California Department of Public Health
Center for Health Care Quality
AFC Skilled Nursing Facilities Infection Prevention Call
February 16 & 17, 2022

Recordings, notes and slides for the Wednesday Webinars and Thursday calls can be accessed at the Health Services Advisory Group (HSAG) registration website:
https://www.hsag.com/en/covid-19/long-term-care-facilities/cdph-ip-webinars-past/

CDPH Weekly Call-in Information:
Tuesday 8:00am All Facilities Calls: 844.721.7239; Access code: 7993227
Wednesday 3:00pm SNF Infection Prevention Webinars: Register at: https://www.hsag.com/cdph-ip-webinars
Thursday 12:00pm SNF Infection Prevention Calls: 877.226.8163; Access code: 513711

Important Links to State and Federal Guidance	
Important Links and FAQs to CDPH State Guidance	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Guidance.aspx
2020 CDPH All Facilities Letters (AFLs)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL20.aspx
2021 CDPH AFLs	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL21.aspx
2022 CDPH AFLs	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/LNCAFL22.aspx
State Public Health Officer Order: Requirements for Visitors in Acute Health Care and Long-Term Care Settings (Amended 2/7/2022)	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 Guidance for Limiting the Transmission of COVID-19 in SNFs—includes updated visitation and communal dining guidance (2/7/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-07.aspx
CMS QSO-20-39-NH: Visitation Guidance (11/12/2021)	https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf
State Public Health Officer Order – extended HCP booster requirement from February 1 to March 1, 2022 (Updated 1/25/2022)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Health-Care-Worker-Vaccine-Requirement.aspx
AFL 21-34.2 COVID-19 Vaccine/Booster Requirement (Updated 1/26/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-34.aspx
AFL 22-02 Notice of Testing Supply Availability and Distribution Process (1/14/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-02.aspx
AFL 21-28.2 Testing, Vaccination Verification and PPE for HCP (Updated 1/26/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-28.aspx
AFL 22-06 Online Application Period for Patient Needs Waiver and Workforce Shortage Waiver (1/26/2022)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-06.aspx

Testing Questions & Answers

Q-1: Will the 14-day response testing window also be shortened to 10 days?
A: No, we don't anticipate the 14-day response testing window to shorten. Fourteen days is the maximum length of the incubation period following exposure. Omicron has a shorter incubation period, so 14 days keeps us around two full incubation periods with no new cases which had always been our usual practice for determining the absence of ongoing transmission.

Q-2: When should HCP be tested for COVID-19 in a SNF? Is it still twice weekly if unvaccinated or not boosted if eligible?
A: See below testing guidance taken from the HAI PowerPoint slide deck presented during the Wednesday Webinar on February 16, 2022.

When Should HCP be Tested for COVID-19 in a SNF?					
Vaccination Status	**Routine Diagnostic Screening**	**Response Testing**	**Testing Following High-risk Exposure**	**Symptomatic Testing**	**Return-to-Work for Infected HCP***
Fully Vaccinated & Boosted (or not yet Booster Eligible)	Not required, but strongly recommended	Yes	Yes	Yes	Yes, if returning at 5 days after symptom onset or positive test
Fully Vaccinated and Booster Eligible, but NOT Boosted	Yes, twice weekly	Yes	Yes	Yes	Yes, if returning at 7 days after symptom onset or positive test
Unvaccinated or Incompletely Vaccinated with Exemption	Yes, twice weekly	Yes	Yes	Yes	Yes, if returning at 7 days after symptom onset or positive test
Recovered from COVID within 90 Days	No	No	Consider, antigen test preferred	Yes, with new symptom onset	Yes, if reinfected and returning at 5-7 days after symptoms onset
*Antigen test preferred.					

Q-3: In reference to the testing guidance table above, if an HCP discontinued isolation from COVID a week ago, but now has a new cough not associated with their original symptoms when COVID positive, should we consider this person to have new symptom onset and should we test to be safe?
A: It would be unusual for a person to have a reinfection within 90 days of recovering from COVID, and especially after only a week of discontinuing isolation. However, with Omicron there was a greater risk of reinfection when compared to other variants. There is no specified timeframe in the CDC guidance that indicates when a person should be tested if they have new symptom onset and are in the 90-day recovery time frame. New symptoms within a week of recovery from COVID could be due to other pathogens, like influenza or RSV, so would consider testing for those. We recommend that this unique situation be managed on a case-by-case basis with the local health department.

Q-4: Can you review the February 10, 2022 State Order "Revision Of Mandatory Reporting Of Covid-19 Results By Health Care Providers" 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. Does this apply to SNFs? Is it related to NHSN data reporting?
A: This State Order does apply to SNFs and other health providers and laboratories and has to do with reporting of individual COVID-19 cases to CalREDIE. This is different from the daily and weekly aggregate case reporting to CDPH via Survey 123, which CDPH uploads to NHSN on behalf of SNF. Due to the high number of COVID-19 cases currently being identified, the State recognizes the reporting burden, therefore is no longer mandating that laboratories report cases immediately within one hour of being identified. Now reporting is required within 24 hours (not 1 hour). For nursing homes, this affects reporting of point-of-care antigen tests that need to be reported to CalREDIE. Prior to this Order, antigen test results needed to be reported within 8 hours; but now they need to be reported within 24 hours. Keep in mind, that the NHSN point-of-care test module reports to CalREDIE, but CalREDIE does not report to NHSN. We would recommend reporting antigen test results to NHSN in order to avoid having to report twice.

Q-5: Is there a timeline on reporting daily POC negative and positive test results? Can we report once a week on NHSN or does it have to be reported daily?
A: Refer to the August 19, 2020 Letter to Laboratories: Testing for SARS-CoV-2/COVID-19 https://www.cdph.ca.gov/Programs/OSPHLD/LFS/Pages/LFSCOVID19ltr-1.aspx and the February 10, 2022 State Order "Revision Of Mandatory Reporting Of Covid-19 Results By Health Care Providers" 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. Prior to the February 10, 2022 State Order, both positive and non-positive antigen test results need to be reported through the CalREDIE Electronic Laboratory Reporting system (ELR) within eight hours from the time the laboratory notifies the health care provider or other person authorized to receive the report. However, now, nursing homes have 24 hours to report the antigen test results. Keep in mind that the NHSN point-of-care test module reports to CalREDIE, but CalREDIE does not report to NHSN. We would recommend reporting antigen test results to NHSN in order to avoid having to report twice.

Isolation/Quarantine Questions & Answers

Q-6: Should SNFs follow CDC's new quarantine and isolation guidance for residents?
A: Yes. On February 2, 2022, CDC updated their isolation and quarantine guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html); updates to CDPH AFLs are in process. At this time, it is reasonable for nursing homes to adopt CDC's updated guidance:

- New admissions that are not up to date with all recommended COVID-19 vaccine doses (including booster, if eligible) should be tested and quarantined for at least 7 days from the date of admission until results are known for testing obtained 5-7 days after admission.
- The 14-day quarantine duration for exposed residents has been shortened to 10 days of quarantine following the exposure (day 0); or 7 days if testing is performed between days 5 and 7 and the resident tests negative.

Q-7: We are a large forensic psychiatric hospital. We have over 30 units that house around 50 patients each. We place units on quarantine due to positive staff or patients. Units' quarantines are further extended if during serial response testing we identify a new positive patient or surveillance testing identifies a new positive staff. Many patients have scheduled appointments with medical specialists either within our hospital or at outside medical facilities. Examples, going to a hemodialysis center, a chemotherapy appointment, or to a long-awaited consultation. What strategies would you recommend to avoid rescheduling these urgent or important medical appointments?
A: Refer to CDC's guidance in a recent FAQ Clinical Questions about COVID-19: Questions and Answers | CDC that indicates that for patients who are either COVID positive or exposed, it is safest to defer medical appointments until after the patient has completed their quarantine. We acknowledge that quarantine could be quite long for some patients if there are ongoing exposures with new cases identified in the facility. We understand that there may be some medical appointments that should not be deferred because they are critical or life sustaining, such as hemodialysis and chemotherapy. We recommend that facilities work with providers to identify the safest possible strategy for providing care for those residents, such as having them dialyzed in a private room at the last shift of the day, or if the facility has a particular shift that they reserve for COVID positive patients or individuals who have been exposed, that would be preferred. For other urgent outpatient visits such as a specialty clinic visit, we'd recommend working with the provider to schedule the visit at the end of the day, have the patient brought directly to the exam room (no sitting in a waiting area around other patients), wear well-fitting source control and have the clinic staff wear appropriate PPE.

Q-8: If a new admission being discharged from a hospital is fully vaccinated, but not boosted, can we count the days in the acute as part of their 7- or 10-day quarantine timeframe?
A: Per CDPH AFL 20-53.6 (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-53.aspx), it states that "SNFs may consider acute care hospital days as part of the quarantine observation period for unvaccinated or partially vaccinated new admissions as long as the following criteria are met: SNF is in regular communication with their local health department (LHD) and/or the hospital infection preventionist and/or occupational health program, and there is no suspected or confirmed COVID-19 transmission among patients or staff at the hospital." Note that it may be challenging to provide absolute assurance that there was no exposure in the acute facility, especially during the recent surge due to return-to-work for COVID positive staff in light of staffing shortages. There must be active communication between the SNF, hospital and local health department to ensure there were no potential exposures in the hospital before transfer to the nursing home.

Q-9: Why do SNFs have to quarantine and test new admissions coming from the hospitals if they are not up to date on their boosters? It doesn't seem fair that the hospitals do not have to quarantine them.
A: There is a difference in the level of risk of transmission from patients to other patients in the hospital and to workers that are different than in long-term care nursing homes. Most hospitals are testing patients upon admission and periodically throughout a stay, they have more single rooms, and they may be implementing universal PPE including respiratory protection for workers per CDC guidance. Hospitals are implementing similar precautions to quarantine, even though they don't officially call it quarantine.

Q-10: Are hospitals being held accountable for ensuring a booster is given prior to transfer to SNF?
A: Per CDPH AFL 21-20.1 COVID-19 Vaccine Recommendations for Eligible Individuals Prior to Discharge (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-20.aspx), CDPH recommends that prior to discharge from the hospital, 24-hour observation, or emergency department, General Acute Care Hospitals (GACHs) and Acute Psychiatric Hospitals (APHs) offer COVID-19 vaccinations, including booster doses, to eligible patients, especially those at highest risk of morbidity and mortality from COVID-19, such as:

- Patients age 65 years or older
- Psychiatric patients
- Patients being discharged to congregate care or residential settings, such as: post-acute medical facilities, skilled nursing facilities, residential care facilities for the elderly, correctional facilities, behavioral health facilities, and homeless shelters.

Administering the booster is not a requirement for hospitals, but highly recommended to reduce the spread of COVID-19 and to help broaden and strengthen the protection against the Omicron variant. 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 patients to your facility.

Q-11: CDPH AFL 22-07 discusses residents who leave and return to the facility. Does this apply for dialysis residents as well?
A: Per AFL 22-07 (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-07.aspx), the section, "Residents Who Leave and Return to the Facility" states that residents who are fully vaccinated and leave for any duration (including hospital admissions) and return to the facility do not routinely need to quarantine and be tested upon return to the facility. Unvaccinated and incompletely vaccinated residents who leave the facility for < 24 hours and return to the facility should be tested at 2 days after their return and again 5-7 days after their return. In summary, residents who leave for outpatient appointments, including dialysis appointments, would be included in this guidance. There is a potential risk of exposure while attending dialysis appointments, but we do not recommend placing residents in need of dialysis in perpetual quarantine. We recommend that facilities be in

communication with outpatient centers and dialysis centers to ensure awareness of potential exposures so that testing and quarantine occurs for residents that are affected by the exposure. Periodic testing dialysis residents is a best practice, but not a requirement.

Visitation Questions & Answers

Q-12: If the privacy curtain is closed, is it acceptable for the roommate to stay in the room while the resident has a visitor?
A: It's not ideal for the roommate to be in the room during a visit, but it is permissible if there are no other options, such as an outdoor visit. Ideally, the resident and roommate are boosted. Also, ensure physical distancing, hand hygiene and appropriate source control or PPE if necessary.

Q-13: Our facility is almost done with our 14-day response testing. We do not have any COVID-19 positive residents. Fully vaccinated residents want to go out on pass with their family for 4 hours. Do we need to test our residents that leave when they return? Should we ask family members their vaccination status even if they never enter our facility?
A: Refer to CDPH AFL 22-07 https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-07.aspx in the section "Residents Who Leave and Return to the Facility". SNFs are not required to ask family members their vaccination status if they do not enter the SNF. AFL 22-07 states that residents taking social excursions outside the facility should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces. Residents who have prolonged close contact with someone with SARS-CoV-2 infection while outside the facility should quarantine in the yellow-observation area, regardless of their vaccination status. Residents who are fully vaccinated and leave for any duration (including hospital admissions) and return to the facility do not routinely need to quarantine and be tested upon return to the facility. Unvaccinated and incompletely vaccinated residents who leave the facility for < 24 hours and return to the facility should be tested at 2 days after their return and again 5-7 days after their return; unvaccinated and incompletely vaccinated residents who leave the facility for > 24 hours should be quarantined in the yellow-observation area and tested prior to return to their usual room in green-unexposed/recovered area. Note that this guidance may change to align with updated CDC guidance that new admissions and readmissions who leave the facility for > 24 hours that are not up to date with all recommended COVID-19 vaccine doses (including booster, if eligible) should be tested and quarantined for at least 7 days from the date of admission until results are known for testing obtained 5-7 days after admission.

Q-14: Do EMTs entering our SNF for non-emergency transport visits have to be screened prior to entry to our SNF? We have encountered EMT's who are argumentative and resist complying with our COVID screening process upon entry. Can you clarify?
A: Yes, EMT transporters who enter the facility for non-emergency purposes should be screened for symptoms or recent exposure prior to entry. If EMT or first responders are entering the facility in response to an emergency, they do not need to be screened prior to entry because there is not time when responding to an emergency in crisis mode. However, transport companies that are independent or privately owned, are not subject to the State Public Health Officer Orders (Health Care Worker Vaccine Requirement Updated on January 25, 2022; Requirements for Visitors in Acute Health Care and Long-Term Care Settings Updated February 7, 2022), therefore they do not need to comply with the CDPH vaccination or testing mandates. To reduce the risk of transmission, some facilities are delivering the resident to the front door or to the pick-up area just outside the entrance of the building. CDPH strongly recommends that SNFs proactively include requirements for vaccination and testing when negotiating contracts with transportation companies. See FAQ for more information:

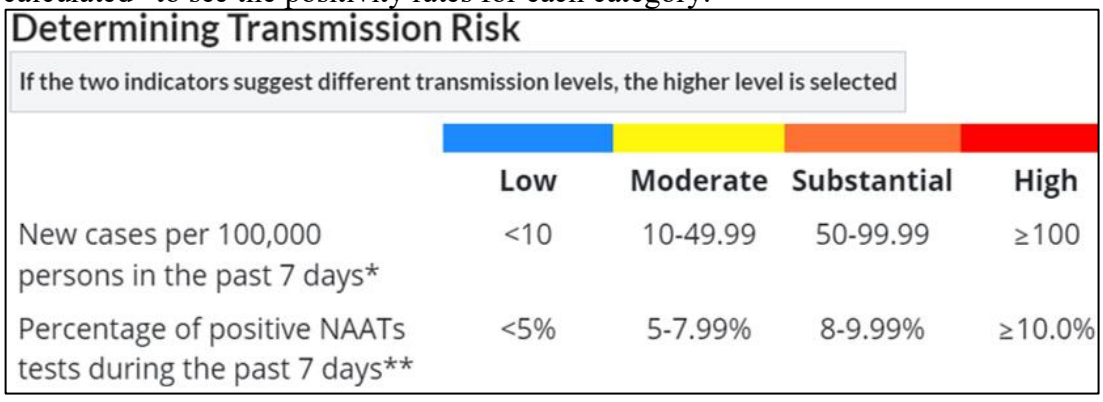
- **Are fire, police, ambulance, other pre-hospital care workers and county child welfare and adult protective services emergency response (ER) social workers who may need to enter the facility while on duty for their job, covered under this Order?** No, these staff are not deemed visitors if they are entering the facility while on duty for their job, and therefore are not covered by this Order.

Q-15: If fully vaccinated (not boosted) new admissions need to be tested and quarantined in yellow observation, then why are fully vaccinated (not boosted) visitors not required to be tested?
A: The testing and quarantine guidance for new admissions who do not have a booster is an updated CDC recommendation from February 2, 2022 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html). CDC recognizes the need for boosters to improve protection, which was reviewed in the PowerPoint slides during the CDPH Immunization Branch presentation on February 16, 2022. There is waning effectiveness of the primary vaccine series, particularly in the long-term care population, so the booster is necessary to increase protection against infections and hospitalizations. Due to the high risk of transmission in long-term care settings, new admissions that are not up to date with their vaccinations need to quarantine upon admission. Boosters are also recommended for visitors; however, one difference is that residents are present in the facility 24/7, therefore there are greater risks for exposures when compared to visitors who are in the facility for a shorter period typically and are just visiting with one resident.

PPE Questions & Answers

Q-16: If our nursing home has high HCP booster rates, do we still have to wear eye protection in the green zone?
A: Eye protection (face shields, goggles) is required as PPE during all resident care, including green zones, in facilities in counties with substantial or high COVID-19 transmission (see CDC's COVID-19 Data Tracker), and during a COVID-19 outbreak in a facility, regardless of HCP vaccination status. Eye protection in the green zone is NOT required in counties with low to moderate county transmission (see CDC's COVID-19 Data Tracker), unless otherwise indicated as part of standard precautions. Eye protection is NOT necessary in non-patient care areas, such as the kitchen, hallways, nurses' station, regardless of county transmission. https://covid.cdc.gov/covid-data-tracker/#datatracker-home

Q-17: What percentages are considered high or low for county positivity rates?
A: View the CDC COVID Data Tracker website that has a map of the country at: https://covid.cdc.gov/covid-data-tracker/#county-view. As of February 16, 2022, 56 out of the 58 counties in CA have high COVID transmission rates; Alpine and Sierra counties are the only counties in California that have substantial COVID transmission. Click on "How is community transmission calculated" to see the positivity rates for each category.



Determining Transmission Risk

If the two indicators suggest different transmission levels, the higher level is selected

	Low	Moderate	Substantial	High
New cases per 100,000 persons in the past 7 days*	<10	10-49.99	50-99.99	≥100
Percentage of positive NAATs tests during the past 7 days**	<5%	5-7.99%	8-9.99%	≥10.0%

Q-18: Are N95s 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: N95s 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 county transmission. The only situation where N95s would be required as source control is for COVID positive HCP returning to work during a critical staffing shortage before meeting usual criteria to discontinue isolation per CDPH AFL 21-08.7.

Q-19: What are the masking requirements for tracheostomy-dependent residents during visitation?
A: Refer to **CDPH Guidance for the Use of Face Masks** updated on February 7, 2022—**Exemptions to masks requirements:** 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. https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/guidance-for-face-coverings.aspx

Q-20: Our staff have been wearing N95s for source control since December 2021. They would like to move to a surgical mask for the green zone and non-patient care areas. Would a qualitative benchmark of <4% county test positivity rate x 2 weeks be a reasonable goal for transition back to surgical masks?
A: Surgical masks are acceptable for source control in general. It is reasonable for HCPs to wear N95s to improve source control (since they fit more tightly against the face), but it is not required unless used for return-to-work purposes for COVID positive HCP during critical staffing shortages. We acknowledge that it is challenging to wear an N95 properly for a prolonged shift, so the benefits of an N95 versus a surgical mask need to be assessed, including HCP preferences and adherence to wearing them correctly. Regarding county test positivity rates, this refers to CDC's recommendations for universal N95s for PPE during patient/resident care, even in the green zone, in areas where there is high community transmission. CDPH does not have a strong recommendation on the county rates influencing whether or not N95s should be worn by HCP for source control.

Vaccine Questions & Answers

Q-21: When can an individual get the booster if they recently recovered from COVID-19?
A: People with known current SARS-CoV-2 infection should defer vaccination at least until recovery from the acute illness (if symptoms were present) has been achieved and criteria to discontinue isolation have been met. (https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#considerations-covid19-vax-booster)

Q-22: We have an immunocompromised resident who received the original two-dose Moderna vaccine primary series one year ago. Five months ago, she received the booster. She never had the third shot before getting the booster, so does she need to re-do the series? If not, should she get a second booster shot which would count as the 4th shot? Or should she receive a full dose to ensure optimal coverage?
A: In this scenario, the resident has received a total of 3 doses, and qualifies for a 4th COVID-19 dose due to immunocompromise. There is no need to repeat the previous series. The 4th dose should be given 3 months or more after the 3rd dose. If the Moderna vaccine is used for a booster dose, a 50 mcg (0.25mL) dose should be used. CDC guidance allows for clinical consideration when choosing the use of a full dose vs half dose of Moderna for the 4th vaccination of immunocompromised persons. More information can be found at https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#vaccination-people-immunocompromised

Q-23: Will another booster be required in the next few months?
A: This is unknown. There is no current guidance from CDC related to more booster doses.

Q-24: For immunocompromised patients, is it recommended to use the same mRNA vaccine for ALL 4 shots; or is it beneficial to mix Moderna and Pfizer?
A: CDC guidance does not specify a preference between mRNA vaccine products for immunocompromised patients. For the first three doses, CDC recommends using the same mRNA vaccine. For the 4th dose, CDC states that any COVID-19 vaccine can be used, but that mRNA vaccines are preferred.

Q-25: Is the Pfizer booster better than the Moderna booster because Moderna's booster shot is only a half dose and the Pfizer booster is a full dose?
A: CDC guidance does not indicate a preference between mRNA vaccines (Pfizer or Moderna).

Cohorting Questions & Answers

Q-26: We have 6 asymptomatic positive residents. Due to a critical staffing shortage, can we have staff cross-over by working in both the red and yellow zones? The HCP wear full PPE, are boosted and tested negative.
A: AFL 20-74 (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-74.aspx) addresses cohorting and dedicated staff for the red zone by saying, "The COVID-19 positive cohort should be housed in a separate "red area" (building, unit or wing) of the facility and have dedicated HCP who do not provide care for residents in other cohorts and should have separate break rooms and restrooms if possible." In alignment with AFL 20-74, CDPH recommends dedicated staff for residents being cared for in the red zone. However, CDPH acknowledges that there are situations due to critical staffing shortages and a small number of residents in the red zone that it may not be feasible to have staff dedicated only to those residents. There could be situations due to low staffing that HCP may need to provide care for both residents in the red zone who are in isolation and in the yellow zone to residents who have been exposed or are in quarantine. If HCP need to crossover from the red to yellow zones, the facility needs to ensure that HCP wear appropriate PPE and perform hand hygiene between each resident care activity (this applies to both residents within isolation as well as going between those with different isolation status).

Other Questions & Answers

Q-27: What is the incubation period for Omicron?
A: The usual incubation period for Omicron is approximately 3 days, which is a bit shorter than for prior variants. More information can be found in the MMWR December 31, 2022 report "Investigation of a SARS-CoV-2 B.1.1.529 (Omicron) Variant Cluster — Nebraska, November–December 2021" https://www.cdc.gov/mmwr/volumes/70/wr/mm705152e3.htm#:~:text=1.617.,has%20been%20reported%20(4).

Q-28: When will we be allowed to do activities and communal dining?
A: Refer to communal dining and group activities guidance which has not changed in CDPH AFL 22-07 https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-22-07.aspx. Residents in the green zone who are fully vaccinated may eat in the same room without physical distancing; if any unvaccinated residents are dining in a communal area (e.g., dining room) all residents should use source control when not eating. Residents who are fully vaccinated in the green zone may also participate in group/social activities together without face masks or physical distancing; if any unvaccinated residents are present, then all participants in the group activity should wear a well-fitting

face mask for source control and unvaccinated residents should physically distance from others. When it is not possible to ensure all persons participating in an activity are vaccinated (e.g., in break rooms and other common areas where staff or residents may come and go), then all participants should follow all recommended infection prevention and control practices including physical distancing and wearing a well-fitting face mask for source control. As such, activities where participants do not use source control and physical distancing should be carefully planned in advance and monitored so that vaccination status of all participants can be verified and ensured throughout the activity. 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. In response to outbreaks, the local health department may limit group activities until outbreak control protocols are implemented.

Q-29: At this stage of the pandemic, what are your recommendations regarding indoor training of a large number of staff? Can we allow unvaccinated or unboosted staff to attend in person training?
A: Unvaccinated HCP with exemptions, and unboosted HCP are allowed to provide resident care, so are also allowed to attend trainings as long as they are complying with the required testing and 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.