refer to CDC guidance "FAQs About Medical Consent & Pfizer-BioNTech Booster Doses for Long-term Care Residents" (https://www.cdc.gov/vaccines/covid-19/long-term-care/medical-consent-faqs.html).

4. **Q: How can a nursing home learn how to administer vaccines on our own in-house?**
   A: All nursing homes are strongly encouraged to enroll in myCAvax to be able to administer COVID-19 vaccines on their own. To become your own vaccine administrator, you must be able to accept, store, administer, and report COVID-19 vaccine administration data to the California Immunization Information System (IIS). Please refer to Steps to Enrollment (https://eziz.org/covid/enrollment/) and Systems Overview (https://eziz.org/assets/docs/COVID19/IMM-1354-Provider.pdf) for details on the onboarding process into myCAvax. Contact COVID-19 Call Center for enrollment issues: COVIDCallCenter@cdph.ca.gov; 833.502.1245. Information on becoming a vaccine provider can be found in the CDPH Long-Term Care Facility COVID-19 Vaccine Toolkit: https://eziz.org/resources-for-longterm-care-facilities/.

5. **Q: What is the California Immunization Registry (CAIR2) and how do I get access to vaccine records?**
   A: CAIR2 is a secure, confidential, statewide computerized immunization information system for California residents. SNFs are encouraged to register with CAIR2 to record vaccine doses administered and get access to immunization records (e.g., flu, COVID-19, pneumococcal vaccine). Visit the immunization registry website to request an account with the registry that serves your county.
   - **CAIR2:** Serves 49 California counties https://cairweb.org/enroll-now/
   - **San Diego Regional Immunization Registry (SDIR):** http://www.sdiz.org/cair-sdir/enrollment.html
   - **Healthy Futures:** Serves the San Joaquin Region, including Alpine, Amador, Calaveras, Mariposa, Merced, San Joaquin, Stanislaus, and Tuolumne counties http://www.myhealthyfutures.org/

   Contact your Local CAIR Representative (LCR) for assistance (https://go.cdph.ca.gov/cair-lcr). Another method to access a vaccine record for a California resident is to have them request their Digital COVID-19 Vaccine Record (DCVR) at https://myvaccinerecord.cdph.ca.gov/. Any individual who received a vaccine record in California can access their vaccine record using that website. The records in DCVR are directly tied to the information that is in CAIR2. DCVR requires an email address or mobile phone number match, so sometimes there may be data entry problems or delays and the information cannot be accessed until those are corrected. To troubleshoot, individuals can utilize the CDPH Virtual Vaccination Support website: https://chat.myturn.ca.gov/?id=17 or email DCVRRemediation.Requests@cdph.ca.gov. Another option is to seek vaccine records from the provider who administered the vaccine, or have the provider correct the information in CAIR2. If SNFs have access to CAIR2, they may be able to update the correct vaccine information directly into CAIR2.

6. **Q: Can we utilize CAIR2 to confirm vaccination status of our employees and visitors?**
   A: No. The uses of CAIR2/immunization registries are limited by law to protect confidentiality. Employers can use CAIR2 to verify vaccine records for patients/residents, but cannot look up vaccine records for employees or visitors. With regard to vaccination verification, please refer to this guidance: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Vaccine-Record-Guidelines-

Standards.aspx. Details on the legal language can be found on this website: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=120440. To troubleshoot CAIR2 discrepancies, contact the CDPH Virtual Vaccination Support website: https://chat.myturn.ca.gov/?id=17 or email DCVRRemediation.Requests@cdph.ca.gov.

7. **Q: An HCP cannot find documentation from the booster. The pharmacy lost the record and booster records are not in CAIR2 or the Digital COVID-19 Vaccine Record. Can the HCP receive another booster?**
   A: Yes. If all efforts to find documentation of the initial booster have been exhausted, the HCP would need to get another dose in order to meet the requirement for work because documentation is required. Resources for troubleshooting missing vaccination doses can be found at: https://myvaccinerecord.cdph.ca.gov/faq.

8. **Q: A resident received the first dose of the mRNA vaccine last year but never got a second dose. Should we restart the vaccine series, or just give the second dose at this time?**
   A: CDC guidance does not recommend restarting the series. The individual should get the second dose as soon as possible, and will be considered fully vaccinated 2 weeks after receiving that dose.

9. **Q: A new admission received the bivalent booster, but did not receive the primary series. There is no record of the primary series in CAIR2. Should we administer the primary series now?**
   A: Providers should only accept written, dated records as evidence of vaccination; an attempt should be made to locate records and if records cannot be located within a reasonable time, these persons should be considered susceptible and started on the age-appropriate vaccination schedule. Consider alternate options for locating and verifying if the patient has received the vaccines https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Vaccine-Record-Guidelines-Standards.aspx. Additionally, healthcare providers may enter it as historical data into CAIR https://cair.cdph.ca.gov/CAIRHelp/webhelp/immunizations/Record_Historical_Immunizations.htm. More information can be found at: CDC Timing and Spacing of Immunobiologics https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/timing.html.

10. **Q: Are staff and resident vaccine rates reported publicly?**
    A: Yes, CMS and CDC display nursing home vaccine and booster data for every nursing home in the country at: https://data.cms.gov/covid-19/covid-19-nursing-home-data and https://www.cdc.gov/nhsn/covid19/ltc-vaccination-dashboard.html. Vaccine data are also displayed publicly on Care Compare https://www.medicare.gov/care-compare/.

11. **Q: Where can I access my nursing home's COVID-19 vaccine run chart?**
    A: Health Services Advisory Group (HSAG) produces COVID-19 vaccine run charts for all nursing homes in California every Monday, so you can easily see if your vaccine data reported to NHSN are accurate. To access your run charts, visit HSAG's Quality Improvement Innovation Portal (QIIP) www.hsag.com/qiip-start. Contact qiip@hsag.com if you have questions.

B. Testing

Testing Guidance	
CDPH AFL 21-28.3 Testing, Vaccination Verification and PPE for HCP (Updated 2/22/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-28.aspx
CDPH AFL 22-13.1: SNF HCP and Resident Testing Guidance (10/5/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-13.aspx
CDPH COVID-19: Information for Laboratories	https://www.cdph.ca.gov/Programs/OSPHLD/LFS/Pages/COVID-19.aspx
CDPH State Public Health Officer Order "Revision of Mandatory Reporting Of COVID-19 Results by Health Care Providers" (10/4/22)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Revision-of-Mandatory-Reporting-of-Covid-19-Results-by-Health-Care-Providers.aspx
CDPH COVID-19 Point of Care Test Expiration Guidance (11/10/21)	https://testing.covid19.ca.gov/wp-content/uploads/sites/332/2021/12/COVID-Point-of-Care-Test-Expiration-Guidance.pdf

Testing Guidance	
CDPH Updated Testing Guidance (9/15/22)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Updated-COVID-19-Testing-Guidance.aspx
CDPH Guidance on the Use of Antigen Tests for Diagnosis of Acute COVID-19 (9/12/20)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CDPH-Guidance-on-the-Use-of-Antigen-Tests-for-Diagnosis-of-Acute-COVID-19.aspx
CDC Self-Testing at Home or Anywhere	https://www.cdc.gov/coronavirus/2019-ncov/testing/self-testing.html
CDC Laboratory Outreach Communication System (LOCS): CDC's Gateway to Engage with Laboratory and Testing Community	https://www.cdc.gov/csels/dls/locs/2020/cms_guidance_for_the_use_of_expired_sars-cov-2_tests.html
CDPH Laboratory Field Services—COVID-19 for Laboratories: FAQs	https://www.cdph.ca.gov/Programs/OSPHLD/LFS/Pages/COVID-19FAQ.aspx#Laboratory%20Questions
CDPH COVID-19 Antigen Self-Test Expiration Extensions (7/7/22)	https://testing.covid19.ca.gov/wp-content/uploads/sites/332/2022/03/Temporary-Extension-At-Home-Test-Expirations.pdf
CMS FAQs, CLIA Guidance During the COVID-19 Emergency (12/17/20)	https://www.cms.gov/files/document/frequently-asked-questions-faqs-clia-guidance-during-covid-19-emergency-updated-12-17-2020.pdf
Instructional Video on Self-Swabbing for COVID-19	https://www.youtube.com/watch?v=dtIzs05DGNU

1. **Q: Who can perform swabbing for COVID-19 tests?**
   A: See the table below for information on licensed personnel who can perform swabbing for COVID-19 tests. More information can be found in the COVID-19 for Laboratories FAQ under Laboratory Personnel https://www.cdph.ca.gov/Programs/OSPHLD/LFS/Pages/COVID-19FAQ.aspx#Laboratory%20Questions.

2. **Q: Who can observe self-testing?**
   A: Any trained individual may observe another individual who is self-swabbing, adding the reagent to the test, and reading, interpreting, and reporting the test results if they are working under the supervision of the laboratory director who holds a CLIA waiver. See FAQs on website in above question.

Who Can Perform Swabbing for COVID-19 Tests?

Licensed Personnel	Observe Self Swabbing	Anterior Nasal	Nasopharyngeal, Oropharyngeal
Medical Assistants	Yes	Yes	No
Physicians	Yes	Yes	Yes
Physicians Assistants	Yes	Yes	Yes
EMTs	Yes	Yes	Yes
Registered Nurses	Yes	Yes	Yes
LVNs	Yes	Yes	Yes
Psychiatric Technicians	Yes	Yes	Yes
CNAs, Home Health Aides, Certified Hemodialysis Technicians	Yes	No	No
Respiratory care practitioners	Yes	Yes	Yes
Pharmacists	Yes	Yes	Yes
Pharmacy Technicians	Yes	Yes	Yes
For questions about other licensed personnel, contact appropriate licensing board for information on scope of practice			

3. **Q: What is the updated CDPH routine diagnostic screening testing guidance for HCP?**
A: CDPH AFLs (AFL 22-13.1; AFL 21-34.4; AFL 20-88.3) are aligned with the updated CDC guidance, CMS QSO 20-38-NH, and the CDPH State Public Health Officer Order (SPHO), "Health Care Worker Vaccine Requirement," updated Sept. 13, 2022. **The routine diagnostic screening COVID-19 testing requirements are rescinded (no longer required) for all unvaccinated exempt HCP and booster-eligible HCP who have not yet received their booster.** Per CDC and CMS, routine testing of asymptomatic staff is no longer recommended, regardless of community transmission rate, but may be performed at the discretion of the facility. Check with your local health department for more stringent guidance.

4. **Q: Following an exposure, does a resident need to be tested for 14 days, or just on days 1, 3, and 5?**
A: Per AFL 22-13.1, "CDPH 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." Vaccination status does not influence the decisions concerning testing. "All contacts should be tested promptly (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and at 5 days after the exposure. If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify more individuals who need to be tested. For residents with repeated exposures/close contacts, this might result in additional post-exposure testing beyond the first round of three tests. If a contact tracing approach fails to halt transmission, facility-wide or group-level approach with quarantine for exposed groups should be considered. In this scenario, serial retesting of all residents and HCP should be performed every 3–7 days until no new cases are identified among residents in sequential rounds of testing over 14 days.

5. **Q: If a COVID-19 recovered individual is tested again days 31–90 due to symptoms or exposure, is it still recommended to NOT use a PCR test?**
A: Antigen testing is still preferred over a PCR test when testing an individual who has previously recovered within the prior 90 days. Per AFL 22-13.1, the interval from a prior infection and recovery and the recommendation against testing an asymptomatic person who has been exposed has been shortened from 90 days to 30 days.

6. **Q: When are confirmatory PCR tests needed following negative antigen tests?**
A: Below is guidance regarding confirmatory PCR tests needed following negative antigen tests:
   - PCR testing is recommended for symptomatic individuals following a negative antigen test result.
   - Confirmatory PCR testing following a positive antigen test result is not necessary for symptomatic or exposed individuals.
   - Confirmatory PCR testing following a positive antigen test result for asymptomatic individuals without a known exposure is not generally necessary but may be considered if there is strong information to suggest that it could be a false positive (e.g., individual was asymptomatic and not exposed; community has low transmission rate). Contact your local health department for guidance in these situations.

7. **Q: What should a facility do when an antigen test kit has expired?**
A: Unexpired tests can be requested through the MHOAC. However, per CMS, if unexpired tests cannot be obtained, testing programs are allowed to use expired professional CLIA waived tests if the lab director of your CLIA waived lab establishes a written policy for this use. Some tests have had their expiration dates extended based on additional data that was not available when the test was first authorized. Go to this FDA website (www.fda.gov/medical-devices/coronavirus-covid-19-and-medical-devices/home-otc-covid-19-diagnostic-tests#list), current as of 12/22/2022, to determine if a home test that you have has an extended expiration date.

8. **Q: Can an antigen test be used for HCP that are returning to work early after testing positive under routine circumstances?**
A: Yes, per AFL 21-08.9 (updated 12/2/2022), antigen tests are acceptable and preferred. The antigen test needs to be observed or validated by the facility to verify the identity of the HCP being tested, the date of the test, and that the test is negative. This proctoring does not need to happen physically in person with the HCP (i.e., telehealth, time-stamped picture of the test). See AFL 21-08.9 table "Work restrictions for HCP with SARS-CoV-2 Infection (Isolation)," which says, "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 48 hours of return."

9. **Q: Is a confirmatory PCR test needed following a negative antigen test result for an individual who recently recovered from COVID-19 (less than 30 days) with new symptoms?**
   A: It is not generally recommended that a confirmatory PCR test in this scenario because the individual is within 30 days of testing positive for COVID-19, and a positive PCR test could represent persistent positivity from the prior COVID-19. Alternatively, it is recommended to repeat the antigen test and test for other respiratory pathogens, such as influenza, and consider a confirmatory molecular test depending on the timing and likelihood of alternate diagnosis.

10. **Q: Does a COVID-recovered resident (within 30 days of testing positive) who is exposed to COVID-19 need to be tested with an antigen test and quarantined?**
    A: No. Reinfection within 30 days of recovery is very unlikely. Quarantine is no longer recommended for exposed individuals who are asymptomatic.

11. **Q: What is the proper way to dispose used rapid antigen tests?**
    A: Used antigen tests can be disposed in the regular trash if the test result is negative. However, if the test result is positive, it should be disposed in biohazard trash.

12. **Q: Can antigen tests be used for staff and resident response testing?**
    A: Yes, antigen testing can be used for post-exposure and for response testing if used at least twice a week and may be preferable to rapidly identify, isolate, and cohort positives. Confirmatory molecular (i.e., PCR) testing is not required for negative antigen test results during response testing but may be considered (in consultation with your local health department) for higher-risk close contacts. If an antigen test is used, testing must be done twice weekly; a PCR test may be used for one of the twice-weekly tests if the turnaround time for the PCR result is 24–48 hours. See AFL 22-13.1.

13. **Q: A resident tested positive for COVID-19 immediately on admission. Does the facility need to initiate response testing?**
    A: Since the resident tested positive immediately on admission, they should be placed directly in the COVID-19 isolation area. Since this was not a facility onset case, response testing is most likely not necessary because the likelihood of exposure in the facility would be quite low. Post-exposure testing might be necessary if anyone was exposed. The referring facility should be informed of the positive test either directly or via the local health department.

14. **Q: Does response testing need to occur if only one HCP tests positive?**
    A: Per CDPH AFL 22-13, "CDPH 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. All contacts should be tested promptly (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and at 5 days after the exposure. If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify more individuals that need to be tested."

15. **Q: If an HCP tests positive, how many days from the last day worked does our facility need to look back for contact tracing?**
    A: The potential infectious period of the HCP that could have exposed residents and other HCP in the facility would start 48 hours before the onset of symptoms or before the positive test was taken if asymptomatic.

16. **Q: If an HCP tested positive at home with an at-home test, does that mean our nursing home has an outbreak?**
    A: No, not necessarily. In this scenario, the facility would need to consider whether or not the HCP worked during their potential infectious period, or during the time in which they could have exposed someone in the facility. If the HCP did work in the days when infectious, then it would trigger an outbreak investigation and contact tracing or response testing of other HCP and residents who may have potentially been exposed. Refer to updated (8/10/2022) CORHA guidance (www.corha.org/wp-content/uploads/2022/08/COVID-19-HC-Outbreak-Definition-Guidance-8-10-22.pdf) for thresholds for outbreak investigation and outbreak reporting.

17. **Q: An HCP went on vacation and tested positive. Their last day of work was 8 days ago. Due to it being 8 days since the HCW was in our facility, do we need to initiate response testing?**
A: No. This is most likely not a facility-acquired case and likely did not result in any potential exposures, so the case does not need to be reported and response testing does not need to be initiated. The infectious period for an individual is considered to start 2 days before their symptoms start or the date of their positive test if asymptomatic. If they worked at all within those 2 days or the day that they tested positive, then you would consider them to have posed potential exposure risk and you would need to initiate response testing.

18. **Q: A visitor tested positive one day after their visit to the SNF. The resident now has symptoms and tested positive for COVID-19. Does that trigger an outbreak and the need for response testing?**
A: Yes. Any resident that tests positive would trigger an outbreak and contact tracing or response testing would be indicated because others may have been exposed.

19. **Q: Per AFL 22-13.1, "serial retesting of all residents and HCP who test negative upon the prior round of testing (regardless of their vaccination status) should be performed every 3–7 days until no new cases are identified among residents in sequential rounds of testing over 14 days… ." Why only residents? What if staff test positive?**
A: "Staff" were intentionally not included. The requirement is to continue response testing until there are no new cases among residents for 14 days to demonstrate transmission has ceased within the facility. After the 14 days, a new case in a staff member may or may not be related to the first outbreak (because the staff member might have had a community exposure unrelated to the SNF outbreak); the facility would re-initiate facility-wide response testing, but could be focused on the unit(s) where a positive staff member worked (consult with your local health department).

20. **Q: Will the 14-day response testing window be shortened to 10 days?**
A: No, CDPH does not anticipate shortening the window of 14 days with no new positive tests during response testing to determine the containment of transmission. For other respiratory viral pathogens (e.g., influenza), one generally monitors for two full incubation periods to determine the absence of ongoing transmission. Fourteen days was the maximum length of the incubation period following exposure to the original SARS-CoV-2 viral variants and, given the shorter incubation period with more recent variants, will now allow two full incubation periods to occur to determine the absence of ongoing transmission.

21. **Q: Do negative tests need to be reported in NHSN?**
A: No. Per the April 6, 2022, CDPH letter to entities performing COVID-19 testing, effective April 4, 2022, reporting of non-positive results (negative, indeterminate, etc.) is no longer required. This applies to long-term care facilities as well as other settings. The letter can be found at: http://publichealth.lacounty.gov/acd/NCorona2019/docs/CDPHLabResultReportingChanges.pdf. More information about testing can be found at: CDC COVID-19 Testing: What You Need to Know https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/testing.html#negative-test-result.

22. **Q: Do SNFs need to report antigen test results for visitors or HCP?**
A: Positive test results of visitors and HCP who "self-swab" or "self-collect," but facility staff perform the actual test, **do need** to be reported by the facility to NHSN and CalREDIE. Test results of visitors and HCP who "self-test" **do not need** to be reported by the facility. If visitors test positive, per the CDC, they should report their own test results to their healthcare provider. However, if HCP test positive, the positive result **does need to be reported** to NHSN and CalREDIE (also include in CDPH SNF 123 survey). (https://www.cdc.gov/coronavirus/2019-ncov/testing/self-testing.html).

23. **Q: Should HCP positive home test results be reported?**
A: If HCP test themselves at home and are positive, and have worked in the facility during their infectious period, then those positive test results should be reported. Positive results need to be reported to NHSN and CalREDIE (also include in CDPH's SNF 123 survey). Note that the NHSN point-of-care test module reports to CalREDIE, but CalREDIE does not report to NHSN. It is recommended that you report antigen test results directly to NHSN to avoid having to report twice.

C. Isolation and Quarantine

Isolation and Quarantine Guidance	
CDC Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic (9/23/2022)	www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
CDPH AFL 22-07.1: Guidance for Limiting the Transmission of COVID-19 in SNFs (10/6/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-07.aspx
CDPH AFL 21-08.9: Guidance on Quarantine and Isolation for HCP Exposed to SARS-CoV-2 and Return to Work for HCP with COVID-19 (12/2/22)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx
CDPH AFL 22-13.1: COVID-19 Mitigation Plan Recommendations for Testing of HCP and Residents at SNF (10/5/22)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-13.aspx

1. **Q: Do COVID-19 positive residents still need to isolate for 10 days?**
   A: Yes. Per CDPH AFL 22-13.1 (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-13.aspx):
   - Residents who test positive and are asymptomatic throughout their infection should be isolated for 10 days following the date of their positive test.
   - Residents who test positive and are symptomatic with mild to moderate illness 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.
   - **Note**: The duration of isolation could be extended to up to 20 days for individuals who had critical illness (i.e., required intensive care) and beyond 20 days for individuals who are moderately to severely immunocompromised (e.g., currently receiving chemotherapy, or recent organ transplant); use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when transmission-based precautions could be discontinued for these individuals. Serial testing prior to ending isolation can be considered in consultation with infectious disease experts under these special circumstances (CDC Ending Isolation and Precautions for People with COVID-19: Interim Guidance https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html).
2. **Q: Is a test-based strategy necessary for discontinuing 10-day isolation in residents?**
   A: In general, test-based strategies are not required for discontinuing the 10-day isolation period in most individuals because individuals may shed noninfectious fragments of the virus and test persistently positive. This is the case especially with PCR tests, but antigen tests may also detect fragments of the virus. Refer to AFL 22-13.1 for guidance on the isolation of symptomatic or asymptomatic residents, as described above.
3. **Q: If a COVID-19 positive resident is experiencing an occasional or intermittent cough as their only symptom, should they continue to be isolated past day 10 until their cough is completely resolved?**
   A: Isolation can end at day 10 if symptoms have improved (do not need to be completely resolved) as long as they are not moderately to severely immunocompromised, as described above.
4. **Q: What is the definition of exposure?**
   A: Per CDPH AFL 21-08.9, SNFs must use the CDC definition (https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html) to determine exposure risk for HCP with potential occupational exposure to patients, residents, visitors, and other HCP with confirmed COVID-19 in a healthcare setting. CDC's exposure framework for HCP occupational exposures accounts for the type of PPE worn and whether an aerosol generating procedure was done. CDPH guidance for assessing community-related exposures should continue to be applied to all other potential exposures (i.e., HCP with potential exposures outside of work [e.g., household]; among HCP exposed to each other while working in non-patient care areas [e.g., administrative offices]; and for residents with potential exposures to HCP or other residents). CDPH "Beyond the Blueprint" defines a close contact as "In indoor spaces 400,000 or fewer cubic feet per floor (such as home, clinic waiting room, airplane etc.), a close contact is defined as sharing the same indoor airspace for a

cumulative total of 15 minutes or more over a 24-hour period (for example, three separate 5-minute exposures for a total of 15 minutes) during an infected person's (confirmed by COVID-19 test or clinical diagnosis) infectious period."

5. **Q: Do residents who frequently leave the facility for dialysis need to be tested and quarantined?**
A: No. Dialysis residents do not need to be tested and quarantined, regardless of vaccination status. We recommend that facilities communicate with outpatient centers, dialysis centers, and the local health jurisdiction to ensure awareness of potential exposures in dialysis facilities. If there was an exposure, the resident should be tested promptly (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and at 5 days after the exposure (total of 3 tests; antigen or PCR tests are acceptable). The resident should also wear a mask outside of the room for a minimum of 10 days following the exposure.

6. **Q: Do HCP need to quarantine if they are exposed?**
A: No. Per AFL 21-08.9, "Guidance on Quarantine and Isolation for Health Care Personnel (HCP) Exposed to SARS-CoV-2 and Return to Work for HCP with COVID-19" (12/2/2022), quarantine and work restriction are not required for exposed asymptomatic HCP, regardless of vaccination status. Following an exposure, HCP must be tested immediately (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and if negative, again at 5 days after the exposure. To provide an additional layer of safety, exposed HCP should wear a fit-tested N95 for source control for 10 days.

Management of Asymptomatic HCP with Exposures

Vaccination Status	Routine	Critical Staffing Shortage
All HCP, regardless of vaccination status	No work restriction with **negative** diagnostic test† upon identification (but not earlier than 24 hours after exposure) and if negative, test at days 3 and 5	No work restriction with diagnostic test† upon identification (but not earlier than 24 hours after exposure) and at days 3 and 5

7. **Q: When can COVID-19 positive HCP return to work?**
A: Recognizing that staffing shortages continue to persist, per AFL 21-08.9, under routine staffing conditions, COVID-19 positive HCP may return to work after 5 days with proof of a negative antigen, or after 10 days without a negative test (and afebrile x 24 hours and symptoms improving). To provide an additional layer of safety, these HCP should wear a fit-tested N95 for source control through day 10.
   - If there is a critical staffing shortage, no additional testing is required to return beyond the initial positive test. Per the table below from AFL 21-08.9, positive asymptomatic HCP, regardless of vaccination status, may return to work immediately with a fit-tested N95 for source control. When returning to work early, use the results of the most recent test result (which may be the test at diagnosis) to determine work placement:
     – If the most recent test result is positive, HCP can only provide direct care to residents with confirmed SARS-CoV-2 infection, preferably in a cohort setting. This may not apply for staff types or in settings where practically infeasible (e.g., emergency departments where patient COVID-19 status is unknown) or where doing so would disrupt safe nurse to patient ratios, and for staff who do not have direct patient/resident care roles.

   HCP who are not already fit-tested for their role do not need to become newly fit-tested solely for the purpose of being able to return to work; these workers should wear a well-fitting N95. COVID-19 positive staff should take meal breaks outdoors or in a well-ventilated area, away from other HCP or residents when removing their N95. If break rooms are shared, N95s should not be removed; avoid crowding in break rooms. Notify the L&C District Office and local health department if there is an anticipated staffing crisis.

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

Vaccination Status	Routine	Critical Staffing Shortage
All HCP, regardless of vaccination status	5 days* with at least one negative diagnostic test† same day or within 24 hours prior to return OR 10 days without a viral test	<5 days with most recent diagnostic test† result to prioritize staff placement‡

8. **Q: Can COVID-19 positive HCP return to work after 10 days of isolation even with signs and symptoms?**
   A: If an individual continues to have signs and symptoms after 10 days of isolation, and their symptoms are not improving, they may need to stay in isolation for a longer period of time. If the individual had a severe or critical illness (e.g., intubation, ICU stay), or is moderately to severely immunocompromised, the isolation period may be extended to ≥ 20 days per CDC guidance. Consider consulting with an infectious disease physician to see if a test-based strategy should be followed when an isolation period of ≥ 20 days is indicated. See above table from CDPH AFL 21-08.9 for further information on return to work guidance. for HCP instructions about return to work.

9. **Q: How are the days counted for return-to-work purposes (routine staffing) for COVID-19 HCP in isolation?**
   A: Per CDPH AFL 21-08.9, in routine staffing circumstances, COVID-19 positive HCP may return to work after 5 days with proof of a negative antigen, or after 10 days without a negative test (and afebrile x 24 hours and symptoms improving). The 5 days are counted in the following way (see image of calendar as an example):
   - Day 0 = day of symptom onset, or if asymptomatic, day of first positive test
   - Day 5 = last day of isolation with proof of a negative antigen test. Return to work would be Day 6.
   - Day 10 = last day of isolation without a negative test. Return to work would be Day 11.

   CDC isolation guidance for the general public (including the calendar image) can be found at: (https://www.cdc.gov/coronavirus/2019-ncov/downloads/your-health/COVID-19_Isolation.pdf).

10. **Q: For contact tracing, how long is the exposure period for other residents and HCP who may have been exposed to the individual that tested positive?**
    A: The infectious period for an individual is considered to start 2 days before their symptoms start or 2 days before the date of their positive test if asymptomatic. If HCP or residents were exposed at all to the COVID-19 positive individual within those 2 days or during their isolation period, then you would consider them to have potential exposure risk for contact tracing and response testing purposes.

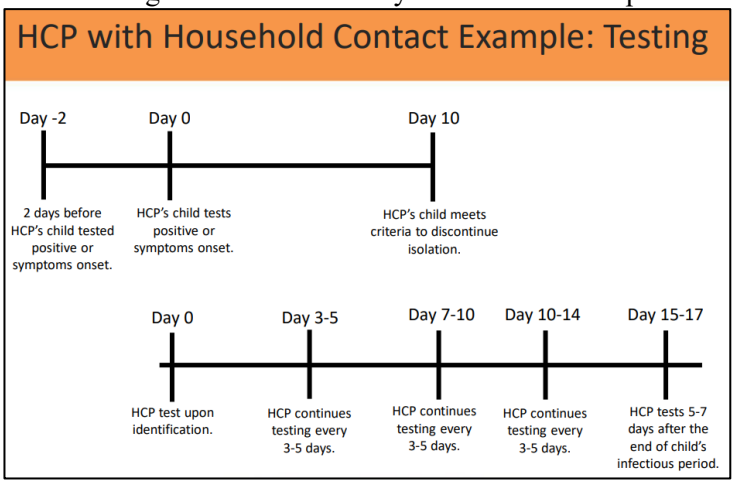
11. **Q: Does a resident who had close contact with a positive visitor, HCP or resident need to quarantine?**
    A: No. Per AFL 22-13.1, a resident who is in close contact with any COVID-19 positive person does not need to quarantine, regardless of vaccination status.
    - Resident should wear a mask outside their room for source control for a minimum of 10 days following the exposure.
    - Resident should not participate in communal dining for 10 days following the exposure because masks must be removed during eating and drinking.
    - Resident should be tested promptly (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and at 5 days after the exposure.

12. **Q: If a staff member wearing full PPE (N95, eye protection, gown, gloves) tests positive, are the residents now considered exposed?**
    A: In healthcare settings, residents are considered potentially exposed even if the HCP was wearing full PPE.

13. **Q: During contact tracing, a resident tested positive 7 days after being exposed. Does the 14 days of contact tracing response testing start over?**
A: Yes. Per AFL 22-13.1, if testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection. A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach with quarantine for exposed groups should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Serial retesting of all residents and HCP who test negative upon the prior round of testing (**regardless of their vaccination status**) should be performed every 3–7 days until no new cases are identified among residents in sequential rounds of testing over 14 days.

14. **Q: An HCP's child tested positive, and the HCP is unable to quarantine away from the child who is immunocompromised. The HCP is fully vaccinated and boosted. When can the HCP return to work? What if the HCP is symptomatic, but still testing negative for COVID-19?**
A: If the HCP cannot isolate from their infected household member, the HCP would be considered exposed throughout the infected household member's infectious period. Since the child is immunocompromised, the isolation period may be extended to ≥ 20 days per CDC guidance, which means the HCP would be considered exposed for the 20 days of the child's isolation period. Per AFL 21-08.9, if the HCP is asymptomatic during this exposure, they can work without restriction, as long as they continue to test negative (see table: Management of for Asymptomatic HCP with Exposures). During the exposure period, the HPC should test as follows:
    - Test upon identification of the exposure, which starts 2 days prior to the infected person's symptoms onset or positive test, if asymptomatic.
    - Continue testing every 3–5 days through 7 days after the end of the infected household member's infectious period (generally at least 5 days if testing negative on day 5 or later, or 10 days if no negative test, and improving symptoms if symptomatic). In this scenario, the infectious period may be longer since the child is immunocompromised.

    If the HCP is symptomatic, but testing negative for COVID-19, the HCP should not return to work until further investigation is completed. Test symptomatic individuals for other respiratory viral pathogens, such as influenza and RSV. If the COVID-19 or influenza antigen test is negative, we recommend repeating the antigen test and/or considering a confirmatory molecular test depending on the timing and likelihood of alternate diagnosis. Consult with your local health department for a more comprehensive respiratory panel.



D. New Admission Guidance

1. **Q: Do new newly admitted/readmitted residents, need to be <u>tested</u> and <u>quarantined</u> on admission?**
A: Per CDPH AFL 22-13.1, guidance for new admissions and residents who have left the facility for > 24 hours (i.e., readmitted), regardless of vaccination status or COVID-19 community transmission levels, includes the following:
    - All new admissions should have a **series of three SARS-CoV-2 tests**; immediately upon admission and, if negative, again at 3 and 5 days after their admission. Antigen or PCR tests are acceptable. Testing is not

required for asymptomatic new admissions who tested positive and met criteria for discontinuation of isolation and precautions prior to admission and are within **30** days of their infection.
Quarantine is not required for asymptomatic newly admitted and readmitted residents, regardless of vaccination status.
- Newly admitted residents and those who have left the facility for > 24 hours should wear **source control** when outside their room for 10 days.

2. **Q: If a patient is tested in the hospital for placement within 48 hours of transfer to the nursing home, can this test count as the first viral test upon admission?**
A: No, the test at the hospital would not count because the incubation period of the virus can be so short (i.e., 2–3 days) and positive cases could be missed. Per AFL 22-13.1, regardless of vaccination status, newly admitted residents should have a series of three viral tests for SARS-COV-2 infection. If the test was taken at the hospital immediately prior (e.g., a few hours before) to the nursing home transfer, it could be counted as the first test that is required immediately upon admission. and, if negative, testing would be done again at 3 days and 5 days after their admission (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-13.aspx).

3. **Q: Can nursing homes require a negative test at the hospitals prior to discharge?**
A: No. Per AFL 22-31.1, SNFs may not require a negative test result prior to accepting a new admission. Results for asymptomatic patients tested in the hospital do not have to be available prior to SNF transfer. Nursing homes should work collaboratively with hospital discharge planners and local health departments to facilitate the safe and appropriate placement of nursing home residents, including new and returning residents requiring isolation and transmission-based precautions.

4. **Q: Do hospitals need to offer patients the booster prior to transfer to the SNF?**
A: Per AFL 21-20.1, CDPH recommends that prior to discharge, hospitals should offer COVID-19 vaccinations, including booster doses, to eligible patients, especially those at highest risk of morbidity and mortality from COVID-19. CDPH recommends that nursing homes reach out to their local hospital infection preventionists to discuss AFL 21-20.1 and to encourage them to offer boosters prior to transferring. https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-20.aspx.

5. **Q: If a new admission's test result come back positive, is that considered an outbreak or a facility-acquired infection?**
A: If a new admission tests positive upon arrival to the facility, that would not be considered a facility outbreak or a facility-acquired infection as long as there were no exposures to other residents and assuming that HCP were wearing appropriate PPE during all care activities. It would be considered acquired either in the community or in the facility of transfer. Notify the facility of transfer of any positive tests upon admission to the new facility.

6. **Q: Can nursing homes close to new admissions during an outbreak?**
A: Per AFL 22-31, many local health departments require SNFs to close to new admissions during an outbreak until transmission is contained.
   - COVID-19: Containment is evidenced by no new cases among residents for 14 days.
   - Influenza: Containment is evidenced by no new cases for 7 days.

   During hospital surges, local health departments should consider the following to allow SNFs to admit new residents before containment is demonstrated:
   - SNF has implemented outbreak control measures (e.g., post-exposure or response testing, cohorting, transmission-based precautions, and chemoprophylaxis for influenza, assuming adequate availability).
   - SNF has no staffing shortages or operational problems.
   - SNF has adequate PPE, staff have been fit-tested, and staff have access to adequate hand hygiene and environmental cleaning supplies.

E. Cohorting

Cohorting Guidance	
CDPH AFL 23-12 COVID-19 Recommendations for PPE, Resident Placement/Movement, and Staffing (1/24/23)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-12.aspx
CDPH COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category (7/22/21)	COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category
CDC Ventilation in Buildings	https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html
CDPH Interim Guidance for Ventilation, Filtration, and Air Quality in Indoor Environments (7/27/22)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Interim-Guidance-for-Ventilation-Filtration-and-Air-Quality-in-Indoor-Environments.aspx

1. **Q: Do nursing homes still need to have a red zone even if there are no COVID-19 positive residents?**
   A: SNFs still need to have a dedicated COVID-19 isolation area (formerly referred to as "red zone"). Per AFL 22-13.1, "SNFs should continue to ensure residents identified with confirmed COVID-19 are promptly isolated in a designated COVID-19 isolation area. The COVID-19 isolation area may be a designated floor, unit, or wing, or a group of rooms at the end of a unit that is physically separate and ideally includes ventilation measures to prevent transmission to other residents outside the isolation area. SNFs that do not have any residents with COVID-19 and do not have a current need for an isolation area should remain prepared to quickly reestablish the area and provide care for and accept admission of residents with COVID-19."

2. **Q: Do nursing homes still need to have a yellow zone to quarantine residents?"**
   A: The "yellow zone" is no longer generally applicable because quarantine and empiric transmission-based precautions are no longer routinely required for COVID-19-exposed and newly admitted residents. However, per AFL 22-13.1, "A facility-wide or group-level approach with quarantine for exposed groups should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission." If a contact tracing approach is infeasible or does not successfully halt COVID-19 transmission, in consultation with the local health department, the facility may need to revert back to the unit-based approach wherein all residents on a unit where a case was identified would be considered exposed and placed in quarantine with empiric transmission-based precautions. In this scenario, that unit would essentially be what we previously referred to as a yellow zone.

3. **Q: For symptomatic residents, can we still use yellow zone terminology?**
   A: CDPH is moving away from the color zone framework that was developed early in the pandemic to guide infection control precautions for groups of residents solely based on their COVID-19 status. SNFs now need to consider COVID-19 along with many other transmissible pathogens (e.g., influenza, MDROs) and individualize precautions based on a resident's specific situation. A symptomatic resident should be empirically isolated and cared for with transmission-based precautions based on their suspected diagnosis, which might be COVID-19, influenza, or another pathogen. While test results are pending, isolate the resident in their current room with empiric transmission-based precautions, and avoid moving the resident so that new exposures throughout the facility are not created. If the resident tests positive for COVID-19, then move them to the designated COVID-19 isolation area and consider the roommate(s) exposed.

4. **Q: Do nursing homes need to have dedicated staffing for caring for residents in the red zone?**
   A: Dedicated staffing for the COVID-19 isolation area and sequencing care for uninfected residents before positive residents are no longer required.
   - Dedicated staffing and/or sequencing care might be preferable from a practical standpoint when there are large numbers of residents in the COVID-19 isolation area (i.e., to facilitate extended use of N95s).
   - Ensure all HCP perform hand hygiene and change gloves and gowns between residents and when leaving the resident's room, or area of care (e.g., treatment or therapy room).
   - Ensure all HCP strictly adhere to masking for source control (to prevent an infected HCP from inadvertently exposing the residents they are caring for).

The facility's full-time infection preventionist should assist with adherence monitoring of hand hygiene and PPE donning/doffing between all residents, and provide just-in-time feedback.

5. **Q: Can HCP working with residents in isolation share the same breakrooms and bathrooms with other HCP?**
   A: Yes. Dedicated staffing for the COVID-19 isolation area is no longer required, therefore HCP can share the same breakrooms and bathrooms. Reinforce teaching about the importance of hand hygiene, managing PPE, avoiding crowding, and performing environmental cleaning for shared spaces. During critical staffing shortages, if COVID-19 positive HCP return to work early per AFL 21-08.9, these workers should:
   - Wear a fit-tested N95 for source control through day 10.
   - Take meal breaks outdoors, or in a well-ventilated area, away from other HCP or residents when removing their N95.
   - Not remove N95s if break rooms are shared; avoid crowding in break rooms.

6. **Q: Can COVID-19-recovered residents be transferred to their previous room assignment even if their roommate is still under investigation for COVID-19?**
   A: Yes. In general, the resident can return to their previous room.

7. **Q: If our SNF has all private rooms, can COVID-19 positive residents isolate in place?**
   A: No. It is still preferrable to have a designated isolation area in the SNF to care for COVID-19 positive residents. This separate isolation area to manage infected residents needs to have recommended ventilation and air flow that will minimize exposure via shared air with residents in other areas of the facility that are not infected.

8. **Q: What signage needs to go on the door?**
   A: It is preferable that the signage on doors illustrate exactly what PPE needs to be worn and what measures HCP need to take when entering and exiting the room. Use of the terms "airborne and contact precautions" by themselves, does not communicate effectively what exactly the HCP needs to do or wear. Note that, although an N95 and eye protection are required when caring for COVID-19 patients, an airborne infection isolation room is not required.

9. **Q: Are nursing homes able to use plastic barriers to indicate a separation between the isolation area (red zone) and the other areas of the facility?**
   A: Avoid using plastic barriers to separate different zones of care. The use of visual clues is preferred to identify your cohort zones and keep unauthorized personnel from entering the unit. If a plastic barrier is used to keep air from the isolation unit from leaving that zone, there are site-specific considerations based on the building design, properties of the barrier, and the resident population. Consultation with a professional who understands the airflow of the building is advised. Any time barriers are deployed, airflow distribution testing with tracer "smoke" or a handheld pressure monitor should be used to be certain that air flow is from clean to dirty, (i.e., from hallway to room where infected individuals may be housed). For more information, visit CDC Ventilation in Buildings and the CDPH Interim Guidance for Ventilation, Filtration, and Air Quality in Indoor Environments.

10. **Q: Is it necessary to treat COVID-19 positive meal trays differently? For instance, should those trays be disposable, or should trays be bagged prior to being sent to the kitchen for cleaning?**
    A: No, there is no need to treat meal trays differently for residents; and there is no need to use disposable trays or utensils for COVID-19 positive residents. As with other meal trays, staff should follow Standard Precautions, wearing gloves if potentially infectious materials are present on the tray (e.g., soiled tissue) and all staff should perform hand hygiene after removing PPE or handling used trays.

11. **Q: Can COVID-19 positive residents in isolation receive group physical therapy (PT)?**
    A: No. Per AFL, 22-07.1, COVID-19 positive residents should remain in isolation in their room until they are no longer infectious. COVID-19 positive residents should only leave their room during this time when it is medically necessary. Guidance for Individual PT sessions for COVID-19 positive residents:
    - Resident can receive individual PT in their room or outdoors.
    - Resident must wear a face mask for source control during PT.
    - Physical therapists working with COVID-19 positive residents must wear appropriate PPE, including an N95 and eye protection, throughout the entire PT encounter.

- The physical therapist can keep the same N95 and eye protection on during the entire PT encounter, even as they transfer the patient throughout the facility.
- Be sure to clean beds or equipment used during physical therapy with an EPA-approved cleaning product for COVID-19 (List N) after each use.

12. **Q: Do the doors to rooms for COVID-19 positive residents need to remain closed?**
A: Yes. CDC's guidance for all healthcare settings is that doors must remain closed, except when entering or leaving the room, when COVID-19 transmission-based precautions are required. This guidance can be modified to facilitate safe resident care. For example, if a resident is a high fall-risk due to physical or mental challenges, the following methods can be used to safely provide care with the door open for observation:
    - The resident should be at least six feet away from the open door.
    - Fans or other ventilation devices should not blow air out of the resident's room.
    - HCPs should wear full PPE when caring for the resident under observation.
    - If able, the resident can wear a mask in the room.
    - Consider the use of video cameras for monitoring; this would require that there is someone monitoring the video input at all times.
    - CDC Considerations for Memory Care Units in Long-Term Care Facilities https://public4.pagefreezer.com/browse/CDC%20Covid%20Pages/11-05-2022T12:30/https://www.cdc.gov/coronavirus/2019-ncov/hcp/memory-care.html.

F. Visitation, Communal Dining and Group Activities

Visitation	Guidance
State Public Health Officer Order: Requirements for Visitors in Acute Health Care and Long-Term Care Settings (Issued 08/26/21; Amended 12/31/21 and 2/7/22; Rescinded 9/15/2022)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Requirements-for-Visitors-in-Acute-Health-Care-and-Long-Term-Care-Settings.aspx
CDPH AFL 22-07.1 Guidance for Limiting the Transmission of COVID-19 in SNFs—includes updated visitation and communal dining guidance (10/6/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-07.aspx
CDPH Guidance for the Use of Face Masks – includes requirements for masking in healthcare settings (9/20/2022)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx
CDC Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes	https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html
CMS QSO-20-39-NH: Visitation Guidance (revised 9/23/2022)	https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

1–5. **Q: Can you provide highlights of the new visitation guidance in CDPH AFL 22-07.1 (revised 10/06/2022)?**
A: AFL 22-07.1 further expands visitation opportunities for SNF residents. Highlights from this new guidance include:

1. **General Visitation Guidance**
Adhere to core principles of COVID-19 infection prevention outlined in CMS QSO 20-39-NH, including universal masking (source control) for HCP and residents and frequent hand hygiene. Visitation should be person-centered; consider the resident's physical, mental, and psychosocial well-being; and support their quality of life. Any visitor, regardless of vaccination status, must adhere to the following:
    - ***Visitor Screening:*** Visitors are not required to show proof of vaccination or a negative test to have indoor or outdoor visitation. However, CDPH continues to strongly recommend that all persons (including residents, visitors, and staff) complete the COVID-19 primary vaccination series and recommended boosters. While not required, facilities may offer and encourage testing for visitors. Visitor screening for COVID-19 signs and symptoms, and exposures is still required, but may be conducted via passive

screening as recommended by CDC (refer to Section F, question #6). Documentation of visitor screening is not required. If the visitor has a confirmed COVID-19 infection or symptoms consistent with COVID 19, they should defer non-urgent, in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent in-person visitation until 10 days after their close contact. Those with COVID-19 symptoms or have been in close contact with a confirmed positive case, must reschedule their visit, regardless of vaccination status.

- ***Visitor Masking:*** Visitors must continue to comply with CDPH Masking Guidance. In healthcare settings, visitors must wear a well-fitting face mask with good filtration (N95, KF94, KN95, or surgical masks are preferred over cloth face coverings) and perform hand hygiene upon entry and in all common areas in the facility (https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx).
- Visitor movement in the facility should be limited, regardless of visitor's vaccination status.

2. **Indoor, In-Room, and Large Communal Space Visitation Requirement**

Facilities shall allow indoor in-room visitation for all residents, regardless of vaccination status, including in isolation areas.

Indoor, in-room visitation shall meet the following conditions:

- Both the resident and visitor must wear a well-fitting face mask.
- Regardless of vaccination status, resident and visitors 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 unless eating or drinking.
- Visits for residents who share a room should be conducted in a separate indoor space or with the roommate not present in the room (if possible), regardless of the roommate's vaccination status. Conducting the visit with the roommate present is not ideal, but is permissible if there are no other options, such as an outdoor or large communal space visit. If roommate(s) is present during a visit:
  - Ensure residents and visitor(s) wear masks for source control.
  - Provide as much distance as possible between roommate and visitor(s).
  - Try to limit total number of individuals present to avoid crowding in small rooms and enclosed spaces.
- Visitors to residents in isolation areas should be provided the same PPE recommended for HCP when visiting COVID-19 positive residents in isolation (N95 respirator, eye protection, gown, gloves). HCP should instruct visitors on proper hand hygiene and donning and doffing PPE. Fit testing for N95 respirators is not required for visitors, but the visitors should be instructed how to perform a respirator seal check. Visit https://www.cdc.gov/niosh/docs/2018-130/pdfs/2018-130.pdf?id=10.26616/NIOSHPUB2018130 for information on how to do a seal check.

Accommodate visitation in large, communal indoor spaces for residents who are not in isolation:

- Indoor spaces used for visitation should be arranged to accommodate physical distancing between visitor/resident groups.
- Provide ongoing assessment of the number of visitors. When the maximum is reached, visits will need to be conducted in the resident's room (if appropriate) or outdoors (preferable).
- Both the resident and visitor who are fully vaccinated must always wear a well-fitting face mask unless eating or drinking while in designated spaces for visitation. These visits may be conducted without physical distancing and include physical contact (e.g., hugs, holding hands).

3. **Continuing Outdoor Visitation Requirements**

- All facilities must continue to allow outdoor visitation options for all residents, regardless of vaccination status.
- Outdoor visits are preferred as meeting outdoors poses a lower risk of transmission due to increased space and airflow and should be offered unless the resident cannot leave the facility or when there are weather or poor air-quality constraints.
- Outdoor visits between residents and all visitors do not need to be conducted with face masks and may include physical contact (e.g., hugs, holding hands).
- Other options for visitors to communicate with residents are encouraged and discussed in AFL 22-07.1.

4. **Communal Dining and Group Activities**
   - ***Communal Dining:*** Residents who are not in isolation and have not recently been exposed to COVID-19, may eat in the same room without masks or physical distancing (when no visitors are present), regardless of vaccination status. Avoid crowding within spaces**.** Residents who have been exposed to COVID-19 must wear a mask for 10 days following the most recent exposure. Therefore, they should not participate in communal dining because masks must be removed during eating and drinking.
     - Visitors can dine with the resident they are visiting, regardless of the visitor's vaccination status. Masks may be removed while eating or drinking. Physical distancing should be maintained between resident-visitor groups in communal indoor spaces.
   - ***Group Activities:*** Residents who are not in isolation may participate in group/social activities together without masks or physical distancing (when no visitors are present), regardless of vaccination status. Exposed residents can participate in group activities as long as they wear a mask throughout the activity for a minimum of 10 days following the most recent exposure.
   - 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, (e.g., when one or more cases has been identified in facility staff or residents).

5. **Residents Who Leave and Return to the Facility**

   Educate residents leaving the facility about potential risks of public settings. Encourage and assist with adherence to source control, physical distancing, and hand hygiene regardless of whether visiting in public or private settings. Refer to CDC guidance: How to Protect Yourself & Others https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.
   - ***Non-essential Personnel/Contractors***
     - Barbers, manicurists/pedicurists, and other non-essential personnel/contractors who comply with universal face mask requirements of the facility may enter the facility and provide services to residents in appropriate spaces (outdoors, if feasible, or indoors in a well-ventilated area where physical distancing can be maintained between residents).
   - ***Additional Considerations for Pediatric Residents***
     - Visitation must be permitted for pediatric residents.
     - Involve Child Life workers, parents, legal guardians, or authorized representatives in planning the facility visitation program.
     - Extended periods of physical contact may be allowed between the pediatric resident and fully vaccinated visitors.
     - See additional pediatric guidance in AFL 22-07.1.

6. **Q: Do healthcare settings need to actively screen visitors prior to entry?**

   A: No. CDPH AFL 22-07.1 is now aligned with CMS QSO 20-39 and CDPH SPHO "Requirements for Visitors in Acute Health Care and Long-Term Care Settings" which was rescinded Sept 15, 2022. Visitors are no longer required to show proof of vaccination or a negative test to have indoor visitation. While not required, facilities may offer and encourage testing for visitors. Visitors must continue to comply with CDPH Masking Guidance. Visitor screening for COVID-19 signs and symptoms, and exposures is still required, but may be conducted via **passive screening** as recommended by CDC. Options for passive screening to ensure visitors are educated to screen themselves prior to entry, include **posting signs at entrances and sending emails or letters to families and visitors to provide guidance** about recommended actions for visitors who have:
   - A positive viral test for COVID-19,
   - Symptoms of COVID-19, or
   - Have had close contact with someone with COVID-19.

   If they have a confirmed COVID-19 infection or symptoms consistent with COVID-19, they should defer non-urgent, in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent, in-person visitation until 10 days after their close contact. Refer to "CDC Notice on Facility Access" for more information, including the "CDC Facilities COVID-19 Screening Tool" (https://www.cdc.gov/screening/privacy-notice.html). A facility may decide to return to active screening if visitors with symptoms or exposure are continuing to visit.

7. **Q: With passive visitor screening now acceptable, can nursing homes have multiple entrances?**
A: Yes. The single point of entry made it feasible for a facility to actively screen staff and visitors prior to entry. Now that passive screening is acceptable, it would be reasonable to have more than one entry point to the facility. However, visitors that enter the facility still need to check in to sign a visitor log like they did pre-pandemic so that the facility is able to track who is in the building. Visitors no longer need to complete a screening log to indicate their vaccination records, testing results, or that they have screened themselves for signs and symptoms of COVID-19 or exposures.

8. **Q: If the facility is experiencing an outbreak, are we still expected to coordinate visitation?**
A: Yes. Visitation is expected to be coordinated even when there is an outbreak, per CDPH AFL 22- 07. Consult with your local public health department for further guidance. In some circumstances, at the beginning of an outbreak, the local health department may temporarily discontinue visitation and group activities to determine the extent of transmission and ensure response measures are underway. If PPE is required for contact with the resident due to quarantine or COVID-19 positive isolation status, it must be donned and doffed according to instruction by HCP. Visitors should be taught how to do a seal check for N95 respirators, but fit testing is not required.

9. **Q: Can COVID-19 positive residents in isolation have outdoor visits?**
A: Outdoor visitation for COVID-19 positive residents in isolation can be accommodated for outdoor visits on a case-by-case basis, but must be conducted safely. COVID-19 positive residents in isolation should generally not be leaving their rooms during their isolation period unless medically necessary. They can have in-room visits while in isolation (visitors must wear proper PPE). On a case-by-case basis, an outdoor visit would be reasonable if their room has an attached outdoor patio.

10. **Q: Is there a limit to the number of visitors for one resident?**
A: CDPH does not specify a limit; however, the number of visitors allowed for one resident may need to be limited if the space available for visitation is insufficient to ensure safety precautions are in place. Keep in mind that physical distancing must be maintained from other visitors, other residents, and staff.

11. **Q: Are nursing homes allowed to require testing of all visitors prior to entry as a precautionary measure, regardless of vaccination status?**
A: It may be reasonable to implement a policy to test all visitors prior to entry regardless of vaccination status; however, a nursing home cannot refuse entry to a visitor. Denying entrance would not align with CMS QSO-20-39 that expands visitation opportunities for nursing home residents.

12. **Q: Are there any suggestions for how to conduct visits that reduce the risk of COVID-19 transmission?**
A: Refer to question #11 in the CMS QSO-20-39-NH FAQs (https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf). There are ways facilities can and should take extra precautions, such as hosting the visit outdoors, if possible; creating dedicated visitation space indoors; permitting in-room visits when the resident's roommate is not present; and the resident and visitor should wear a well-fitting mask (preferably those with better protection, such as surgical masks or KN95), in accordance with CDC recommendations, perform frequent hand-hygiene, and practice physical distancing when in large gatherings. Some other recommendations include:
    - Offering visitors surgical masks or KN95 masks.
    - Limiting the visitor's movement in the facility, during an outbreak, to only the location of the visit.
    - Increasing air-flow and improving ventilation and air quality. See CDPH Improving Ventilation Practices to Reduce COVID-19 Transmission Risk in Skilled Nursing Facilities: https://www.cdph.ca.gov/Programs/CCDPHP/DEODC/OHB/Pages/ventilationFAQ.aspx.
    - Cleaning and sanitizing the visitation area after each visit.
    - Providing reminders in common areas (e.g., signage) to maintain physical distancing in large gatherings, perform hand-hygiene, and wear well-fitting masks.

13. **Q: What are the visitation guidelines for children under 5 years old?**
A: The visitor guidance does not distinguish between age groups. If a visitor (whether child or adult) is unable to adhere to recommended universal masking, any PPE requirements, and the core infection prevention principles, facilities should explore other safe methods of visitation (e.g., a virtual visit, or a visit with a safety barrier in place, such as a window).

14. **Q: When small children visit nursing homes, does the nursing home need to provide pediatric-size gowns and gloves for visits in the isolation area?**
A: When a small child visits a nursing home, the nursing staff should assess the child's size for proper PPE, ability to comply with the use of PPE, and educate/work with the parent or guardian to create a plan so the child can safely visit. Based on the assessment of the child's ability, understanding, and compliance with safety recommendations, staff can work with the parent or guardian to create a plan for a safe visit with the resident. Factors such as the child's ability to wear PPE, follow instructions, and the resident's mobility should be considered when creating a visitation plan. In-person, outdoor visits are preferable; in some cases, window-based visits, visits behind a barrier, or virtual visits may provide safer visit options.

G. PPE and Face Masks

PPE and Face Masks: Important Links	
CDPH AFL 23-12 COVID-19 Recommendations for PPE, Resident Placement/ Movement, and Staffing in SNFs (1/24/23) Chart (pdf)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-12.aspx https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-23-12-Attachment-01.pdf
CDPH AFL 21-28.3 COVID-19 Testing, Vaccination Verification and PPE for HCP at SNFs (updated 2/22/22)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-28.aspx
CDC Interim Infection Prevention and Control Recommendations for HCP During the COVID-19 Pandemic	https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html
CDC COVID Data Tracker	https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk&null=Risk
CDC Summary of Strategies to Optimize Use of PPE in Presence of Shortages	https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html
State Health Officer Guidance for Face Masks (Updated 9/20/22)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx
Get the Most Out of Masking (printable reference materials; multiple languages available)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx
CDC Standard Precautions	https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html

1. **Q: When do HCP need to wear eye protection (face shields, goggles)?**
A: HCP need to wear eye protection when caring for symptomatic or confirmed COVID-19 positive residents in isolation. Eye protection should also be worn when performing tasks that could generate splashes or sprays of blood, body fluids, secretions, and excretions per Standard Precautions.
   - Universal eye protection is no longer required during care of residents who do not have COVID-19 or for recently exposed residents, regardless of community transmission rates.
   - Universal eye protection and N95 respirators for AGPs can be considered:
     - During a surge or periods of high community transmission
     - During a COVID-19 outbreak in the facility.
     - If recommended by the local health department.
   - Eye protection is not necessary in non-patient care areas (i.e., kitchen, hallways, nurses' station).

2. **Q: Do visitors and HCP need to wear masks for source control while in a nursing home?**
   A: Yes. In healthcare settings, CDPH continues to require universal masking (source control) of all visitors and HCP, regardless of vaccination status or community transmission rates. Surgical masks or higher-level respirators (e.g., N95s, KN95s, KF94s) with good fit are highly recommended. In healthcare settings, masks continue to be required in non-patient care areas, including meeting or break rooms.
   - CDPH Get the Most Out of Masking https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx
   - CDPH Guidance for the Use of Face Masks https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Guidance-for-Face-Coverings.aspx

3. **Q: Can HCP wear KN95s instead of surgical masks in non-patient care areas and when caring for residents that are not in isolation?**
   A: Yes, surgical masks, KN95s, KN94s, and N95s can be worn as source control by SNF HCP when caring for patients who do not have COVID-19 and when working in non-patient care areas. While KN95s are acceptable, CDPH cautions against the use of KN95s as source control to avoid confusion with N95s. Because of concerns that some KN95s are counterfeits, only NIOSH-approved N95s should be worn as PPE for transmission-based precautions.

4. **Q: Can HCP wear surgical masks rather than N95s when caring for residents who do not have COVID-19 or for recently exposed residents?**
   A: Yes. Surgical masks are acceptable as source control when HCP are caring for residents who do not have COVID-19 or for recently exposed residents, and when working in non-resident care areas. However, N95 respirators for AGPs can be considered as **both** PPE and source control:
   - During a surge or periods of high community transmission.
   - During a COVID-19 outbreak in the facility.
   - If recommended by the local health department.

5. **Q: Are face masks required in non-patient care areas?**
   A: Yes, per state guidance on face masks and CDC infection control guidance, universal masking as source control remains required for HCP and visitors in specified high-risk settings, including healthcare. https://www.cdph.ca.gov/Programs/CID/DCDC/pages/covid-19/guidance-for-face-coverings.aspx.

6. **Q: Are N95 respirators required for staff working in non-patient care areas, such as the kitchen, hallways, nurses' station, and back offices, or is a surgical mask sufficient?**
   A: No, N95 respirators are not required for staff to use as source control in non-patient care areas. A surgical mask is sufficient. Eye protection is also **not** necessary in non-patient care areas, regardless of level of county transmission. The only situation where N95s would be required as source control is for COVID-19 positive HCP returning to work during a critical staffing shortage before meeting usual criteria to discontinue isolation, per CDPH AFL 21-08.9.

7. **Q: Are residents required to wear masks in nursing homes?**
   A: Masks are not required for residents in their rooms (i.e., their home); however, they are still required during in-room visits (unless eating or drinking). Masks are recommended, but not required, for residents when outside of their rooms (e.g., hallways, common areas). If outside visitors are present (e.g., during large communal space visitation), both residents and visitors must wear a mask unless eating or drinking. If residents have been exposed to an individual with COVID-19, they must wear a mask for 10 days following the most recent exposure, even during group activities. Residents who have been exposed should not participate in communal dining since masks must be removed during eating and drinking.

8. **Q: When can masks be removed in high-risk settings, such as nursing homes?**
   A: Examples when individuals are exempt from wearing masks are:
   - Persons with a medical condition, mental health condition, or disability that prevents wearing a mask. This includes persons with a medical condition for whom wearing a mask could obstruct breathing or who are unconscious, incapacitated, or otherwise unable to remove a mask without assistance.
   - Persons who are hearing impaired or communicating with a person who is hearing impaired (i.e., the mouth is essential for communication).
   - Persons who are working alone in a closed office or room.

- Persons/providers who are obtaining or providing a speech, occupational or language therapy session.
- People do not need to wear masks when outdoors.
- For residents who are not in isolation and not exposed, masks may be removed while actively eating or drinking, and while participating in group/social activities together (when outside visitors are not present).

More information can be found in the CDPH Q&As:
https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Face-Coverings-QA.aspx.

9. **Q: What is CDC's updated guidance regarding universal PPE (i.e., use of eye protection and N95 respirators) for AGPs based on community transmission?**
A: CDC no longer routinely recommends HCP wear eye protection for all direct patient/resident care, and N95 or higher-level respirator while caring for all residents undergoing AGPs, based on the level of community transmission. Eye protection and N95 respirators for AGPs can be considered:
   - During a surge or periods of high community transmission, or
   - During a COVID-19 outbreak in the facility.

   However, for California nursing homes, Cal/OSHA requires that nursing homes use respirators for any AGPs on residents with aerosol transmitted diseases (i.e., COVID-19, tuberculosis) per Cal/OSHA's Aerosol Transmissible Disease standard (https://www.dir.ca.gov/dosh/Coronavirus/Skilled-Nursing.html). Also, CDC recommends, and Cal/OSHA requires, HCP to use N95s for AGPs for residents with suspected/confirmed seasonal influenza. See updated guidance in CDPH AFL 23-12 (distributed 1/24/23), including the attached PPE table which is now aligned with CDC recommendations.

10. **Q: What is the updated guidance for Enhanced Standard Precautions (ESP)?**
A: On October 5, 2022, CDPH distributed AFL 22-21 (supersedes AFL 19-22) which updates ESP guidance for SNFs and Distinct Part/SNFs. AFL 22-21 distributes the updated CDPH document "ESP for SNFs, 2022" (20 pages). Visit https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/ESP.aspx for links to ESP resources:
   - Adherence Monitoring Tool
   - Six Moments Sign
   - Trifold Pamphlet

   Additional resources to guide implementation are under development.

11. **Q: Can surgical masks be used past their expiration date?**
A: No.

12. **Q: Can N95 respirators be used beyond their expiration date?**
A: No. NIOSH, CDC, and FDA state that respirators cannot be used as PPE beyond their expiration date in the absence of shortages. However, expired masks (N95 or surgical style) can be used for source control in the facility (but **not** as PPE), as long as the integrity of the mask and elastic ties are intact.
   - https://www.cdc.gov/niosh/npptl/respirators/testing/ExpiredN95results.html
   - https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
   - https://www.fda.gov/media/135763/download

13. **Q: Are staff required to change N95s after caring for residents with probable or confirmed positive COVID-19 status? Or can they continue to wear the same N95 throughout the shift?**
A: Cal/OSHA removed all guidelines allowing for contingency capacity (extended use) or crisis capacity (reuse) because the supply and availability of NIOSH-approved respirators is sufficient. All respirators must be used in accordance with their NIOSH certification without exception.
   - When used as PPE, N95s should generally be removed and discarded after each patient encounter.
   - However, extended use may be implemented for HCP who are sequentially caring for a greater volume of patients with suspected or confirmed SARS-CoV-2, including those cohorted in a SARSCoV-2 unit, those placed in quarantine, and residents on units impacted during a SARS-CoV-2 outbreak, even in the absence of a supply shortage. Extended use refers to the practice of wearing the same N95 respirator for repeated encounters with several different patients, without removing the respirator between patient encounters. Cal/OSHA has clarified that if the HCP is caring for multiple residents with the same infectious disease, the HCP does not need to discard the N95 after each patient encounter if that aligns with the manufacturer's instructions on how long the respirator can be used. When practicing extended use of N95 respirators over the course of a shift, the respirator should be discarded after being removed

for a break and at the end of the shift. If removed for a meal break, for example, the respirator should be discarded and a new respirator put on after the break. The respirator should also be changed if HCP are moving from one cohort zone to another. N95 respirators should be removed and discarded if soiled, damp, or damaged.

- When an N95 is used strictly for source control in areas with no known COVID-19 exposure or non-patient care areas, the N95s may be used for multiple patient encounters until soiled or damaged (i.e., once the strap breaks it should be discarded).

CDC Strategies for Optimizing the Supply of N95 Respirators
https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html.

14. **Q: What PPE is necessary when HCP are caring for an asymptomatic resident that has been exposed to COVID-19?**
A: Empiric transmission-based precautions and full PPE are no longer required for asymptomatic exposed residents, because quarantine (i.e., yellow zone) is no longer required following an exposure. CDPH continues to require universal masking (source control) of all HCP. Surgical masks or higher-level respirators (e.g., N95s, KN95s, KF94s) with good fit are highly recommended.

15. **Q: Are empiric, transmission-based precautions for exposed, symptomatic residents that have not been confirmed to have COVID-19 (waiting for test result) still recommended?**
A: Yes. Transmission-based precautions are required and include eyewear (face shield or goggles), N95, gloves and gown.

16. **Q: Can an N95 respirator with an exhalation valve be used as PPE and as source control?**
A: Yes, a NIOSH-approved N95 respirator with an exhalation valve offers the same respiratory protection to the wearer as one that does not have a valve. As source control, NIOSH research suggest that, even without covering the valve, N95 respirators with exhalation valves provide the same or better source control than surgical masks. In general, people wearing NIOSH-approved N95s with an exhalation valve should not be asked to use one without an exhalation valve or to cover it with a face covering or mask. Note that NIOSH-approved N95 respirators with an exhalation valve are not fluid resistant and should not be used in situations where a fluid resistant respirator is indicated (e.g., in surgical settings). See CDC: PPE Questions and Answers for additional information on N95 respirators with exhalation values. Cal/OSHA respirator standard prohibits the use of masks over, or on top of, N95 filtering facepiece respirators because these could disrupt the seal of the N95 respirator to the face. Check also with your local health department as they may have additional requirements.

H. Infection Prevention Training

Infection Preventionist Guide	
CDPH AFL 20-52 COVID-19 Mitigation Plan Implementation and Submission Requirements for SNF and Infection Control Guidance for HCP (5/11/20)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-52.aspx
CDPH AFL 20-84 IP Recommendations and Incorporation into the Quality and Accountability Supplemental Payment (QASP) Program (11/4/20)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-84.aspx
AB 2644 (Chapter 287, Statutes of 2020)	http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB2644
CDPH AFL 21-51: Assembly Bill 1585—Expansion of SNF IP Minimum Qualifications (12/13/21)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-51.aspx

1. **Q: Are nursing homes required to have a full-time infection preventionist (IP)?**
A: California nursing homes are required to have an IP 40 hours a week per AFL 20-52, AFL 20-84, AFL 21-51, and AB 2644. Effective January 1, 2021, SNFs are required to have a full-time, dedicated IP. The IP role may be filled either by one full-time IP staff member or by two staff members sharing the IP responsibilities, if the total time dedicated to the role equals at least the time of one full-time staff member. In original guidance, the IP must be filled by an RN or LVN; however, AFL 21-51 guidance distributed on December 13,

2021, expanded eligibility and minimum qualifications for a SNF's IP. The new guidance is that the IP must have primary professional training as a licensed nurse, medical technologist, microbiologist, epidemiologist, public health professional, or other healthcare related field. The IP must be qualified by education, training, clinical or healthcare experience, or certification, and must have completed specialized training in infection prevention and control. The IP hours shall not be included in the calculation of 3.5 hours of direct patient care per day provided to residents. The IP must complete 10 hours of continuing education in the field of infection prevention and control (IPC) on an annual basis.

2. **Q: Which training courses meet the requirements for IP training in AB 2644?**
A: Per AFL 20-84, each IP should receive initial training (minimum 14-hour program), followed at least 10 hours of continuing education on an annual basis.

   The initial IPC fundamentals training program should be completed by a new IP within 90 calendar days of hire. If an existing SNF employee is designated for the IP role, that person should complete the initial IP training within 30 calendar days of their designation.

   The initial IPC fundamentals training should include the following topic areas:
   a. Role of the Infection Preventionist
   b. Infection Prevention Plan
   c. Standard, Enhanced Standard, and Transmission-Based Precautions
   d. Hand Hygiene
   e. Injection Safety
   f. HAI Prevention (e.g., respiratory, BSI, UTI, scabies, CDI, MDRO)
   g. Infection Surveillance
   h. Cleaning, Disinfection, Sterilization, and Environmental Cleaning
   i. Microbiology
   j. Outbreaks
   k. Antibiotic Stewardship
   l. Laws and Regulations (e.g., reporting requirements)
   m. Preventing Employee Infections

   Examples of approved courses include:
   - CDPH Infection Preventionist Training for SNFs Online Course cdph.ca.gov/Programs/CHCQ/HAI/Pages/IP_TrainingForSNFs_OnlineCourse.aspx
   - CDC Nursing Home Infection Prevention Training Course https://www.cdc.gov/longtermcare/training.html
   - CAHF AHCA Infection Preventionist Specialized Training (IPCO) https://www.cahf.org/Education-Events/QCHF-Education-Foundation/AHCA-Infection-Preventionist-Specialized-Training-IPCO
   - CALTCM Infection Preventionist Orientation Program https://www.caltcm.org/infection-preventionist-orientation-program2

   The IP should complete 10 hours of continuing education in the field of IPC on an annual basis. Facilities should provide encouragement and support for IP staff to stay abreast of current news and training sources through a nationally recognized infection prevention and control association.

3. **Q: What is F945—Infection Control Training?**
A: F945 is a new CMS phase 3 requirement specific to infection control that was issued October 21, 2022, and became effective October 24, 2022. F945 requires that **nursing homes develop, implement, and permanently maintain an effective training program for <u>all staff</u>**, which includes, training on the standards, policies, and procedures for the infection prevention and control program as described at §483.80(a)(2), that is appropriate and effective, and as determined by staff need.
   - For the purposes of this training requirement, staff includes all facility staff (direct and indirect care functions), contracted staff, and volunteers (training topics as appropriate to role).
   - Changes to the facility's resident population, community infection risk, national standards, staff turnover, the facility's physical environment, or facility assessment may necessitate ongoing revisions to the facility's training program for infection prevention and control.

- All training should support current scope and standards of practice through curricula which detail learning objectives, performance standards, evaluation criteria, and addresses potential risks to residents, staff, and volunteers if procedures are not followed.
- There should be a process in place to track staff participation in and understanding of the required training.
- Such infection control training must, at a minimum, include the following areas:
  - The facility's surveillance system designed to identify possible communicable diseases or infections before they can spread to other persons in the facility.
  - When and to whom possible incidents of communicable disease or infections in the facility should be reported.
  - How and when to use standard precautions, including proper hand hygiene practices and environmental cleaning and disinfection practices.
  - How and when to use transmission-based precautions for a resident, including but not limited to, the type and its duration of use depending upon the infectious agent or organism involved.
  - Occupational health policies, including the circumstances under which the facility must enforce work restrictions and when to self-report illness or exposures to potentially infectious materials.
  - Proper infection prevention and control practices when performing resident care activities as it pertains to particular staff roles, responsibilities, and situations.

Resources:

- CMS 483.95 Training Requirements https://qsep.cms.gov/data/352/TrainingRequirements.pdf
- CMS State Operations Manual: Appendix PP—Guidance to Surveyors for Long Term Care Facilities https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

4. **Q: What infection prevention training programs are available to assist nursing homes in meeting the F945 staff infection control training requirements?**
   A: Per F945, the below trainings will assist nursing homes in meeting the requirement to have all staff trained in infection prevention practices.
   - CMS Targeted COVID-19 Training for Frontline NH Staff and Management Training
     - Accessible at qsep.cms.gov
     - 3-hour training for frontline staff
     - 4.5-hour training for management
   - CDPH Project Firstline Training for SNF Certified Nursing Assistants (CNAs)
     - Eight 30-minute trainings
     - Contact ProjectFirstline@cdph.ca.gov
   - CDC Project Firstline Infection Control Training (2-hour training accessible at www.train.org)

I. Other Questions

1. **Q: How do I determine the level of community transmission for my facility?**
   A: Use the CDC COVID Data Tracker (https://covid.cdc.gov/covid-data-tracker/#county-view?list_select_state=all_states&list_select_county=all_counties&data-type=Risk&null=Risk). Enter the state and county and ensure the Data Type is set to "Level of Community Transmission" to determine the level in your county. Community Transmission refers to measures of the presence and spread of SARS-CoV-2, the virus that causes COVID-19. The two metrics used are (1) new cases per 100,000 persons in the past 7 days, and (2) percentage of positive NAAT tests during the past 7 days.

2. **Q: How can I register for the California Health Alert Network (CAHAN) notifications to receive the call notes and alerts when new AFLs and statewide guidance are distributed?**
   A: CAHAN is CDPH's emergency preparedness notification platform to distribute CDC Health Alerts and CDPH AFLs. The CAHAN is intended for 2–3 key contacts at each healthcare facility. Interested parties should complete the Contact Add Request Form and return it to their Local Health Alert Network Coordinator https://member.everbridge.net/892807736722952/faq. Contact CAHANinfo@cdph.ca.gov with enrollment issues.

3. **Q: When do the CDPH daily and weekly 123 surveys need to be completed?**
   A: The CDPH daily 123 survey needs to be completed daily by 12 noon PT. The CDPH weekly survey 123 needs to be completed weekly anytime on Monday, Tuesday, or Wednesday by 11:59 p.m. If your facility missed the deadline and did not submit the CDPH 123 survey responses timely, SNFs need to report directly into NHSN to meet CMS reporting requirements to avoid a deficiency and CMP.
   a. For access or to reset a password, contact COVID-19SNFSURVEY@cdph.ca.gov.
   b. Include your email and facility ID from CDPH Health Care Facility ID Lookup https://cdphdata-hub.maps.arcgis.com/apps/Media/index.html?appid=52ccd0d4ceae4836a931e91797a59974&locale=en-us&center=-114.8924,37.6713&level=6.
   c. More information: How to Login to the COVID-19 SNF Survey Hub (ca.gov) https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-43-Attachment-02.pdf.

4. **Q: What is the definition of an outbreak in a nursing home?**
   A: The definition of an outbreak in a nursing home can be found in CDPH AFL 23-09: COVID-19 Outbreak Investigation and Reporting Thresholds, updated on January 18, 2023; https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-09.aspx:

   Threshold for Additional Investigation by Facility
   - ≥1 suspect, probable or confirmed COVID-19 case in a resident or HCP;
   - ≥3 cases of acute illness compatible with COVID-19 in residents with onset within a 72-hour period;
   - ≥1 suspect, probable or confirmed COVID-19 case in HCP

   Threshold for Reporting to Local Public Health
   - ≥1 probable or confirmed COVID-19 case in a resident or HCP;
   - ≥3 cases of acute illness compatible with COVID-19 in residents with onset within a 72-hour period;
   - ≥1 probable or confirmed COVID-19 case in HCP

   Outbreak Definition
   - ≥1 facility-acquired COVID-19 case in a resident;
   - ≥3 suspect, probable or confirmed COVID-19 cases in HCP with epi-linkage and no other more likely sources of exposure for at least 2 of the cases

5. **Q: How often do vital signs need to be taken?**
   A: CDC and CDPH infection control guidance for nursing homes recommend:
   a. Vital signs for COVID-19 negative or recently recovered residents should be monitored daily.
   b. Vital signs, including pulse oximeter measures for COVID-19 exposed residents who are asymptomatic should be monitored every shift, which can be defined as either an 8- or 12-hour shift, (i.e., twice daily), allowing residents to get uninterrupted sleep.
   c. Vital signs for COVID-19 positive residents in isolation should be monitored every 4 hours and include pulse oximeter measurements.

   Refer to CDPH AFL 20-25.2 Attachment (https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-20-25-Attachment-05-SNF-Assessment-Checklist.pdf).

6. **Q: What monoclonal antibody treatments are available for COVID-19?**
   A: None. On 11/30/2022, the FDA (www.fda.gov/drugs/drug-safety-and-availability/fda-announces-bebtelovimab-not-currently-authorized-any-us-region) revoked authorization for the only remaining COVID-19 monoclonal antibody treatment, Bebtelovimab, because it is not active against the variants circulating at this time. It is possible that newer monoclonal antibody preparations will be developed in the future.

7. **Q: Is civil money penalty (CMP) funding available to help nursing homes with expenses?**
   A: Per CDPH AFL 20-77 (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-77.aspx) federal CMP funding has been available to nursing facilities during the last 2 years for facilities to purchase materials that aid with in-person visitation. Up to $3,000 is available for tents, clear partitions, installation costs, and technology solutions, or other products to facility visitation remotely. Information on how to apply for CMP funds can be found at: https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/CitationPenaltyAccountsReports.aspx.

9. **Q: What are the guidelines for the use of fans in resident rooms or in common areas?**
   A: Fans can help improve ventilation; however, they must be used in a safe manner so they do not blow potentially contaminated air from one person to another. Measures to ensure fans are used properly include:
   - Avoiding the use of high-speed settings on fans.
   - Orienting fans to promote airflow from parts of a facility toward locations with known or suspected positive cases and then to the outside (i.e., clean-to-less-clean direction).
   - Mounting fans in open windows or place them near open windows to direct indoor air to flow outside.
   - Positioning fans so that air does not blow from one person to another.
   - Not having residents congregate in outside areas where window fans are located.
   - Keeping ceiling fans turned off unless necessary for the thermal comfort of building occupants. If they are turned on, they should be used at low velocity with fan blades set to pull air upwards.

10. **Q: How long do we need to keep COVID-19 records for employees?**
    A: View Title 8: §3204. Access to Employee Exposure and Medical Records—Preservation of Records https://www.dir.ca.gov/title8/3204.html. Each employer shall assure the preservation and retention of records as follows:
    - **(A) Employee Medical Records.** The medical record for each employee shall be preserved and maintained for at least the duration of employment plus 30 years.
    - **(B) Employee Exposure Records.** Each employee exposure record shall be preserved and maintained for at least 30 years.

11. **Q: Should we follow CDC or CDPH cleaning and disinfecting guidance?**
    A: CDPH guidance complements CDC guidelines. Here are links to the guidance.
    - CDPH resources:
      - CDPH HAI Program Environmental Cleaning Webpage https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/EnvironmentalCleaning.aspx
      - Environmental Services (EVS) Adherence Monitoring Tools and CDC EVS Guidelines https://www.cdph.ca.gov/Programs/CHCQ/HAI/Pages/MonitoringAdherenceToHCPracticesThatPreventInfection.aspx
    - CDC Guidelines and EVS materials:
      - Healthcare Environmental Infection Prevention and Control https://www.cdc.gov/hai/prevent/environment/index.html

12. **Q: What are your recommendations regarding indoor training for a large number of staff?**
    A: HCP, regardless of their vaccination status, are allowed to attend trainings as long as they are complying with the required source control measures in place for them when they are at work. Large trainings are acceptable, but we encourage attendees to be mindful of the use of source control, physical distancing, and hand hygiene. If possible, hold the training outdoors or in a well-ventilated space.

13. **Q: Are there any regulations about how often to change the tubing on an oxygen cylinder or concentrator when not visibly soiled or contaminated?**
    A: Tubing for an oxygen cylinder or concentrator should be changed between their use on different patients, when it is visibly soiled or mechanically malfunctioning. Follow published guidelines or the manufacturer's instructions for use (IFU) about specific products.

    CDC MMWR: Guidelines for Preventing Health Care Associated Pneumonia, 2003—Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm.

14. **Q: Could you give an update on safe administration of nebulizer treatments for bedbound SNF residents in multiple occupancy rooms who do not have COVID-19 or are COVID-19 recovered?**
    A: CDC no longer recommends implementing universal use of N95s for HCP during care for residents undergoing aerosol generating procedures in facilities located in counties with substantial or high levels of community transmission per the CDC COVID Data Tracker.

15. **Q: Is there a way to get previous versions of the CDPH AFLs?**
    A: Yes, past AFL versions, as well as other federal and state guidance, can be found at Clear Pol, which is a

free search engine designed to make compliance easier for long term care professionals (https://app.clearpol.com/).

16. **Q: Can pets visit in the nursing home?**
A: There are no COVID-19 restrictions of pet visitation. Allowing pets to visit is at the discretion of each facility. Please refer to the CDC website: "Information about COVID-19, Pets, and Other Animals" (https://www.cdc.gov/healthypets/covid-19/index.html) to learn more about COVID-19 and pets. Please ensure any pet therapy program encourages good hand hygiene before and after touching the pet.

17. **Q: Do healthcare settings need to continue to screen HCP prior to entry?**
A: CDC still recommends screening for signs and symptoms of COVID-19, and potential exposures, but has transitioned from an **active** screening to a **passive** self-screening process. Examples of passive screening, include posting signs at entrances, and sending emails and letters providing guidance to HCP about recommended actions for HCP who have:
    - A positive viral test for COVID-19.
    - Symptoms of COVID-19.
    - Close contact/higher-risk exposure with someone with COVID-19.

    There is no longer a requirement for nursing homes to actively ask screening questions prior to entry, and temperatures do not need to be checked. Facilities may choose to continue to screen HCP in an active way, especially when community transmission rates are high or during a surge if they choose.

J. Acronym Definitions

Acronym	Definitions
AB	Assembly Bill
AFL	All Facilities Letter
AGP	aerosol-generating procedure
ATD	aerosol transmissible disease
BSI	bloodstream infection
CAHAN	California Health Alert Network
CAIR2	California Immunization Registry
Cal/OSHA	California Division of Occupational Safety and Health
CalREDIE	California Reportable Disease Information Exchange
CDC	Centers for Disease Control and Prevention
CDI	*Clostridioides difficile* infection
CDPH	California Department of Public Health
CLIA	Clinical Laboratory Improvement Amendment
CMP	civil money penalty
CMS	Centers for Medicare & Medicaid Services
CNA	certified nursing assistant
COVID-19	coronavirus disease 2019
DCVR	Digital COVID-19 Vaccine Record
ELR	Electronic Laboratory Reporting system
EMT	emergency medical technician
ER	emergency response
EUA	Emergency Use Authorization (FDA)

Acronym	Definitions
EVS	environmental services
FAQ	frequently asked question
FDA	U.S. Food and Drug Administration
HAI	healthcare-associated infection
HCP	healthcare personnel
HCW	healthcare worker
HR	human resources
HSAG	Health Services Advisory Group
IIS	Immunization Information System
IP	infection prevention or infection preventionist
IPC	infection prevention and control
IPCO	infection prevention control officer
J&J	Johnson & Johnson
L&C	Licensing and Certification
LHD	local health department
LVN	licensed vocational nurse
MDRO	multi-drug resistant organism
MHOAC	Medical Health Operational Area Coordinator
MMWR	Morbidity and Mortality Weekly Report (CDC)
NAAT	Nucleic Acid Amplification Test (viral diagnostic test)
NHSN	National Healthcare Safety Network (CDC)
NIOSH	National Institute for Occupational Safety & Health
OTC	over the counter
PCP	primary care physician
PCR	polymerase chain reaction (detects virus genetic material)
POC	point of care
PPE	personal protective equipment
QIIP	Quality Improvement Innovation Portal
QSO	Quality, Safety, and Oversight
RN	registered nurse
RSV	respiratory syncytial virus
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2, the virus that causes COVID
SNF	skilled nursing facility
UTI	urinary tract infection

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