Infection Prevention of COVID-19 in Long-Term Care Facilities

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1. Introduction

This Infection Prevention Toolkit is based on guidance of the County of Santa Clara Public Health Department (SCC PHD), California Department of Public Health (CDPH), and Centers for Disease Control and Prevention (CDC). Though this Toolkit was written with Skilled Nursing Facilities (SNFs) in mind, it is largely applicable to other Long-Term Care Facilities (LTCFs) as well. Since the last version, we have included newer guidance in the Addendums regarding: CDC Guidance for Antigen Testing, duration of quarantine, health care workers’ return to work after exposure, evaluation of possible reinfection, use of employee breakrooms, and new CDC guidance on ways to improve ventilation in buildings. COVID-19 vaccines are beyond the scope of this Toolkit and are discussed in detail in recent SCC PHD, CDPH and CDC updates.

Given their congregate nature and resident population served (e.g., older adults with chronic medical conditions), LTCFs are at the highest risk of serious illness or death due to COVID-19. Given the high risk of spread, facilities must be prepared to take immediate action to protect residents and healthcare workers (HCWs).

COVID-19 is the disease caused by SARS-CoV2 virus. The incubation period for COVID-19 is 2-14 days with an average of 5 days. Residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not have any symptoms. Asymptomatic and pre-symptomatic infections contribute to transmission in the congregate setting. Symptoms may include fever, chills, night sweats, sore throat, cough, shortness of breath, loss of appetite, nausea, vomiting, diarrhea, fatigue, myalgias, headaches, dizziness. There may be atypical symptoms such as altered mental status and loss of sense of taste and smell.

Current data suggests person-to-person transmission most commonly happens during close exposure to a person infected with SARS-CoV2 via respiratory droplets produced when the infected person speaks, coughs, or sneezes. Droplets can land in the eyes, nose or mouth of others in close proximity. Transmission might also occur through contact with contaminated surfaces (i.e., fomites) followed by contamination of the eyes, nose, or mouth. Transmission via smaller respirable particles, called aerosolized or airborne particles, to those in close proximity may be an issue in small enclosed spaces with poor ventilation. COVID-19 specific Transmission Based Precautions (TBP) includes Social Distancing and specific Personal Protective Equipment (PPE) as well as Standard Infection Prevention measures such as Hand Hygiene and Surface Decontamination.

2. Definitions

- Healthcare Worker (HCW): EMS, nurses, nursing assistants, physicians, technicians, therapists, phlebotomists, pharmacists, trainees, contractual staff not employed by the facility, persons not directly involved in patient care, (e.g., clerical, dietary, environmental services, laundry, security, facilities, administrative, billing personnel).
- Healthcare Personnel (HCP): same as HCW.
- Source Control: face covering or mask that covers nose/mouth to contain respiratory secretions, which may reduce the risk of transmission from symptomatic and asymptomatic persons.
- Person Under Investigation (PUI): a person who has symptoms consistent with COVID-19 and is awaiting test results, or a person who has been exposed to a confirmed case of COVID-19 and is awaiting evaluation.
- Transmission-Based Precautions (TBP): refers to COVID-19 specific infection control measures, as mentioned above. TBP is used in the care of residents, who are in isolation with known or suspected COVID-19, or who are in observation/quarantine.
- Cohorting: refers to the separation of residents and HCW within the facility to reduce transmission of disease.
- Personal Protective Equipment (PPE): equipment such as mask or isolation gown necessary for protection against contact, respiratory droplets or aerosolized particles.
- Surgical Mask: a part of PPE designed for source control and to protect against respiratory droplets. These are prioritized for use by staff while working in the facility.
• **Eye Protection:** a part of PPE such as face shield or goggles, to be worn in addition to a mask, for protection against splashes and sprays.

• **N95 Mask:** a part of PPE, also called a respirator, to protect against aerosolized or airborne infectious particles.

• **COVID-19 Tests:**
  - PCR (aka NAAT) tests for the SARS-CoV-2 virus which causes COVID-19. The original test involves a nasopharyngeal (NP) swab. The newer tests involve anterior nares (AN) and mid-turbinate (MT) swabs, and more recently released saliva sampling (NEJM, Wylie, Aug. 28, 2020). The newer tests are suitable for self-collection by staff, under observation by a HCW, standing at 6 ft distance, without the need to wear N95. PCR tests are positive during an acute infection. The positivity (or sensitivity) varies by the date of collection after initial exposure, the lowest false negative rate or highest sensitivity being day #8 after exposure (or about day #3 of symptoms). (Annals IM, Kucika, Aug. 18, 2020).
  - POC antigen test kits were released in the fall by HHS to select SNFs. Facilities sign CLIA waiver to operate test, viral media is not needed, and test results are available in 15-20 minutes on average. Antigen tests are not as sensitive as PCR. Refer to [CDC Interim Guidance for Antigen Testing SARS-CoV-2](https://www.cdc.gov/coronavirus/2019-ncov/lab/antigen-testing.html) (see Addendum).
  - POC Antigen Testing can be used in Skilled Nursing Facilities and Congregate Care Facilities that have a CLIA Waiver as a screening tool for both symptomatic and asymptomatic populations. Test specimens are typically collected using an anterior nares (AN) swab and yield results within 15 minutes. POC Antigen Testing enables facilities to prevent outbreaks before they happen as isolation measures can be subsequently taken after detection of active contagions.
  - At this point, based on CDPH/CDC guidance Positive POC Antigen Tests for screening are traditionally confirmed with PCR testing. The BinaxNow antigen tests are most sensitive (independent of symptoms) when someone has a high viral load of COVID-19, and were found to be highly specific as well, based on community testing data from UCSF here: [Performance characteristics of a rapid SARS-CoV-2 antigen detection assay at a public plaza testing site in San Francisco](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7405368/). This means that when the tests are positive, they are highly likely to pick up people who have high viral loads, which can then reduce transmission within the congregate facility.
  - The frequency of PCR or antigen testing is beyond the scope of the Toolkit. The frequency of testing of residents and staff in LTCF is determined by the “tier” or the % positivity COVID-19 in the community.
  - Serology is a blood test to detect if the body has developed antibodies to the virus. It is still unclear if antibodies are protective against reinfection and how long antibodies last. Some persons do not mount an antibody response at all. Serology is being used by epidemiologists for population surveillance and convalescent serum is occasionally used in the treatment of severely ill hospitalized patients. Vaccine status may affect antibody result but does not affect PCR or antigen result.

3. **Key Concepts**

- Educate Residents and Families
- Educate Healthcare Workers
- Restrict Visitors
- Infection Prevention Measures
- PPE Use and Conservation
- Containment by Cohorting Residents and HCW

4. **Educate Residents and Families about COVID-19**

Educate residents and families about steps the facility is taking to protect them and their loved ones (e.g., visitor restrictions) and actions needed to protect themselves in the facility (e.g., social distancing, hand hygiene, respiratory hygiene, cough etiquette, and masking). Have a plan to regularly communicate with residents, family members and HCW if cases of COVID-19 are identified in the facility. Consider using pamphlets and video (see Addendum) as tools to
educate residents and families. Regularly review local (CDSS, CDPH and SCC PHD) memos for current information and provide residents and families with updates.

Take the following proactive steps with residents/families (see CDPH ALF 20-73):

- Ensure that residents/decision makers are informed about COVID-19 and the higher risk of severe illness and death from COVID-19 for older persons and those with comorbidities.
- Inform residents/decision makers of possible treatment options for those who become seriously ill from COVID-19, including treatment options that are available in the facility.
- Inform residents/decision makers that cardiopulmonary resuscitation (CPR) is the default treatment for cardiac arrest and will be started unless there is an existing valid "do not resuscitate" (DNR) order in the Advance Directive or POLST.
- POLST form is appropriate for residents of LTCF and allows for residents/decision makers to specify Preferred Intensity of Care.
- Confirm with the residents/decision makers the resident’s preferences for treatment in the event of severe COVID-19 symptoms.
- Create a treatment plan and obtain orders from the medical provider or Medical Director that reflect resident preferences, including whether the resident wants to be transferred to a hospital for treatment of severe COVID-19 symptoms.
- Implement telehealth program to support advance care planning and, if the need arises, access for residents/families to hospice palliative care services.

5. Enforce Visitor Policies

Limit visitors in facilities when there is an outbreak (defined as one of more cases among resident or staff). Encourage alternative methods for visitation, e.g., phone calls, video chats, iPads. Develop a plan for when the facility will allow more visitors, including number of visitors, duration of visit, select hours, etc. The specific situations of end of life visitation, emotional support person, and family visits are discussed below. All visitors should be carefully screened, (e.g., temperature, detailed review of symptoms, questions regarding exposure within past 14 days) and not permitted to enter if they fail screening. Have versions in different translations available. All visitors should be instructed regarding hand hygiene, masking, social distancing, restriction to resident’s room or specified location, and minimal contact with surfaces. Refer to CDPH AFL 20-22 Guidance for Limiting the Transmission of COVID-19 in Long-Term Care Facilities, Visitation Fact Sheet.

End of Life Visits for Residents

Recommendations for end of life visits by family or friends of residents with suspected or confirmed COVID-19 and who exhibit a rapid decline in health (as determined by the medical provider or medical director):

- End of life visits should occur in a single-occupancy room.
- The visit should be approved by the medical provider/director and the DON.
- Visits should be scheduled. Limit # visitors at given time, duration of visit, and # visits per day. Children <12 years of age are not permitted.
- Visitors should be screened and masked, and should perform hand hygiene upon entry.
- Visitors should be instructed about COVID-19 with a pamphlet/video.
- Visitors should be escorted to the resident’s room.
- The DON or designee should instruct the visitor regarding donning/doffing of PPE, hand hygiene, social distancing, and minimal contact with surfaces.
- Visitors are restricted to resident’s room and should leave facility immediately after visit.
• Surfaces in resident’s room/bathroom should be sanitized after the visit.
• Visitors should self-monitor for symptoms of COVID-19 for 14 days after the visit and report to the facility if symptoms appear or COVID-19 is diagnosed.

Recommendations for end of life visits by family or friends of residents without suspected or confirmed COVID-19 and who exhibit a rapid decline in health (as determined by the medical provider or Medical Director):

• Same as above but, in this case, the visitor does not need specific instructions regarding specific PPE.

**Emotional Support Persons for Residents**

Emotional Support Persons (ESPs) are important to residents with physical, intellectual, or developmental disabilities, as well as those with cognitive impairment. There are other indications for ESP listed in the CMS guidance for safe visitation.

• These visits are permitted for residents who do not have suspected/confirmed COVID-19.
• One ESP (the same one) is permitted per resident; # hours per day should be limited.
• If resident is in a shared room, the visit should take place elsewhere, e.g. outdoors or in a large communal indoor space.
• The other recommendations are as above (e.g. screening, masking, hand hygiene, social distancing, restricting to room).
• ESP should be instructed about COVID-19 with an instructional pamphlet/video.
• At facilities where COVID-19 transmission is being investigated, (e.g. response driven testing or during a small outbreak), ESP visits may still occur. See CDPH AFL 20-22.5
• The facility has the right to disallow ESP, if the facility is short staffed or involved in a major outbreak
• ESP involved in indoor visit should be tested (see Addendum) “Testing Required for Indoor Visitors.”

**Visits by Family or Friends**

Visits by family or friends are important to the emotional well-being of the resident as well as that of visitor. Visits are safest if they occur outdoors, e.g. on a patio. Alternatively, visits may take place in a large well-ventilated communal indoor space. Whether indoors or outdoors, plexiglass partitions can be used to maintain separation between the resident and visitor (see Photographs). All parties should be masked and maintain social distancing. Affected surfaces should be sanitized after each visit. The visits should be scheduled in advance. These sessions need to be monitored to ensure compliance. The facility can determine the number of family members, the duration of visit, and number of visits per day. See CMS QSO 20-39: Guidance for Safe Visitation.

• At facilities where COVID-19 transmission is being investigated, (e.g. response driven testing or during a small outbreak), visits may still occur. See CDPH AFL 20-22.5
• The facility has the right to disallow visits. if the facility is short staffed or involved in a major outbreak.
• Allowance of indoor visits may vary, depending on the county’s “tier” of community transmission or % positivity.

**Guidance Regarding Testing for Indoor Visits and Returning Residents:**
(See Addendum)

6. Educate HCW on Infection Control, Sick Leave Policies, and Staffing
• Utilize webinars and other educational materials in translations (see Addendum) to educate staff, including ancillary staff such as Dietary and Housekeeping.
• DON and IP nurse can offer regular coaching sessions using material learned from COCA or CMS IP modules.
• Consider a buddy system so staff can watch and protect each other.

Source Control

• Staff should wear a surgical mask at all times while in the facility. Staff may wear a cloth mask, if not involved in patient areas (e.g., Medical Records or Billing).
• Monitor social distancing in staff break rooms or common areas (see Addendum)

Eye Protection

• See CDC’s Interim Infection Prevention and Control Recommendations. Eye protection pertains to all persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or their infectious secretions. Even an administrator who chats with a resident in the hallway, is at risk. Goggles or face shields may be used; face shields also protect the mask (surgical or N95) but may further impact hearing impaired residents.

Temperature and Symptom Screening

• HCWs (including ancillary staff) should regularly monitor themselves for fever or other symptoms of COVID-19.
• Facility should screen staff at the beginning of shift. If shift is longer than ten hours, repeat screening mid-shift.
  o Fever is defined as temperature ≥99°F or subjective fever.
  o Staff should be asked if fever reducer has been taken in the past 24 hours.

Ill Healthcare Workers

• Sick leave policies should be non-punitive. Staff should not report to work when ill. If staff develop fever or other symptoms of COVID-19 while at work, they should promptly inform their supervisor, exit the workplace, and seek medical attention.

Return to Work

• For guidance as to when HCW with suspected or confirmed COVID-19 may return to work, refer to the New Isolation and Quarantine Guidance.

Minimizing Healthcare Worker Exposures

• Staff who work in multiple locations pose a higher risk and are encouraged to inform their supervisor if they have had exposure at other facilities with confirmed cases. Staff who travel should monitor themselves more closely during the 14 days after return from the trip.

Staffing Shortage

• Facility should have plans for anticipated staffing shortages during an outbreak.
• This may include plans to hire from Registry or transfer staff from a sister facility.
• If resources are limited, submit a 213RR to resourcetracking@eoc.sccgov.org. Refer to SCC PHD Resource Request Process
• If there is staffing shortage, HCW under quarantine may be allowed to RTW early. Refer to Updated Quarantine Guidance (see Addendum)

**Consultant Staff**

• Educate consultants (e.g., wound care, podiatry, dental, hospice) who provide care in the facility, as consultants work in multiple facilities and can serve as a source of transmission. Some consultants can provide services via telehealth.

• Outside consultant and ancillary (e.g., lab radiology) staff are expected to have regular COVID-19 testing, per guidance of SCC PHD and CDPH.

7. **Strategies for Infection Prevention**

SNFs must have a full time Infection Prevention (IP) specialist; this can be a shared position. Other LTCFs are strongly encouraged to do the same. CDC certification can be met by attending a 19 hour online course: CDC Infection Preventionist Training Course.

• **Hand Hygiene**
  - Place alcohol-based hand sanitizer ABHS with 60-70% alcohol in hallways, other resident care and common areas.
  - Wall-based ABHS may be placed in hallways in memory care units.
  - Staff can carry easy-to-dispense ABHS on their belts/fanny packs.
  - ABHS is to be used if there is limited access to soap and water; handwashing with soap and water is still preferred.
  - Consider implementing handwashing stations at entrance and on patio; this invites hand washing by staff and visitors.
  - Monitor frequent hand washing among residents, especially before/after meals and after toileting.
  - Monitor frequent hand washing of staff, especially before/after direct resident care and upon entering/leaving resident rooms.

• **Respiratory Hygiene**
  - Provide tissues in common areas/resident rooms.
  - Instruct on cough etiquette.

• Place hands-free trash cans (and laundry bins if needed) inside resident rooms and in common areas. Place hands-free laundry bins inside resident rooms or common areas.

• **Surface decontamination**
  - Develop a schedule for regular disinfection of shared equipment (e.g., Hoyer lift, scales, monitors, exercise equipment) and high touch surfaces (e.g., resident rooms, shared resident bathrooms, staff breakrooms and staff bathrooms) in common areas.
  - Engage staff at all levels to disinfect, e.g., CNA or caregiver to assist in cleaning shared bathrooms; nursing staff to assist in cleaning stations.
  - Refer to List N: Disinfectants for Use Against SARS-CoV-2 for EPA-registered disinfectants qualified for use. Review the contact time (time surface should stay wet) of each product.
  - Encourage staff to clean common spaces such as break rooms and patios; set up caddies of cleansers/towels or disinfectant strips so they are readily accessible.

8. **Personal Protective Equipment Use and Conservation**

PPE is essential for protection of the HCW. Due to impending shortage of PPE, there is a need to conserve use. Refer to CDC PPE Burn Calculator and designate staff to monitor inventory and stewardship. During PPE shortages with limited supply chain, refer to SCC PHD Resource Request Process. Submit a 213RR to resourcetracking@eoc.sccgov.org.
Bundle patient care activity to reduce PPE waste. Ensure PPE is available in all resident care areas. Instruct staff regarding proper donning and doffing of PPE. Staff who provide care for residents with known or suspected COVID-19 should wear N95 masks (or surgical masks if N95 are not available), eye protection, gown and gloves. During PPE shortages, N95 masks are prioritized for aerosolizing procedures. Once there is adequate supply, staff should resume use of N95 masks in the care of COVID-19 residents.

Extended use of PPE is for the purpose of conservation and refers to wearing personal equipment for an entire shift or during the care of more than one resident. For additional PPE strategies, refer to CDC Strategies for Optimizing PPE Shortages (see Addendum).

9. General Management and Cohorting of Residents

- Encourage residents to remain in their rooms.
- Encourage residents, especially those with memory issues (see Addendum) to practice social distancing, to mask when outside of the room, and to perform frequent hand hygiene, e.g. assist memory impaired resident by frequently washing hands with soapy hand towels.
- Masks should not be placed on residents who have trouble breathing or on residents who are incapacitated or unable to remove mask without assistance.
- If in a shared room, residents should be separated by 6 feet. If the room is small, a curtain should be drawn between the head of beds.
- To accommodate social distancing, consider reducing the number of beds in a multi-occupancy room.
- Some group activities can be resumed, as isolation and lack of stimulation increase the risk of behavioral problems and poor physical health. The safest place for group activities to occur is outdoors or in a large indoor communal space.
- Residents without COVID-19 may participate in small group activities and chair exercise.
- The Activities Coordinator needs to enforce masking of residents and hand hygiene, sanitization of surfaces and shared items between activities, and limiting the number of participants in shifts to maintain six feet of social distancing.
- Additional staff (e.g., CNA or caregiver) should assist the Activities Coordinator in monitoring residents, especially those with memory issues, to maintain masking hand hygiene and social distancing.
- Other activities (e.g., use of salons, facility pool, communal dining, and outdoor excursions) will be guided by reopening policies of the County.

Cohorting of Residents

Cohorting residents is to prevent transmission and is based on the result of COVID-19 tests. For discussion of baseline, screening and response-driven testing, refer to the SCC PHD memo and CDPH ALF 20-53.3

**COVID unit** is designated for residents with confirmed COVID-19. This unit could be a dedicated floor, unit, or wing in the facility. Dedicated staff should be assigned to work only in this area. These staff should be physically separated from other staff by having a separate entrance, exit, breakroom, and restroom. Ideally there is a foyer between the COVID unit and staff breakroom or restroom where PPE donning/doffing occurs.

**PUI unit** is designated for residents who develop symptoms or who may have been exposed to a confirmed COVID-19 case and are awaiting results of the COVID-19 test. These residents should be left in the original room rather than being moved about. No new residents should be moved in with the possibly exposed residents. See CDPH AFL 20-74. There should be clear signage on the door. Doors should be kept closed unless there is a safety risk to the resident, in which case this should be documented.
**Observation Unit** is to monitor new admissions, those who may have been exposed in the community or hospital prior to admission. These residents should ideally be placed in single-occupancy rooms and should be treated with TBP for 14 days (from last day of exposure) before retesting and being released into the Regular unit.

(Assuming that the resident is transferring from the hospital and there is no “ongoing transmission at the hospital,” the acute care hospital days may count toward the 14 day observation period. See [CDPH AFL 20-53.3](https://www.cdph.ca.gov/Programs/EID/ nid/mos/germs/posn/covid19/pdf/20-53.3.pdf). The determination of whether there is ongoing transmission at the hospital can be determined by speaking with hospital infection preventionist.

Assuming there is no ongoing transmission at the hospital, readmissions do not require testing or quarantine. Residents who leave the facility for ED evaluation do not require testing or quarantine. Residents who leave the facility for dialysis do not require testing or quarantine but consider cohorting dialysis residents in one unit. Residents who go out regularly should be tested regularly. This is captured in the county-mandated monthly surveillance of SNF residents but should also be performed for residents of other LTCFs).

**Regular or General Unit** is for residents without known exposure to COVID-19 and who do not require isolation or quarantine.

See photos for examples of plastic dividers that can be used to separate the units. Dividers or signs can be used to clearly indicate that one is entering the Observation unit.

TBP (including full PPE) is needed when caring for residents in the COVID, PUI and New Patient Observation Units. Staff should be especially cautious when moving between the PUI and New Patient Observation rooms, to avoid cross-contamination. Cessation of TBP and transfer to the Regular Unit can be done under guidance. Refer to [New Isolation and Quarantine Guidance](#).

10. Evaluation of Residents with Confirmed or Suspected COVID-19

Screen residents daily for symptoms of COVID-19 (see list of symptoms in Introduction) Also consider atypical symptoms such as loss of appetite and altered mental status. If a resident develops symptoms, immediately notify the medical provider or director for evaluation. Isolate the resident and implement TBP. Prioritize testing for residents suspected to have or exposed to COVID-19.

SCC PHD should be notified immediately of residents with suspected/confirmed COVID.

Monitor ill or exposed residents more frequently (e.g., symptoms, vital signs, oxygen saturation and general appearance) once or twice per shift. Engage the medical provider early and provide frequent updates. Notify the medical provider immediately regarding the need for further evaluation or possible transfer to higher level of care, should a resident develop altered mental status, low blood pressure, low O2 saturation or dyspnea. Transport personnel and the receiving facility should be notified of suspected diagnosis prior to transfer. Signed advance directive or POLST form should be available (see above).

To remove residents from isolation or TBP, refer to the [New Isolation and Quarantine Guidance](#).

11. Airborne Transmission and Aerosol Generating Procedures

**Airborne transmission** of SARS-CoV-2 can occur under special circumstances. Pathogens that are mainly transmitted through close contact (i.e., contact and droplet transmission) can sometimes also be spread via airborne transmission.
under special circumstances. There are several well-documented examples in which SARS-CoV-2 appears to have been transmitted over long distances or over prolonged period of time. These transmission events appear uncommon and have typically involved the presence of an infectious person producing respiratory droplets for an extended time (>30 minutes to multiple hours) in an enclosed space. Enough virus was present in the space to cause infections in people who were more than 6 feet away or who passed through that space soon after the infectious person had left. Circumstances under which airborne transmission of SARS-CoV-2 appears to have occurred include:

- **Enclosed spaces** within which an infectious person either exposed susceptible people at the same time or to which susceptible people were exposed shortly after the infectious person had left the space.
- **Prolonged exposure to respiratory particles**, often generated with expiratory exertion (e.g., shouting, singing, exercising) that increased the concentration of suspended respiratory droplets in the air space.
- **Inadequate ventilation or air handling** that allowed a build-up of suspended small respiratory droplets and particles.

Existing interventions to prevent the spread of SARS-CoV-2 appear sufficient to address transmission both through close contact and under the above circumstances of potential airborne transmission. Among these interventions, which include social distancing, use of masks in the community, hand hygiene, surface cleaning/disinfection, ventilation and avoidance of crowded indoor spaces are especially relevant for enclosed spaces, where circumstances can increase the concentration of suspended small droplets and particles carrying infectious virus.

**Aerosol Generating Procedures** (AGP) increase the risk of aerosolizing virus particles and require a negative airflow or improved ventilation. Examples of AGP include intubation and bronchoscopy, which occur in the acute hospital setting. Other examples are BiPAP, CPAP, off-line suctioning of ventilator patients, high flow oxygen, and nebulizer treatment. Nebulizer treatment should be switched, if possible, to a hand-held inhaler with a spacer. If nebulizer treatment must continue, it can be carried out in a treatment room with good ventilation; the room can “sit” undisturbed for an hour after the treatment before surfaces are disinfected. In the event of N95 shortage, N95 masks should be prioritized to staff caring for residents with confirmed or suspected COVID-19 who are receiving AGP.

**Ways to Improve Ventilation:** CDC recently posted guidance on ventilation in buildings as part of a layered approach to reduce exposure to SARS-CoV-2. This ventilation guidance provides a range of interventions that can help reduce the concentration of virus particles in the air, ranging from simple low-cost interventions such as opening windows and opening outdoor air dampers to reduce HVAC air recirculation, to use of portable high-efficiency particulate air (HEPA) fan/filtration systems, and upper room ultraviolet germicidal irradiation (UVGI). Utilize facility engineers to help implement these improvements in your facilities. See Addendum #8 for more details.

12. **Other Mitigation Strategies and County of SCC PHD Contact Information**

- Actively engage the Medical Director and the medical provider or LTCF team providing care for the resident at the facility. Clinical teams such as Kaiser, PAMF, and SCVMC work closely with SCC PHD to identify areas for improvement at the LTCFs. Our mutual focus is to help keep residents and staff safe.
- Implement a Hand Hygiene Program Champion
  - Alberta Health Services: Hand Hygiene Toolkit
  - Institute for Healthcare Improvement: Improving Hand Hygiene Practice with Six Sigma
- Implement a Champions for Safety Program
  - Provide comprehensive training for all staff, including supervisors and managers.
  - Engage staff champions as role models.
  - Disseminate best practices for improving PPE use.
- Implement observational rounds and conduct regularly scheduled audits.
- Use monitoring systems and checklists.

- **SCC Public Health Provider Call Center** for prompt reporting of cases
  - 408-885-4214, press option 3 and ask for the Provider Branch

- **Medical Health Joint Operations Center Skilled Nursing Liaison:**
  - Marina Zamarron, marina.zamarron@phd.sccgov.org
Addendum #1 Additional Strategies regarding PPE Use and Conservation:

- CAL OSHA allows for extended use of N95, e.g., for an entire shift or maximum of 5 donnings/doffings, assuming there is no damage or contamination.
  
  In August, OSHA issued new guidance against re-use (such as the 5 mask rotation strategy) or Batelle decontamination, citing poor fit after re-use and decontamination.

  This question was recently posed: “in a shortage, can we reuse N95s that have been stored long enough for the virus to deactivate?” OSHA’s reply: “N95s in good condition, properly stored, not used for 7 days or more, can be returned to the original owner for use without decontamination if in a critical shortage.” (CDPH LTCF Call Notes 10/14/2020)

  OSHA guidance on N95s may change in the situation of acute shortage. Refer to Understanding Compliance with OSHA’s Respiratory Protection Standard During the Coronavirus Disease 2019 (COVID-19) Pandemic.

  Fit testing by OSHA approved program is necessary for N95 use. See You-tube video.

  After repeated donning/doffing, a Seal test (see reference) should be performed to ensure fit. Surgical masks are not to be worn over N95 as it would prevent the filtering function of N95 and there would be more “touching” of the masks. Facial hair is not compatible with N95 use. Cloth masks are not to be worn under N95 as it would affect the seal and may reduce the ability of the wearer to aerate.

- Goggles or face shields are required for eye protection in direct patient care areas. Face shield also protect masks (N95 or surgical) if masks are worn in extended fashion. Face shields may further impact residents with impaired hearing. Goggles and face shields should be cleaned with alcohol-based cleanser if soiled/contaminated or at end of a shift. If wearing in extended fashion, staff must refrain from touching the mask, goggles or face shield. Hand hygiene must be performed before and after touching mask, goggles or face shields. These items should be stored in paper bags during breaks.

- Gowns should be isolation gowns (see diagram below), made of microfibre or cloth, knee or calf length, with elastic around wrists. (The county may supply plastic gowns in a contingency). Gowns should not be layered on top of other gowns. Gowns need to be removed if soiled or contaminated.

  During gown shortage, extended use of gowns is permitted in COVID or Red unit. In this case, there should be clean areas on unit where gowns are not worn such as nurses’ station or clean supply rooms.

  Extended use of gowns is not permitted in the Observation or Yellow units. Gown use should be prioritized for staff involved in high contact care of residents, activities where there may be splashes and sprays, and during AGPs. During critical gown shortage, gowns may be re-used in the Observation or Yellow units, one gown per resident per staff per shift; the gown is reserved in the resident’s room. In this case, strict attention must be paid to proper donning and doffing of gown. The gown must be laundered or discarded if soiled or contaminated.

- Gloves are for direct patient care only. Staff must change gloves when moving from one resident to another in a shared room. Gloves are to be discarded before exiting the room and not to be worn in hallways or nursing stations. Handwashing should be performed after exiting the room. Staff must refrain from touching eyes, face or mouth with potentially contaminated gloves, and avoid carrying nonessential items into resident room (e.g., phone, pen, paper).

- A therapist who has to share his time between Regular and Observation unit should start in the Regular unit, then move to Observation unit later in the day. Upon entering the Observation unit, he should don appropriate PPE and spend the remainder of his shift there without moving back and forth to another unit or the PT gym.
IP nurse and DON should regularly educate the staff, so as to avoid confusion over what may appear to be complex and arbitrary PPE rules.

For additional guidance, refer to the table [CDPH HAI: PPE use in relation to Resident Category](#) and CDC: [Summary of Strategies to Optimize Use of PPE in Presence of Shortages](#)
Evaluating the results of an antigen test for SARS-CoV-2 should take into account its performance characteristics, e.g. sensitivity and specificity, of the FDA-authorized assay, the prevalence of SARS-CoV-2 infection in the particular community (positivity rate in the community), and the clinical context of the person being tested.

The evaluation of an antigen test result should consider whether the patient has experienced symptoms. Generally, clinicians can rely upon a positive antigen test result for a symptomatic patient because the specificity of current FDA-authorized antigen tests is high.

The sensitivity of antigen tests varies, and thus negative results should be handled differently depending on the test, its performance characteristics, and intended application (e.g., clinical diagnosis, screening). In most cases, the manufacturers’ instructions for use of antigen tests indicate that negative test results should be considered “presumptive,” meaning that they are preliminary results.

It may be appropriate to confirm antigen test results with another test. CDC recommends following its antigen testing algorithm (Figure 1 below PDF pdf icon[PDF – 457 KB]) to determine when confirmatory testing is recommended. (Nucleic acid amplification test or NAAT is used interchangeably with PCR).

When the person being tested has symptoms of COVID-19, the pretest probability is high. When the person being tested is asymptomatic and has no history of exposure, the pretest probability is low.

Figure 1. Antigen Test Algorithm
Addendum #3 CDC & CDPH Testing Algorithm

CDPH TTF has modified the CDC algorithm, taking into account the number of days of symptoms and the community positivity rate. This is what we should use in practice.
Addendum #4 Guidance Regarding Testing for Indoor Visits and Returning Residents

Testing Required for Indoor Visitors at Long-Term Care Facilities

All visitors must obtain a PCR diagnostic test for COVID-19 within 72 hours of their scheduled visit to a long-term care facility. Any visitor who tests positive for COVID-19 shall not be allowed to visit a long-term care facility during the time that they are supposed to be in isolation.

Visitors must provide the long-term care facility with a copy of their negative test result for COVID-19 prior to or upon arrival at the facility for their visit.

To document compliance with this Directive, long-term care facilities must maintain a log of all visitors, along with copies of their COVID-19 test results, for the prior 30 days.

Visitors with a negative COVID-19 PCR test result can conduct additional visits to a long-term care facility without getting re-tested for COVID-19 if no more than 7 days have passed since the date that the visitor was tested for COVID-19 (i.e., the date the specimen was collected).

The testing requirements in this Directive shall only apply to visitors conducting indoor visits at long-term care facilities and shall not apply to any of the categories of individuals exempt from the visitation restrictions in CDPH’s AFL 20-22.5.

Quarantine Required for Long-Term Care Facility Residents Returning to the Facility After Visits to Family or Friends in the Community

Long-term care facilities shall only allow residents to visit family or friends in the community in compliance with State rules and Mandatory Directive for Gatherings.

Long-term care facilities that allow residents to visit family or friends in the community shall screen returning residents for signs and symptoms of COVID-19, immediately test and isolate returning residents who are symptomatic in a single room pending results, isolate returning residents who test positive, quarantine all other returning residents for 10 days, and test quarantined residents at the end of the 10-day
Addendum #5 Evaluation for Possible Reinfection

SARS-CoV-2 reinfection is a rapidly evolving area of research. The following proposed criteria, which CDC acknowledges may not capture all instances of reinfection, will be refined as new evidence develop.

Criterion A: Persons with/without Covid-19 symptoms 90 days or more after initial illness
Criterion B: Persons with COVID-19 symptoms 45-89 days after initial illness

Investigate cases that meet criterion A or B

For persons with detection of SARS-CoV-2 RNA ≥90 days since first SARS-CoV-2 infection
Persons with detection of SARS-CoV-2 RNA* ≥90 days after the first detection of SARS-CoV-2 RNA, whether or not symptoms were present
AND
Paired respiratory specimens (one from each infection episode) are available
*If detected by RT-PCR, only include if Ct value <33 or if Ct value unavailable

For persons with COVID-19–like symptoms and detection of SARS-CoV-2 RNA 45–89 days since first SARS-CoV-2 infection
Persons with detection of SARS-CoV-2 RNA* ≥45 days after the first detection of SARS-CoV-2 RNA
AND
With a symptomatic second episode and no obvious alternate etiology for COVID-19–like symptoms OR close contact with a person known to have laboratory-confirmed COVID-19
AND
Paired respiratory specimens (one from each infection episode) are available*If detected by RT-PCR, only include if Ct value <33 or if Ct value unavailable.

In settings of limited genomic testing capacity, CDC suggests prioritizing investigation of persons in the ≥90 day time window because the longer time interval between first and second infection might have higher suspicion for reinfection.

Deciding which laboratory tests to conduct
Genomic sequencing of paired specimens—that meet the quality criteria below—is needed to investigate reinfection. Genomic sequencing is available only at research labs such as Biohub in San Francisco. SCC PHD would determine if such a test is indicated in the evaluation of a suspected case of reinfection.

Ct (or cycle threshold) is a quantitative value affixed to a positive PCR result but, due to lack of standardization, the result is not reported by the clinical lab. Ct value is an indicator of viral load. A low Ct value is indicative of infectivity; a high Ct value indicates that very little virus is picked up and suggests low infectivity or residua of prior infection. SCC PHD may discuss with Infectious Disease or clinical lab expert regarding Ct value before embarking on further evaluation of a suspected case of reinfection.

Reports of confirmed and suspected cases of reinfection are rare. Per CDPH, there are no documented cases of reinfecions in California to date. Continue to report suspected cases to CoronavirusClinical@cdph.ca.gov
Addendum #6 Updated COVID-19 Quarantine Guidance

General COVID-19 Quarantine Guidance

This updated quarantine guidance applies to everyone exposed to someone diagnosed with COVID-19.

- For persons who are close contacts* of COVID-19 cases and who do not have symptoms:
  - Discontinue quarantine after the end of Day 10 from last exposure (the day of last exposure is Day 0) but continue monitoring for symptoms for a full 14 days.
  - Get tested on Day 6 or later from last exposure. If testing is done earlier than Day 6 and is negative, testing should be repeated on or after Day 6.
  - If any symptoms of COVID-19 develop during Days 0–14, get tested immediately.

For persons who are close contacts* of COVID-19 cases and who do have symptoms:

- Get tested immediately upon symptom onset anytime during Day 0–14 from last exposure. If testing is done earlier than Day 6 and is negative, testing should be repeated on or after Day 6.
- Symptomatic close contacts who test negative may discontinue quarantine after the following criteria are met:
  - At least 10 days have passed since last exposure to case; AND
  - At least 24 hours have passed since resolution of fever without the use of fever-reducing medications; AND
  - Other symptoms have improved

*A close contact is someone who was within 6 feet of the infected person for at least 15 minutes (continuous or repeated short duration interactions) at any time during the infectious period (2 days before the infected person had symptoms or tested positive until 10 days after).

COVID-19 Quarantine Guidance for Healthcare Workers** During Critical Staffing Shortages

The general quarantine guidance above applies to healthcare workers under normal circumstances, and HCWs who have routine workplace exposures that are not high risk should continue to follow their employer’s guidance for returning to work. However, if critical staffing shortages exist, healthcare workers may follow the recommendations outlined below.

Healthcare workers who have been exposed to a COVID-19 positive person in the household or in the community, or during a high-risk exposure in the workplace (e.g., not wearing required PPE), may continue to work or return to work during the quarantine period (which, for this scenario, is defined as 10 days from the date of last exposure to the COVID-19 positive person) under the following conditions:

1. The HCW remains asymptomatic.
2. The HCW undergoes the following testing regimen:
   a. A COVID-19 test is done immediately upon learning of their exposure and the test result is negative.
   b. The HCW remains off work until this initial COVID-19 test is resulted.
   c. Thereafter, during the remainder of the quarantine period, the HCW’s COVID-19 status shall be monitored with daily rapid antigen tests or RT-PCR tests every 3 days. Test type and frequency will depend on the facility’s testing availability and schedules.
3. The HCW wears an N95 respirator and all other required PPE at all times while at work during the quarantine period.
4. The HCW does not eat, drink, or unmask around others at any time, regardless of social distancing.
5. The HCW continues to monitor COVID-19 symptoms daily. If the HCW develops symptoms, the HCW should leave work, contact their manager/employee health, and be tested.

6. The HCW maximizes social distancing (even beyond 6 feet) wherever possible with both patients and co-workers, and maintains excellent hand hygiene at all times.

7. The HCW does not work with severely immunocompromised patients or individuals (e.g., cancer, organ transplants).

8. The HCW’s work duties are assigned in a manner that minimizes the number of different patients cared for by the HCW.

9. The HCW is still under home quarantine for 10 days after last exposure except to go to work. The HCW must not carpool, taxi, or rideshare.

**Healthcare workers are paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials.

CDPH recommendation differs slightly from the above: potentially exposed persons living or working in high-risk congregate settings should continue to quarantine for 14 days. If there is a critical staffing shortage, exposed asymptomatic staff may be allowed to return to work after day 7 if they have had a negative test collected after day 5. In general, during an outbreak, all HCW are considered potentially exposed and can continue working as long as they remain asymptomatic and are being serially tested as part of facility-wide testing (CDPH LTC Call Notes 12/22/2020).
Addendum #7 Breakroom Policies

Eating indoors in a breakroom is one of the highest risk activities during the pandemic because the rooms are usually small and not well-ventilated, and face masks must be removed to eat. The use of employee breakrooms has proven to be one of the most common causes of workplace COVID-19 transmission, and extra precautions must be taken to keep staff safe.

Breakrooms should not be used for gathering or eating. Rather, employees should be encouraged to eat outdoors or in their vehicles whenever possible. Employers can help encourage this by staggering break times and setting up areas, e.g., outdoor patios, where employees can eat and maintain distancing.

When it is not possible to eat outdoors or in employee cars (due to weather or safety reasons), facilities should designate a larger well-ventilated unused space, such as a dining or activity room. If the break room is the only location available, staff should eat only one at a time. When two or more staff must share an indoor space, tables should be spaced a minimum of 6 feet apart and staff should not face each other while their masks are off. If the room has posted occupancy, the limitation is 20% of maximum posted occupancy. (SCC PHD Mandatory Directive on Capacity Limitations).

Staff should be trained as to how to remove, clean, and properly store face shield/goggles and mask before eating, to avoid self-contamination. Alcohol wipes or spray cleaner should be available.

If there is no designated space (cubby or locker), paper bags should be readily accessible in the breakroom/dining or patio area for staff to safely store their face shield/goggle and mask while not in use.

Supplies to disinfect tables and surfaces should be readily accessible in breakroom, dining, or patio area. If wipes are unavailable, a caddy with spray bottle and paper towels is acceptable.

Staff should be instructed to wipe down the table before and after eating. Staff should wipe down other high touch surfaces in the breakroom: microwave, coffee maker, refrigerator handle, faucets, door handles.

Staff should be instructed on this guidance by DON or IP nurse, as well as with appropriate signage posted in these areas.

The breakroom, dining or patio areas should be regularly monitored for adequate supplies, cleanliness, and staff compliance.
Background
Many COVID-19 prevention and mitigation strategies are difficult to implement in the memory care setting. Consult with the HAI Program as needed.

Managing Memory Care Residents with Behavioral Techniques
- Use white boards, signs, reminders for why it is important to wear a mask
- Activities to reduce wandering, for example exercises in room or walking in hallway or outside
- Important to anticipate behaviors and plan proactively rather than responding reactively; disruption in routine sets the residents off
- Do not overmedicate residents
- Promote culture change of staff; various leaders within their own work community can be champions

Reasonable Exceptions for a Resident with Dementia to Not Wear a Face Covering
- Cannot physically put on or wear a face covering
- Wearing the face covering would cause them severe distress
- Someone with them needs to read their lips to communicate
- They need to remove the face covering temporarily to eat, drink, or take medication
- Medical exemptions

Individualized Attention During COVID-19
- Resident exhibiting anxiety and agitation will need gentle reassurance along with behavioral techniques – may require individual assessment by trained psychologist
- Important to identify the triggers and time of day when undesirable behaviors occur
- Know the person: each person may need individualized interventions
  - Put yourself in the person’s shoes
  - Try to understand their surroundings from their perspective
- Contact family members who are supportive to explain to the resident the reason for mask wearing, if the resident refuses to wear their mask; a virtual visit or phone call, if visitation is not possible, could be arranged
- Contact their therapist or counselor for ideas to help the resident cope and accept mask wearing; a video conference or telephone call may also be helpful

Maintaining Spatial Distancing
Signage
- Use clear signage
- Consider markings on the floor in common spaces that indicate where they can sit or stand; or remove chairs from areas where residents are not permitted to sit
- Prevent residents from going into areas where they shouldn’t be, e.g., traveling/movement between zones
- Block exits, e.g., with furniture, to deter wandering
- Use signage in different languages

Physical Distancing
- Model staying outside of an individual’s “space”
- Sending non-verbal “messages”
Coping with Isolation

- Consider alternative ways to reduce feelings of isolation, e.g., music, art

Creative Solutions to Mask Wearing

- Do they simply forget why it’s needed? Consider a sign by the door for when you go out. You may need to gently remind the person we’re still in a pandemic.
- Does the mask fit comfortably? Try different styles or looser fastenings if it’s too tight.
- Are they unhappy with the feel of the fabric? Try different materials, maybe one made from a familiar garment (check with them first before cutting the fabric).
- Do they pull the mask down? Try some distraction or positive reinforcement; describe how wearing a face covering helps to stop the spread of COVID-19 and keep people well.
- Are they anxious it will stop them from breathing? Offer reassurance and show them that it won’t.
- Is there a past experience that might make them fearful about wearing a mask (perhaps as a young child in the war)? Talk to them about it and try to find ways to reassure them.
- Are they lip readers? Clear masks may be an option.
- Is the mask unappealing? Try using masks with themes that would appeal to individuals, such as a sports team, hobby, color, animals, flowers, etc.
- Masks distort the ability to recognize faces or facial expressions and more time may be required for the residents to understand what is being said or asked.

Managing Stress Among Staff

- Body language is important. Individuals with dementia pick up on depression and stress in staff.
- Facility infection preventionist should engage staff: What are you concerned about? What worries you? What do you know about the virus? What would you like to learn? In terms of hand hygiene, pose the question, “What do you think happens if we’re not washing our hands properly?”
- Be patient and offer encouragement – if you show frustration or irritation, the person will pick up on this.

Additional Resources

- The Dice Approach (https://diceapproach.com/)

For more information or consultation, contact HAIProgram@cdph.ca.gov or 510-412-6060
Addendum #9 CDC Guidance on Ventilation Intervention

Consider ventilation system upgrades or improvements and other steps to increase the delivery of clean air and dilute potential contaminants. Obtain consultation from experienced Heating, Ventilation and Air Conditioning (HVAC) professionals when considering changes to HVAC systems. Some of the recommendations below are based on Guidance for Building Operations During the COVID-19 Pandemic from the American Society of Heating, Refrigerating, and Air-Conditioning Engineers (ASHRAE).

Ventilation improvements may include some or all of the following considerations:

Increase outdoor air ventilation, using caution in highly polluted areas.

When weather conditions allow, increase fresh outdoor air by opening windows and doors. Do not open windows and doors if doing so poses a safety or health risk (e.g., risk of falling, triggering asthma symptoms) to occupants in the building.

Use fans to increase the effectiveness of open windows. To safely achieve this, fan placement is important and will vary based on room configuration. Avoid placing fans in a way that could potentially cause contaminated air to flow directly from one person over another. One helpful strategy is to use a window fan, placed safely and securely in a window, to exhaust room air to the outdoors. This will help draw fresh air into room via other open windows and doors without generating strong room air currents.

Decrease occupancy in areas where outdoor ventilation cannot be increased.

Ensure ventilation systems operate properly and provide acceptable indoor air quality for the current occupancy level for each space.

Increase airflow to occupied spaces when possible.

Turn off any demand-controlled ventilation (DCV) controls that reduce air supply based on occupancy or temperature during occupied hours. In homes and buildings where the HVAC fan operation can be controlled at the thermostat, set the fan to the “on” position instead of “auto,” which will operate the fan continuously, even when heating or air-conditioning is not required.

Open outdoor air dampers beyond minimum settings to reduce or eliminate HVAC air recirculation. In mild weather, this will not affect thermal comfort or humidity. However, this may be difficult to do in cold, hot, or humid weather.

Improve central air filtration: Increase air filtration to as high as possible without significantly reducing design airflow. Inspect filter housing and racks to ensure appropriate filter fit and check for ways to minimize filter bypass. Check filters to ensure they are within their service life and appropriately installed.

Ensure restroom exhaust fans are functional and operating at full capacity when the building is occupied.

Inspect and maintain local exhaust ventilation in areas such as kitchens, cooking areas, etc. Operate these systems any time these spaces are occupied. Consider operating these systems, even when the specific space is not occupied, to increase overall ventilation within the occupied building.
Consider portable high-efficiency particulate air (HEPA) fan/filtration systems to help enhance air cleaning (especially in higher risk areas such as a nurse’s office or areas frequently inhabited by persons with higher likelihood of COVID-19 and/or increased risk of getting COVID-19).

Generate clean-to-less-clean air movement by re-evaluating the positioning of supply and exhaust air diffusers and/or dampers (especially in higher risk areas).

Consider using ultraviolet germicidal irradiation (UVGI) as a supplement to help inactivate SARS-CoV-2, especially if options for increasing room ventilation are limited. Upper-room UVGI systems can be used to provide air cleaning within occupied spaces, and in-duct UVGI systems can help enhance air cleaning inside central ventilation systems.

*Note: The ventilation intervention considerations listed above come with a range of initial costs and operating costs which, along with risk assessment parameters such as community incidence rates, facemask compliance expectations and room occupant density, may affect considerations for which interventions are implemented. Cost estimates per room for the listed ventilation interventions in cost. Here are some examples:

In non-residential settings, consider running the HVAC system at maximum outside airflow for 2 hours before and after the building is occupied.

- **No cost:** opening windows; inspecting and maintaining local exhaust ventilation; disabling DCV controls; or repositioning outdoor air dampers

- **Less than $100:** using fans to increase effectiveness of open windows; or repositioning supply/exhaust diffusers to create directional airflow

- **$500 (approximately):** adding portable HEPA fan/filter systems

- **$1500 (approximately):** adding upper room UVGI
Addendum #10 Educational Materials

Webinar Series - COVID-19 Prevention Messages for Long Term Care Staff
These can be used to educate nursing and ancillary staff, as well as residents and visitors.

Sparkling Surfaces: Stop COVID-19’s Spread

Keep COVID-19 Out!

Clean Hands - Combat COVID-19

Closely Monitor Residents for COVID-19

PPE Lessons
Addendum #11 CDC COVID-19 Translated Materials

- **CDC Resources in Languages other than English**

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<td><strong>Handouts, Posters, and Fact Sheets</strong></td>
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| CDPH | Poster: **COVID-19 Prevention**  
Available in English, Spanish, Amharic, Arabic, Burmese, Chaldean, Chinese, Dari, Farsi, French, Haitian Creole, Korean, Pashto, Portuguese (Brazilian), Russian, Somali, Swahili (Congolese), Tagalog, Ukrainian, Vietnamese | Scroll down the list to find title & language of choice: [https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Resources.aspx](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Resources.aspx) |
| CDC | Poster & Fact Sheet: **Donning & Doffing PPE**  
| CDC | Posters, Stickers, & Campaign Materials: **Handwashing**  
Available in English & Spanish | Scroll down the page to find materials & language of choice: [https://www.cdc.gov/handhygiene/campaign/promotional.html](https://www.cdc.gov/handhygiene/campaign/promotional.html) |
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| CDC | Fact Sheets: **Hand Hygiene**  
* 4 fact sheets for different ages, languages, and education levels | Scroll down the list for the fact sheet & language of choice: [https://www.cdc.gov/handwashing/fact-sheets.html](https://www.cdc.gov/handwashing/fact-sheets.html)  
Available in English, Spanish, French, & Haitian Creole |
| CDC | 2-page handout: **How to Protect Yourself and Others** | Scroll down the list to find title & language of choice: [https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Resources.aspx](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Resources.aspx)  
Available in English, Chuukese, Marshallese, Tongan |
| CDC | Form Letter: **Long-term care facility and COVID-19** | Scroll down the list to find title & language of choice: [https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Resources.aspx](https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Resources.aspx)  
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<td>CDC</td>
<td>Poster: <strong>Social distancing, using a cloth face mask</strong> (for residents and visitors only; staff should wear a medical-grade face mask)</td>
<td>Available in English, Spanish, Amharic, Arabic, Burmese, Dari, Farsi, French, Haitian Creole, Karen, Kinyarwanda, Nepali, Pashto, Portuguese, Russian, Somali, Swahili, Tigrinya, Ukrainian</td>
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### CDC

**Handout: What You Should Know About COVID-19 to Protect Yourself and Others**

Available in English, Spanish, Amharic, Arabic, Burmese, Cape Verdean Creole, Chuukese, Dari, Farsi, French, Haitian Creole, Hmong, Karen/Khmer, Kinyarwanda, Korean, Laotian, Marshallese, Malay, Nepali, Pashto, Portuguese, Russian, Simplified Chinese, Somali, Swahili, Tagalog, Thai, Tongan, Tigrinya, Ukrainian, Vietnamese

Scroll down the list to find title & language of choice: [https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html?Sort=Date%3A%3Adesc](https://www.cdc.gov/coronavirus/2019-ncov/communication/print-resources.html?Sort=Date%3A%3Adesc)

### Videos

**CDC**

**Cloth Face Covering Do’s and Don’ts** (Video)

Available in English & Spanish

English: [https://www.cdc.gov/video/socialmedia/Cloth-Face-Covering-Dos-Donts.mp4](https://www.cdc.gov/video/socialmedia/Cloth-Face-Covering-Dos-Donts.mp4)


**COVID-19: Are You at Higher Risk for Severe Illness?** (Video)

Available in English only


**COVID-19: Stay Home if you are Sick** (Video)

Available in English & Spanish


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<td><strong>COVID-19: What Older Adults Need to Know (Video)</strong></td>
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<td><strong>CDC</strong></td>
<td><strong>Demonstration of Doffing (Taking off) Personal Protective Equipment (PPE) (Video)</strong></td>
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<td><strong>Demonstration of Donning (Putting on) Personal Protective Equipment (PPE) (Video)</strong></td>
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<td><strong>CDC</strong></td>
<td><strong>Handwashing videos: 5 videos for all ages and education levels (Video)</strong></td>
<td>Available in English &amp; Spanish</td>
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<td><strong>CDC</strong></td>
<td><strong>How COVID-19 Can Spread in a Community (Video)</strong></td>
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<td>I Had COVID-19, But No Symptoms. When Can I Be with Others? (Video)</td>
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<td>CDC</td>
<td>I Think or Know I had COVID-19, and I Had Symptoms. When Can I Be with Others? (Video)</td>
<td>English: <a href="https://www.cdc.gov/video/socialmedia/316556-A_Scene1-End-Home-Isolation_graphic.wmv">https://www.cdc.gov/video/socialmedia/316556-A_Scene1-End-Home-Isolation_graphic.wmv</a> Available in English only</td>
</tr>
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</table>
**Photographs: Examples of Screening Questions in Various Languages**

Example of outdoor handwashing station, attached to garden hose and operated by foot pump, typically installed at front entrance and on patio:
Example of ergonomic ceiling to floor magnetic plastic dividers to separate units (made by Grainger):

Example of outdoor setup with plexiglass divider for family visits. Non-upholstered and non-rattan material recommended for proper cleaning.
Example of indoor setup with plexiglass divider in large indoor communal space for family visits.

Example of signage to designate different zone with required PPE:
Addendum #12 Donning and Doffing Procedures

Review step by step procedures:

- CDC Sequence for Putting On and Removing PPE
- NEJM Video: Donning and Doffing PPE
- Personal Protective Equipment (PPE) Competency Validation
Addendum #13 Facemask Do’s and Don’ts

Facemask Do’s and Don’ts
For Healthcare Personnel

When putting on a facemask
Clean your hands and put on your facemask so it fully covers your mouth and nose.

DO secure the elastic bands around your ears.

DO secure the ties at the middle of your head and the base of your head.

When wearing a facemask, don’t do the following:

DON’T wear your facemask under your nose or mouth.

DON’T allow a strap to hang down. DON’T cross the straps.

DON’T touch or adjust your facemask without cleaning your hands before and after.

DON’T wear your facemask on your head.

DON’T wear your facemask around your neck.

DON’T wear your facemask around your arm.

When removing a facemask
Clean your hands and remove your facemask touching only the straps or ties.

DO leave the patient care area, then clean your hands with alcohol-based hand sanitizer or soap and water.

DO remove your facemask touching ONLY the straps or ties, throw it away, and clean your hands again.

Additional information is available about how to safely put on and remove personal protective equipment, including facemasks:

cdc.gov/coronavirus
How to Collect Anterior Nasal Swab

Initial set-up

1. Open the sampling kit.
2. Apply hand sanitizer with at least 60% alcohol.

Sample collection

3. Remove the swab from the container, being careful not to touch the soft end with your hand.
4. Insert the swab into your nostril. Do not insert it more than half an inch into your nostril.
5. Slowly twist the swab, rubbing it along the insides of your nostril for 15 seconds.
6. Gently remove the swab.
7. Using the same swab, repeat steps 4-6 in your other nostril.

Preparation of sample for return

8. Place the swab in the sterile tube and snap off the end of the swab at the break line. Place the cap on the tube.
9. Re-apply hand sanitizer.
10. Place the tube containing the swab in the biohazard bag provided and seal the bag.

Returning the sample and clean-up

11. Give the bag with the swab to testing personnel.
12. Throw away remaining sample kit items.
13. Re-apply hand sanitizer.

Source: cdc.gov/coronavirus
References

General Guidance

- SCC PHD Mandatory Directives Capacity Limitations
- SCC PHD Updated Quarantine Guidance for COVID-19
- SCC PHD Mandatory Directives for Long-term Care Facilities
- SCC PHD Visitor Directive for Long-Term Care Facilities
- SCC PHD Letter to All Healthcare Workers
- SCC PHD Health Advisories: Updated COVID-19 Requirements, Guidance, and Strategies for LTCFs in Santa Clara County
  - September 4, 2020
  - July 3, 2020
  - May 29, 2020
  - April 5, 2020
- CDPH All Facilities Letters
  - AFL 20-22 Visitation Fact Sheet - Skilled Nursing Facilities
  - AFL 20-22.3: Guidance for Limiting the Transmission of COVID-19 in Long-Term Care Facilities
  - AFL 20-38.2: Visitor Limitations Guidance
  - AFL 20-52: COVID-19 Mitigation Plan Implementation and Submission Requirements for SNF and Infection Control Guidance for HCP
  - AFL 20-53: COVID-19 Mitigation Plan Recommendations for Testing of HCP and Residents at SNF
  - AFL 20-73: Advance Care Planning, Physician’s Order for Life Sustaining Treatment (POLST) and Coronavirus Disease 2019 (COVID-19)
  - AFL 20-74: Coronavirus Disease 2019 (COVID-19) Recommendations for Personal Protective Equipment (PPE), Resident Placement/Movement, and Staffing in Skilled Nursing Facilities
  - CDPHCOVID-19 and Memory Care Units Reference Sheet
  - CDPH SNF/LTC Call Notes 12/22/20
- CDC Testing Algorithm for SARS COV-2
- CDC Criteria for Investigating Suspected SARS-CoV-2 Reinfection
- CDC Ventilation Guidance in Buildings during COVID-19
- CDC Clinical Considerations for COVID-19 Vaccine
- CDC Lab Resources for Antigen Testing
- CDC Preparing for COVID-19 in Nursing Homes
- CDC Interim Infection Prevention and Control Recommendations
- ASHE Negative Pressure Patient Room Options
- CDC SARS-CoV-2 and Potential Airborne Transmission
- CDC Evaluation for Suspected Cases of Reinfection

PPE

- CDC Strategies to Optimize the Use of PPE
- CDC Proper Donning and Doffing PPE
- How to Perform a SEAL Test
- CDC PPE Burn Calculator
- Personal Protective Equipment (PPE) Competency Validation
- CDPH Protective Equipment Program Webinar
Check Lists

- Coronavirus Disease 2019 (COVID-19) Preparedness Checklist for Nursing Homes and other Long-Term Care Settings
- CMS Emergency Preparedness & Response Operations
- Infection Prevention and Control Assessment Tool for Nursing Homes
- List N: Disinfectants for Use Against SARS-CoV-2

COVID-19 Webinars

- Weekly CDPH HAI Webinar
- CDC COCA Webinar
- CDC Webinar – Sparkling Surfaces: Stop COVID-19’s Spread
- CDC Webinar – Keep COVID-19 Out!
- CDC Webinar – Clean Hands: Combat COVID-19
- CDC Webinar – Closely Monitor Residents for COVID-19
- CDC Webinar – PPE Lessons