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

Frequently Asked Questions

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1. **Q: When did the COVID-19 public health emergency end?**
   A: The Federal Public Health Emergency (PHE) Declaration for COVID-19 ended May 11, 2023. California's State of Emergency ended February 28, 2023.
   - Proclamation by the Governor
   - U.S. Department of Health and Human Services "COVID-19 PHE"
   - CDC End of the Federal COVID-19 PHE Declaration

2. **Q: With the end of the public health emergency, which CDPH AFLs still remain in effect?**
   A: Many AFLs with COVID-19 guidance are outdated (e.g., AFLs from early 2020) or no longer necessary because CDPH's guidance aligns with current CDC guidance. Outdated AFLs are marked as **obsolete, no longer in effect** and remain posted for historical purposes only. There will not be new AFLs to replace them;

rather, moving forward healthcare facilities should **refer to the most recent CDC healthcare infection control guidance** for expectations on patient/resident placement, testing, isolation, etc.

- Interim IPC Recommendations for HCP During the COVID-19 Pandemic https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Refer to the CDPH webpage, https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/COVID-19-AFLs.aspx, for a listing of all COVID-19-related AFLs that are still active, rescinded, or obsolete.

A. COVID-19 Vaccine Guidance

Vaccine Guidance	
CMS and HHS Final Rule, Federal Register (6/5/2023)	https://www.federalregister.gov/documents/2023/06/05/2023-11449/medicare-and-medicaid-programs-policy-and-regulatory-changes-to-the-omnibus-covid-19-health-care
CMS QSO 23-02-ALL: Revised Guidance for Staff Vaccination Requirements (10/26/22)	https://www.cms.gov/files/document/qs0-23-02-all.pdf
CDC Interim Clinical Considerations: Use of COVID-19 Vaccines in the United States	https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html
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HSAG Nursing Home Vaccine Website • NHSN Assistance • Data Portal	www.hsag.com/6-week-booster-sprint www.hsag.com/nhsn-help www.hsag.com/qiip-start

1. **Q: Are COVID-19 vaccines still required for HCP now that the federal public health emergency has ended?**
   A: As of August 4, 2023, CMS will no longer require the COVID-19 primary vaccine series for HCP, as described in the CMS and HHS Final Rule in the Federal Register announced on June 5, 2023 (https://www.federalregister.gov/documents/2023/06/05/2023-11449/medicare-and-medicaid-programs-policy-and-regulatory-changes-to-the-omnibus-covid-19-health-care). The final rule also states: "considering the lower policy priority of enforcement within the remaining time, we will not be enforcing the staff vaccination provisions between now and August 4, 2023." CDPH also no longer requires COVID-19 vaccinations for HCP as of April 3, 2023 (California's State Public Health Office Order "HCW Vaccine Requirement" rescinded April 3, 2023). However, CMS and CDPH continue to strongly recommend that all HCP and high-risk individuals remain up to date on COVID-19, influenza, and other recommended vaccines. Additionally, local health departments and healthcare facilities may implement COVID-19 vaccination requirements for HCP.
2. **Q: Does CMS require nursing homes to educate and offer the COVID-19 vaccine for residents and staff?**
   A: Yes, the CMS and HHS Final Rule in the Federal Register announced on June 5, 2023, (https://www.federalregister.gov/documents/2023/06/05/2023-11449/medicare-and-medicaid-programs-policy-and-regulatory-changes-to-the-omnibus-covid-19-health-care) that CMS and HHS are "finalizing the

educate and offer requirements on a permanent basis." This can be found under section C: COVID–19 Vaccine "Educate and Offer" Requirements for LTC Facilities and ICFs–IID.

3. **Q: Are nursing homes still required to report resident and staff COVID-19 vaccine status to NHSN?**
   A: Yes. Nursing homes are required to report COVID-19 staff and resident vaccination rates to the CDC's NHSN until December 31, 2024, per CMS QSO-23-13-ALL, "Requirements for Reporting related to COVID-19."

4. **Q: What is the COVID-19 vaccine schedule for individuals as of May 2023?**
   A: Visit the CDC website, "CDC Interim Clinical Considerations: Use of COVID-19 Vaccines in the United States" (https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html) for updates regarding the COVID-19 vaccination schedule for individuals. See section "COVID-19 Vaccines, Recommendations, and Schedules:
   - Guidance for people who are immunocompromised https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#immunocompromised.
   - Guidance for people who are not immunocompromised https://www.cdc.gov/vaccines/covid-19/clinical-considerations/interim-considerations-us.html#not-immunocompromised.

   CDPH created the "COVID-19 Vaccine Timing by Age Eligibility Chart that displays the vaccines that individuals are eligible for by age (https://eziz.org/assets/docs/COVID19/IMM-1396.pdf).

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

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

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

   Contact your Local CAIR Representative (LCR) for assistance (https://go.cdph.ca.gov/cair-lcr). Another method to access a vaccine record (COVID-19, influenza, pneumococcal vaccines, etc.) for a California

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

8. **Q: Can we use CAIR2 to confirm vaccination status of our employees and visitors?**
   A: No. The uses of CAIR2/immunization registries are limited by law to protect confidentiality. Employers can use CAIR2 to verify vaccine records for patients/residents, but cannot look up vaccine records for employees or visitors. With regard to vaccination verification, please refer to this guidance: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Vaccine-Record-Guidelines-Standards.aspx. Details on the legal language can be found on this website: https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=120440. To troubleshoot CAIR2 discrepancies, contact the CDPH Virtual Vaccination Support website at https://chat.myturn.ca.gov/?id=17 or email DCVRRemediation.Requests@cdph.ca.gov.

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

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

B. Testing

Testing Guidance	
CDPH COVID-19: Information for Laboratories	https://www.cdph.ca.gov/Programs/OSPHLD/LFS/Pages/COVID-19.aspx
CDPH State Public Health Officer Order "Revision of Mandatory Reporting Of COVID-19 Results by Health Care Providers" (10/4/22)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Revision-of-Mandatory-Reporting-of-Covid-19-Results-by-Health-Care-Providers.aspx
CDPH COVID-19 Point of Care Test Expiration Guidance (11/10/21)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Testing.aspx
CDPH Updated Testing Guidance (9/15/22)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Updated-COVID-19-Testing-Guidance.aspx
CDPH Guidance on the Use of Antigen Tests for Diagnosis of Acute COVID-19 (9/12/20)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/CDPH-Guidance-on-the-Use-of-Antigen-Tests-for-Diagnosis-of-Acute-COVID-19.aspx
CDC Self-Testing at Home or Anywhere (Updated 4/25/23)	https://www.cdc.gov/coronavirus/2019-ncov/testing/self-testing.html
CDC's Laboratory Outreach Communication System (LOCS): CDC's Gateway to Engage with Laboratory and Testing Community	https://www.cdc.gov/csels/dls/locs/2020/cms_guidance_for_the_use_of_expired_sars-cov-2_tests.html
CDPH Laboratory Field Services—COVID-19 for Laboratories: FAQs	https://www.cdph.ca.gov/Programs/OSPHLD/LFS/Pages/COVID-19FAQ.aspx

Testing Guidance	
CDPH COVID-19 Antigen Self-Test Expiration Extensions (7/7/22)	https://www.cdph.ca.gov/Programs/OPA/Pages/Communications-Toolkits/Tested_CA.aspx
CMS FAQs, CLIA Guidance During the COVID-19 Emergency (12/17/20)	https://www.cms.gov/files/document/frequently-asked-questions-faqs-clia-guidance-during-covid-19-emergency-updated-12-17-2020.pdf
Instructional Video on Self-Swabbing for COVID-19	https://www.youtube.com/watch?v=dtIzs05DGNU

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

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

Who Can Perform Swabbing for COVID-19 Tests?

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

3. **Q: What is the updated CDPH routine diagnostic screening testing guidance for HCP?**
   A: CDPH AFL 21-34.5 issued on January 23, 2023, notifies nursing homes that the **routine diagnostic screening COVID-19 testing requirements for asymptomatic HCP are rescinded (no longer required). CDPH's guidance aligns with CDC guidance** and CMS QSO-23-13-ALL, which states that routine testing of asymptomatic staff is no longer recommended, but may be performed at the discretion of the facility. Per CMS QSO-23-12-ALL, "COVID-19 testing is still an important action and is a nationally recognized standard to help identify and prevent the spread of COVID-19. Therefore, while this specific regulatory requirement will end with the PHE, CMS still expects facilities to conduct COVID-19 testing in accordance with accepted national standards, such as CDC recommendations." Please note that local health departments and healthcare facilities may implement more stringent guidance.

4. **Q: Following an exposure, does a resident need to be tested on days 1, 3, and 5?**
   A: Yes. Please refer to the CDC testing guidance, "Interim IPC Recommendations for HCP During the COVID-19 Pandemic" https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html. Section "Perform SARS-CoV-2 Viral Testing" states:
   - Asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than

24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
- Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days.

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

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

7. **Q: Can an antigen test be used for HCP who are returning to work early after testing positive under routine circumstances?**
A: Yes, per AFL 21-08.9 (updated 12/2/2022), antigen tests are acceptable and preferred. The antigen test needs to be observed or validated by the facility to verify the identity of the HCP being tested, the date of the test, and that the test is negative. This proctoring does not need to happen physically in person with the HCP (i.e., telehealth, time-stamped picture of the test). See AFL 21-08.9 table "Work restrictions for HCP with SARS-CoV-2 Infection (Isolation)," which says, "Either an antigen test or nucleic acid amplification test (NAAT) can be used. Some people may be beyond the period of expected infectiousness but remain NAAT positive for an extended period. Antigen tests typically have a more rapid turnaround time but are often less sensitive than NAAT. Antigen testing is preferred for discontinuation of isolation and return-to-work for SARS-CoV-2 infected HCP and for HCP who have recovered from SARS-CoV-2 infection in the prior 90 days; NAAT is also acceptable if done and negative within 48 hours of return."

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

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

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

11. **Q: When there is a COVID-19 exposure, how long should contact tracing and testing be performed?**
A: Per CDC guidance, refer to the section, "Create a Process to Respond to SARS-CoV-2 Exposures Among HCP and Others." Nursing home-specific CDC guidance indicates:

- A single new case of SARS-CoV-2 infection in any HCP or resident should be evaluated to determine if others in the facility could have been exposed. The approach to an outbreak investigation could involve either contact tracing or a broad-based approach; however, a broad-based (e.g., unit, floor, or other specific area[s] of the facility) approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
- Perform testing for all residents and HCP identified as close contacts or on the affected unit(s) if using a broad-based approach, regardless of vaccination status.
- Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days.
- If no additional cases are identified during contact tracing or the broad-based testing, no further testing is indicated. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected unit(s) or facility-wide every 3–7 days until there are no new cases for 14 days.

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

C. Isolation and Quarantine

Isolation and Quarantine Guidance	
CDC Interim Guidance for Managing HCP with SARS-CoV-2 Infection or Exposure 9/23/2022	https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
CDPH AFL 21-08.9: Guidance on Quarantine and Isolation for HCP Exposed to SARS-CoV-2 and Return to Work for HCP with COVID-19 (12/2/22)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-08.aspx
CDPH Q&A: COVID-19 Disease Control and Prevention (4/4/2023)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Order-of-the-State-Public-Health-Officer-Beyond-the-Blueprint-QA.aspx

1. **Q: Do COVID-19 positive residents still need to isolate for 10 days?**
A: Yes, per CDC guidance updated on May 8, 2023 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html):
   - Residents who test positive and are **asymptomatic** throughout their infection should be isolated until at least 10 days have passed since the date of their first positive test.
   - Residents who test positive and are **symptomatic** with mild to moderate illness and are NOT moderately to severely immunocompromised should be isolated until the following conditions are met:
     – At least 10 days have passed since symptoms first appeared; and
     – At least 24 hours have passed since resolution of fever without the use of fever-reducing medications; and
     – Other symptoms (e.g., cough, shortness of breath) have improved.
   - Residents who are with severe to critical illness and who are NOT moderately or severely immunocompromised, may require isolation for up to 20 days after the onset of symptoms.

   Note:
   - Vaccination and treatment status does not influence duration of isolation.

- If symptoms recur (e.g., rebound), place patients back into isolation until they meet the above criteria to discontinue isolation.
- The duration of isolation could be extended beyond 20 days for individuals who had critical illness (i.e., required intensive care) and are moderately to severely immunocompromised (e.g., currently receiving chemotherapy, or recent organ transplant); use of a test-based strategy and (if available) consultation with an infectious disease specialist is recommended to determine when transmission-based precautions could be discontinued for this latter group of moderate to severely immunocompromised individuals.

2. **Q: Is a test-based strategy necessary for discontinuing 10-day isolation in residents?**
   A: No. The only indication for a test-based strategy is in those moderately to severely immunocompromised individuals with severe to critical illness in isolation for > 20 days as described in Question #1.

3. **Q: If a COVID-19 positive resident is experiencing an occasional or intermittent cough as their only symptom, should they continue to be isolated past day 10 until their cough is completely resolved?**
   A: Isolation can end at day 10 if symptoms have improved (do not need to be completely resolved) as long as they are not moderately to severely immunocompromised, and have been afebrile for at least 24 hours without fever reducing medication as described above in Question #1.

4. **Q: What is the definition of exposure?**
   A: Here are key definitions related to exposure:
   - Close contact (for residents, visitors, HCP with exposures outside of work [household] or exposed to each other in non-patient care areas), per CDPH:
     - In indoor spaces 400,000 or fewer cubic feet per floor (such as home, clinic waiting room, airplane etc.), a close contact is defined as sharing the same indoor airspace for a cumulative total of 15 minutes or more over a 24-hour period (for example, three separate 5-minute exposures for a total of 15 minutes) during a confirmed case's infectious period.
     - In large indoor spaces greater than 400,000 cubic feet per floor (such as open-floor-plan offices, warehouses, large retail stores, manufacturing, or food processing facilities), a close contact is defined as being within 6 feet of the confirmed case for a cumulative total of 15 minutes or more over a 24-hour period during the confirmed case's infectious period.
     - Spaces that are separated by floor-to-ceiling walls (e.g., offices, suites, rooms, waiting areas, bathrooms, or break or eating areas that are separated by floor-to-ceiling walls) must be considered distinct indoor airspaces.
   - Occupational higher-risk exposure (for HCP), per CDC:
     - Eyes, nose, or mouth exposed to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure.
     - Prolonged or close contact with a patient, visitor, or HCP with confirmed SARS-CoV-2 infection and:
       - HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask).
       - HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask.
       - HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure..

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

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

days and if negative, again at 5 days after the exposure. To provide an additional layer of safety, exposed HCP should wear a fit-tested N95 for source control for 10 days.

Management of Asymptomatic HCP with Exposures

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

7. **Q: When can COVID-19 positive HCP return to work?**
A: Recognizing that staffing shortages continue to persist, per AFL 21-08.9, under routine staffing conditions, COVID-19 positive HCP may return to work after 5 days with proof of a negative antigen, or after 10 days without a negative test (and afebrile x 24 hours and symptoms improving). To provide an additional layer of safety, these HCP should wear a fit-tested N95 for source control through day 10.
   - If there is a critical staffing shortage, no additional testing is required to return beyond the initial positive test. Per the table below from AFL 21-08.9, positive asymptomatic HCP, regardless of vaccination status, may return to work immediately with a fit-tested N95 for source control. When returning to work early, use the results of the most recent test result (which may be the test at diagnosis) to determine work placement:
     – If the most recent test result is positive, HCP can only provide direct care to residents with confirmed SARS-CoV-2 infection, preferably in a cohort setting. This may not apply for staff types or in settings where practically infeasible (e.g., emergency departments where patient COVID-19 status is unknown) or where doing so would disrupt safe nurse-to-patient ratios, and for staff who do not have direct patient/resident care roles.
   - HCP who are not already fit-tested for their role do not need to become newly fit-tested solely for the purpose of being able to return to work; these workers should wear a well-fitting N95. COVID-19 positive staff should take meal breaks outdoors or in a well-ventilated area, away from other HCP or residents when removing their N95. If break rooms are shared, N95s should not be removed; avoid crowding in break rooms. Notify the L&C District Office and local health department if there is an anticipated staffing crisis.

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

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

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

9. **Q: How are the days counted for return-to-work purposes (routine staffing) for COVID-19 HCP in isolation?**
A: Per CDPH AFL 21-08.9, in routine staffing circumstances, COVID-19 positive HCP may return to work after 5 days with proof of a negative antigen, or after 10 days without a negative test (and afebrile x 24 hours

and symptoms improving). The 5 days are counted in the following way (see image of calendar as an example):

- Day 0 = day of symptom onset, or if asymptomatic, day of first positive test.
- Day 5 = last day of isolation with proof of a negative antigen test. Return to work would be Day 6.
- Day 10 = last day of isolation without a negative test. Return to work would be Day 11.

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

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

11. **Q: Does a resident who had close contact with a positive visitor, HCP or resident need to quarantine and be placed on empiric transmission-based precautions?**
    A: No. Refer to CDC guidance now (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).
    - Resident should wear source control outside their room for a minimum of 10 days following the exposure.
    - Resident should not participate in communal dining for 10 days following the exposure because masks must be removed during eating and drinking.
    - Residents who remain asymptomatic and have not had an episode of COVID-19 within the previous 30 days, should be tested promptly (but not earlier than 24 hours after the exposure) and, if negative, again at 3 days and at 5 days after the exposure. Testing with an antigen test may be considered for those who have recovered from COVID-19 within the previous 31–90 days.

12. **Q: If a staff member wearing full PPE (N95, eye protection, gown, gloves) tests positive, are the residents now considered exposed?**
    A: Yes. We know that there may be unintended breaches in the use of PPE that could expose a resident.

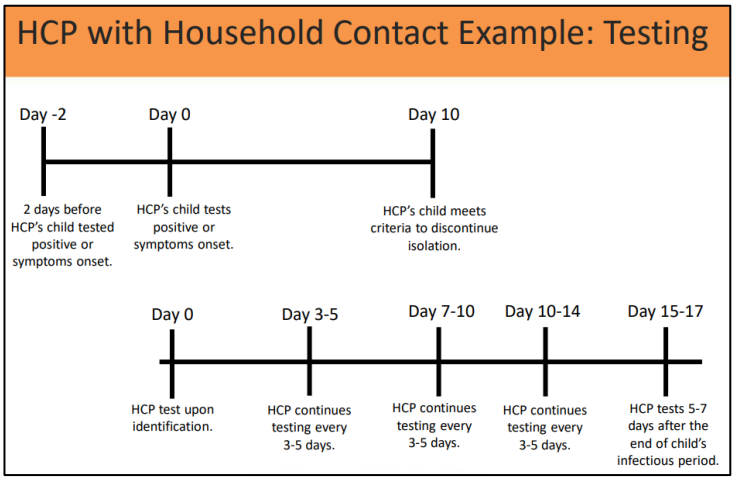
13. **Q: During contact tracing, a resident tested positive 7 days after being exposed. Does the 14 days of contact tracing response testing start over?**
    A: Yes. When testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify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

14. **Q: An HCP's child tested positive, and the HCP is unable to quarantine away from the child who is immunocompromised. The HCP is fully vaccinated and boosted. When can the HCP return to work? What if the HCP is symptomatic, but still testing negative for COVID-19?**

A: If the HCP cannot isolate from their infected household member, the HCP would be considered exposed throughout the infected household member's infectious period. Since the child is immunocompromised, the isolation period may be extended to ≥ 20 days per CDC guidance, which means the HCP would be considered exposed for the duration of the child's isolation period. Per AFL 21-08.9, if the HCP is asymptomatic during this exposure, they can work without restriction, as long as they continue to test negative (see table: Management of for Asymptomatic HCP with Exposures). During the exposure period, the HPC should test as follows:

- Test upon identification of the exposure, which starts 2 days prior to the infected person's symptoms onset or positive test, if asymptomatic.
- Continue testing every 3–5 days through 7 days after the end of the infected household member's infectious period (generally at least 5 days if testing negative on day 5 or later, or 10 days if no negative test, and improving symptoms if symptomatic). In this scenario, the infectious period may be longer since the child is immunocompromised.
- The HCP should wear a mask at home when not separated from the child.
- The HCP should wear an N95 for source control until 4 days after the child's infectious period ends and the HCP is test negative.

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



D. New Admission Guidance

1. **Q: Do new newly admitted/readmitted residents, need to be tested on admission?**
   A: No. Admission testing in nursing homes is now at the discretion of the facility per CDC guidance updated on May 8, 2023 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html). CDPH AFL 22-13.1, which had testing guidance for new admissions, is no longer in effect.

2. **Q: Can nursing homes require a negative test at the hospitals prior to discharge?**
   A: No. SNFs may not require a negative test result prior to accepting a new admission. Nursing homes should work collaboratively with hospital discharge planners and local health departments to facilitate the safe and appropriate placement of nursing home residents, including new and returning residents requiring isolation and transmission-based precautions.

3. **Q: Do hospitals need to offer patients the booster prior to transfer to the SNF?**
   A: CDPH recommends that prior to discharge, hospitals should offer COVID-19 vaccinations, including booster doses, to eligible patients, especially those at highest risk of morbidity and mortality from COVID-19. CDPH recommends that nursing homes reach out to their local hospital IPs to encourage them to offer boosters prior to transferring.

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

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

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

E. Cohorting

Cohorting Guidance	
CDPH COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category (7/22/21)	COVID-19 PPE, Resident Placement/Movement, and Staffing Considerations by Resident Category
CDC Ventilation in Buildings (5/12/23)	https://www.cdc.gov/coronavirus/2019-ncov/community/ventilation.html
CDPH Interim Guidance for Ventilation, Filtration, and Air Quality in Indoor Environments (3/22/23)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Interim-Guidance-for-Ventilation-Filtration-and-Air-Quality-in-Indoor-Environments.aspx

1. **Q: Do nursing homes need to have color-designated zones (i.e., red, yellow, or green zones) designated to care for residents based on their COVID-19 status?**
   A: No, facilities no longer need to designate zones. Facilities should create policies to maintain an IPC plan and practices to manage an outbreak of suspected or confirmed infectious respiratory illnesses, including COVID-19. Per CDPH AFL 23-12, "SNFs should continue to ensure residents identified with confirmed COVID-19 are promptly isolated in a designated COVID-19 isolation area. The COVID-19 isolation area may be a designated floor, unit, or wing, or a group of rooms at the end of a unit that is physically separate and ideally includes ventilation measures to prevent transmission to other residents outside the isolation area. SNFs that do not have any residents with COVID-19 and do not have a current need for an isolation area should remain prepared to quickly re-establish the area and provide care for, and accept admission of, residents with COVID-19." Please also refer to the CDC's guidance, "Interim IPC Recommendations for HCP During the COVID-19 Pandemic," updated on May 8, 2023 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

2. **Q: Do nursing homes still need to have a yellow zone to quarantine residents?"**
   A: The "yellow zone" is no longer generally applicable because quarantine and empiric transmission-based precautions are no longer routinely required for COVID-19-exposed and newly admitted residents. Please refer to the CDC's guidance, "Interim IPC Recommendations for HCP During the COVID-19 Pandemic," section 2. Recommended IPC Practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection, updated on May 8, 2023 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

3. **Q: For symptomatic residents, can we still use yellow zone terminology?**
   A: CDPH has moved away from the color zone framework that was developed early in the pandemic to guide infection control precautions for groups of residents solely based on their COVID-19 status. SNFs now need to consider COVID-19 along with many other transmissible pathogens (e.g., influenza, MDROs) and individualize precautions based on a resident's specific situation. A symptomatic resident should be empirically isolated and cared for with transmission-based precautions based on their suspected diagnosis, which might be COVID-19, influenza, or another pathogen. While test results are pending, isolate the resident in their current room with empiric, transmission-based precautions, and avoid moving the resident so that new exposures throughout the facility are not created. If the resident tests positive for COVID-19, then move them to the designated COVID-19 isolation area and consider the roommate(s) exposed. Please refer to the CDC's guidance, "Interim IPC Recommendations for HCP During the COVID-19 Pandemic," updated on May 8, 2023 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

4. **Q: Do nursing homes need to have dedicated staffing for caring for residents with suspected or confirmed COVID-19?**
   A: Dedicated staffing for the COVID-19 isolation area and sequencing care for uninfected residents before positive residents are no longer required.
   - Dedicated staffing and/or sequencing care might be preferable from a practical standpoint when there are large numbers of residents in the COVID-19 isolation area (i.e., to facilitate extended use of N95s).
   - Ensure all HCP perform hand hygiene and change gloves and gowns between residents and when leaving the resident's room, or area of care (e.g., treatment or therapy room).
   - Ensure all HCP strictly adhere to masking for source control (to prevent an infected HCP from inadvertently exposing the residents for which they are caring).
   - The facility's full-time IP should assist with adherence monitoring of hand hygiene and PPE donning/doffing between all residents, and provide just-in-time feedback. Please refer to the CDC's guidance, "Interim IPC Recommendations for HCP During the COVID-19 Pandemic," updated on May 8, 2023 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

5. **Q: Can HCP working with residents in isolation share the same breakrooms and bathrooms with other HCP?**
   A: Yes. Dedicated staffing for the COVID-19 isolation area is no longer required, therefore HCP can share the same breakrooms and bathrooms. Reinforce teaching about the importance of hand hygiene, managing PPE, avoiding crowding, and performing environmental cleaning for shared spaces.

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

7. **Q: If our SNF has all private rooms, can COVID-19 positive residents isolate in place?**
   A: Yes, CDC guidance for isolation includes placement of the patient with suspected or confirmed SARS-CoV-2 infection in a single-person room. The door should be kept closed (if safe to do so). Ideally, the patient should have a dedicated bathroom. Facilities could consider designating entire units within the facility, with dedicated HCP, to care for patients with SARS-CoV-2 infection when the number of patients with SARS-CoV-2 infection is high. Dedicated means that HCP are assigned to care only for these patients during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of patients with SARS-CoV-2 infection.

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

9. **Q: Are nursing homes able to use plastic barriers to indicate a separation between the isolation area and the other areas of the facility?**
   A: Avoid using plastic barriers to separate different zones of care. The use of visual clues is preferred to

identify different resident cohorts and keep unauthorized personnel from entering the unit. If a plastic barrier is used to keep air from the isolation unit from leaving that zone, there are site-specific considerations based on the building design, properties of the barrier, and the resident population. Consultation with a professional who understands the airflow of the building is advised. Any time barriers are deployed, airflow distribution testing with tracer "smoke" or a handheld pressure monitor should be used to be certain that air flow is from clean to dirty, (i.e., from hallway to room where infected individuals may be housed). For more information, visit CDC Ventilation in Buildings and the CDPH Interim Guidance for Ventilation, Filtration, and Air Quality in Indoor Environments.

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

11. **Q: Can COVID-19 positive residents in isolation receive group physical therapy (PT)?**
A: No. COVID-19 positive residents should remain in isolation in their room until they are no longer infectious. COVID-19 positive residents should only leave their room during this time when it is medically necessary. Guidance for Individual PT sessions for COVID-19 positive residents:
    - Resident can receive individual PT in their room or outdoors.
    - Resident must wear a face mask for source control during PT.
    - Physical therapists working with COVID-19 positive residents must wear appropriate PPE, including an N95 and eye protection, throughout the entire PT encounter.
    - The physical therapist can keep the same N95 and eye protection on during the entire PT encounter, even as they transfer the patient throughout the facility.
    - Be sure to clean beds or equipment used during physical therapy with an EPA-approved cleaning product for COVID-19 (List N) after each use.

    Please refer to the CDC's guidance, "Interim IPC Recommendations for HCP During the COVID-19 Pandemic," updated on May 8, 2023 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html).

12. **Q: Do the doors to rooms for COVID-19 positive residents need to remain closed?**
A: Yes. CDC recommends that residents with suspected or confirmed SARS-CoV-2 should be kept in a room with the door closed, if safe to do so. Please refer to the CDC's guidance, "Interim IPC Recommendations for HCP During the COVID-19 Pandemic," updated on May 8, 2023 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html). This guidance can be modified to facilitate safe resident care. For example, if a resident is a high fall-risk due to physical or mental challenges, the following methods can be used to safely provide care with the door open for observation:
    - The resident should be at least six feet away from the open door.
    - Fans or other ventilation devices should not blow air out of the resident's room.
    - If able, the resident can wear a mask in the room.
    - Consider the use of video cameras for monitoring; this would require that there is someone monitoring the video input at all times.

F. Visitation, Communal Dining and Group Activities

Visitation	Guidance
CDPH Get the Most Out of Masking: Tips & Resources	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx
CDC Appendix: Considerations for Implementing Broader Use of Masking in Healthcare Settings	https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#anchor_1683225484627:~:text=Top%20of%20Page-,Appendix,Considerations%20for%20Implementing%20Broader%20Use%20of%20Masking%20in%20Healthcare%20Settings,-Introduction%3A
CDC's Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings	https://www.cdc.gov/infectioncontrol/guidelines/core-practices/index.html
CMS QSO-20-39-NH: Visitation Guidance (5/8/2023)	https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

Q: What are the highlights (1–4 below) of the CDC and CMS visitation guidance?
A: CMS in conjunction with CDC has updated its visitation guidance in QSO 20-39-NH emphasizing the importance of IP practices. While the PHE has ended, CMS still expects facilities to adhere to IPC recommendations in accordance with accepted national standards, such as CDC recommendations. CMS acknowledges that there may still be concerns associated with visitation; however, adherence to the core principles of COVID-19 IP mitigates these concerns. Please refer to the CDC's guidance, "Interim IPC Recommendations for HCP During the COVID-19 Pandemic," updated on May 8, 2023 (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html). Highlights from the CMS and CDC guidance are included in questions #1–4 below.

1. **General Visitation Guidance**
   - Adhere to core principles of COVID-19 IP outlined in CMS QSO 20-39-NH and CDC guidance, including hand hygiene. Visitation should be person-centered; consider the resident's physical, mental, and psychosocial well-being and support their quality of life. Facilities shall not restrict visitation without a reasonable clinical or safety cause, consistent with 42 CFR § 483.10(f)(4)(v).
   - CDC continues to strongly recommend that all persons (including residents, visitors, and staff) complete the COVID-19 primary vaccination series and recommended boosters.
   - ***Visitor recommendations:*** CDC recommendations include passive visitor screening for COVID-19 signs and symptoms. Examples include posting visual alerts at entrances and strategic locations. Visitors are not required to be vaccinated or show proof of a negative COVID test. If the visitor has a confirmed COVID-19 infection or symptoms consistent with COVID 19, they should defer non-urgent, in-person visitation until they meet CDC criteria for healthcare settings to end isolation. For visitors who have had close contact with someone with COVID-19 infection, it is safest to defer non-urgent, in-person visitation until 10 days after their close contact. Those with COVID-19 symptoms, or who have been in close contact with a confirmed positive case, must reschedule their visit, regardless of vaccination status.
   - ***Masking:*** Visitors are no longer required to mask unless directed by the local health department. Please refer to the CDC infection control and CDPH masking guidance for when to consider source control.
   - Visitor movement in the facility should be limited, regardless of visitor's vaccination status.

2. **Indoor, In-Room, Communal Space Visitation Requirement**
   In accordance with CMS QSO 20-39-NH, facilities shall allow indoor, in-room visitation for all residents, including in isolation areas. While previously acceptable during the PHE, facilities can no longer limit the frequency and length of visits for residents, the number of visitors, or require advance scheduling of visits.
   - Although there is no limit on the number of visitors that a resident can have at one time, visits should be conducted in a manner that adheres to the core principles of COVID-19 IP and does not increase risk to other residents.
   - Visitors to residents in isolation areas should be provided the same PPE recommended for HCP when visiting COVID-19 positive residents in isolation (N95 respirator, eye protection, gown, gloves). HCP should instruct visitors on proper hand hygiene and donning and doffing PPE. Fit testing for N95 respirators is not required for visitors, but the visitors should be instructed how to perform a respirator

seal check. Visit https://www.cdc.gov/niosh/docs/2018-130/pdfs/2018-130.pdf?id=10.26616/NIOSHPUB2018130 for information on how to do a seal check.

3. **Outdoor Visitation: All facilities must continue to allow outdoor visitation options for all residents.**
   - Outdoor visits are preferred, as meeting outdoors poses a lower risk of transmission due to increased space and airflow and should be offered unless the resident cannot leave the facility or when there are weather or poor air-quality constraints.
   - Other options for visitors to communicate with residents are encouraged.

4. **Communal Dining and Group Activities**
   - ***Communal Dining:*** Community activities and dining may occur while adhering to the core principles of COVID-19 IP. Residents who have been exposed to COVID-19 must wear a mask in common areas for 10 days following the most recent exposure. Therefore, they should not participate in communal dining because masks must be removed during eating and drinking.
     – Visitors can dine with the resident they are visiting.
   - ***Group Activities:*** Residents who are not in isolation may participate in group/social activities. Exposed residents can participate in group activities as long as they wear a mask throughout the activity for a minimum of 10 days following the most recent exposure.
   - Facilities should consider, in consultation with their local health department, reimplementing limitations on communal activities and dining based on the status of COVID-19 infections in the facility, (e.g., when one or more cases has been identified in facility staff or residents).

5. **Residents Who Leave and Return to the Facility**
   - Educate residents leaving the facility about potential risks of public settings and to follow all recommended IP practices, especially for those at high risk for severe illness. Refer to CDC guidance: How to Protect Yourself & Others https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html.

6. **What are the requirements for non-essential personnel/contractors?**
   A: Barbers, manicurists/pedicurists, and other non-essential personnel/contractors who comply with visitation guidance may enter the facility and provide services to residents.

7. **Are there additional considerations for pediatric residents?**
   A: Yes, considerations for pediatric residents include:
   - Visitation, including extended physical contact, must be permitted for pediatric residents.
   - Involve child life workers, parents, legal guardians, or authorized representatives in planning the facility visitation program.

8. **Q: With passive visitor screening now acceptable, can nursing homes have multiple entrances?**
   A: Yes. The single point of entry made it feasible for a facility to actively screen staff and visitors prior to entry. Now that passive screening is acceptable, it would be reasonable to have more than one entry point to the facility. However, visitors that enter the facility still need to check in to sign a visitor log like they did pre-pandemic so that the facility is able to track who is in the building.

9. **Q: If the facility is experiencing an outbreak, are we still expected to coordinate visitation?**
   A: Yes. Visitation is expected to be coordinated even when there is an outbreak, per CMS QSO-39-NH. Consult with CDC infection control guidance in healthcare settings and with your local public health department for further guidance. In some circumstances, at the beginning of an outbreak, the local health department may temporarily discontinue visitation and group activities to determine the extent of transmission and ensure response measures are underway. If PPE is required for contact with the resident due to quarantine (i.e., waiting for test result for symptomatic resident) or COVID-19 positive isolation status, it must be donned and doffed according to instruction by HCP. Visitors should be taught how to do a seal check for N95 respirators, but fit testing is not required.

10. **Q: Can COVID-19 positive residents in isolation have outdoor visits?**
    A: Outdoor visitation for COVID-19 positive residents in isolation can be accommodated for outdoor visits on a case-by-case basis, but must be conducted safely. For instance, an outdoor visit would be reasonable if the room has an attached outdoor patio; the positive resident should be masked. COVID-19 positive residents

in isolation should generally not be leaving their rooms during their isolation period unless medically necessary. They can have in-room visits while in isolation. Visitors must wear proper PPE.

11. **Q: Is there a limit to the number of visitors for one resident?**
    A: CDPH does not specify a limit; however, the number of visitors allowed for one resident may need to be limited if the space available for visitation is insufficient to ensure safety precautions are in place.

12. **Q: Are there any suggestions for how to conduct visits that reduce the risk of COVID-19 transmission?**
    A: There are many ways facilities can reduce risk of COVID-19 transmission. Refer to the CDC Infection Control Guidance—Section 1: "Recommended routine IPC practices during the COVID-19 pandemic". "Optimizing the Use of Engineering Controls and Indoor Air Quality" is one strategy. Refer also to CMS QSO 20-39-NH FAQs #9–#11.

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

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

G. PPE and Face Masks

PPE and Face Masks: Important Links	
CDPH AFL 23-12 COVID-19 Recommendations for PPE, Resident Placement/ Movement, and Staffing in SNFs (1/24/23)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-23-12.aspx Chart (pdf): https://www.cdph.ca.gov/Programs/CHCQ/LCP/CDPH%20Document%20Library/AFL-23-12-Attachment-01.pdf
CDC Summary of Strategies to Optimize Use of PPE in Presence of Shortages	https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/strategies-optimize-ppe-shortages.html
Get the Most Out of Masking (printable reference materials; multiple languages available)	https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx
CDC Standard Precautions	https://www.cdc.gov/infectioncontrol/basics/standard-precautions.html

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

2. **Q: Do visitors and HCP need to wear masks for source control while in a nursing home?**
   A: Although CDPH no longer requires masks for source control in healthcare settings, CDPH provides considerations for healthcare facilities assessing their local circumstances and developing plans for recommending or requiring masks. In general, wear a mask around others if you have respiratory symptoms (e.g., cough, runny nose, and/or sore throat).
   - If you have had a significant exposure to someone who has tested positive for COVID-19, wear a mask for 10 days.
   - When choosing to wear a mask, ensure your mask provides the best fit and filtration (respirators like N95, KN95 and KF94 are best).

   In addition, wearing a mask is increasingly important for those that are at higher risk for getting very sick from COVID-19, and as the risk for transmission increases in the community.
   - Examples of settings to consider wearing a mask include indoor areas of public transportation (such as in airplanes, trains, buses, ferries) and transportation hubs (such as airports, stations, and seaports), and other crowded indoor settings, especially where higher-risk individuals are present.

   Local health jurisdictions and other entities may have requirements in specific settings based on local circumstances. For more tips and resources for face masks, visit the CDPH resource hub Get the Most Out of Masking https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx.
3. **Q: Can HCP wear KN95s instead of surgical masks in non-patient care areas and when caring for residents that are not in isolation?**
   A: Yes, surgical masks, KN95s, KN94s, and N95s can be worn as source control by SNF HCP when caring for patients who do not have COVID-19 and when working in non-patient care areas. While KN95s are acceptable, CDPH cautions against the use of KN95s as source control to avoid confusion with N95s. Because of concerns that some KN95s are counterfeits, only NIOSH-approved N95s should be worn as PPE for transmission-based precautions.

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

5. **Q: Are residents required to wear masks in nursing homes?**
   A: No, residents are not required to wear masks; however, they may be recommended for residents when outside of their rooms (e.g., hallways, common areas). If outside visitors are present (e.g., during large communal space visitation), masks are recommended for both residents and visitors, but they are not required. If residents have been exposed to an individual with COVID-19, they must wear a mask for 10 days following the most recent exposure, even during group activities. Residents who have been exposed should not participate in communal dining since masks must be removed during eating and drinking.

6. **Q: When can masks be removed in high-risk settings, such as nursing homes?**
   A: CDPH provides considerations for healthcare facilities assessing their local circumstances and developing plans for recommending or requiring masks. For the general public, CDPH sunset its Guidance for the Use of Face Masks and is recommending all Californians consider the following:
   - Wear a mask around others if you have respiratory symptoms (e.g., cough, runny nose, and/or sore throat).
   - If you have had a significant exposure to someone who has tested positive for COVID-19, wear a mask for 10 days.
   - When choosing to wear a mask, ensure your mask provides the best fit and filtration (respirators like N95, KN95 and KF94 are best).

   In addition, wearing a mask is increasingly important for those who are at higher risk for getting very sick from COVID-19, and as the risk for transmission increases in the community.

- Examples of settings to consider wearing a mask include indoor areas of public transportation (such as in airplanes, trains, buses, ferries) and transportation hubs (such as airports, stations, and seaports), and other crowded indoor settings, especially where higher-risk individuals are present.

Local health jurisdictions and other entities may have requirements in specific settings based on local circumstances. For more tips and resources for face masks, visit the CDPH resource hub Get the Most Out of Masking https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/Get-the-Most-out-of-Masking.aspx.

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

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

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

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

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

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

and at the end of the shift. If removed for a meal break, for example, the respirator should be discarded and a new respirator put on after the break. The respirator should also be changed if HCP are moving from one cohort zone to another. N95 respirators should be removed and discarded if soiled, damp, or damaged.
- When an N95 is used strictly for source control in areas with no known COVID-19 exposure or non-patient care areas, the N95s may be used for multiple patient encounters until soiled or damaged (i.e., once the strap breaks it should be discarded).
- CDC Strategies for Optimizing the Supply of N95 Respirators https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html.

12. **Q: What PPE is necessary when HCP are caring for an asymptomatic resident that has been exposed to COVID-19?**
A: Empiric, transmission-based precautions and full PPE are no longer required for asymptomatic exposed residents, because quarantine is no longer required following an exposure.

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

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

H. Cal/OSHA Aerosol Transmissible Disease (ATD) Requirements

1. **Q: Does Cal/OSHA recognize COVID-19 as a novel virus?**
A: Yes. At the current time, Cal/OSHA considers COVID-19 to meet the definition of a disease caused by a novel ATP, SARS CoV-2.

2. **Q: Do nursing homes need to transfer residents with COVID-19 if they do not have an airborne infection isolation room (AIIR)?**
A: The Cal/OSHA ATD regulations that can be found in Title 8, section 5199, are not new; they came into effect in 2009. Requirements regarding managing COVID-19 patients in AIIRs can be found in this regulation. The regulation indicates that for diseases identified as requiring airborne infection isolation (AII) in section 5199 Appendix A, transfer to an AIIR either in the facility or in another facility is required within 5 hours of identification. Where transfer is not available, 5199(e)(5)(B)2 requires that there be documentation by the employer at the end of the 5-hour period, and at least every 24 hours thereafter. **However, there is a novel pathogen exception:**
   - Cal/OSHA and CDPH recognize that nursing homes may not have capabilities to offer AIIR onsite, and understand the challenge to transfer a COVID-19 resident to another facility that has an AIIR. Additionally, CDPH has instructed nursing homes not to transfer residents that are not in need of hospital-level medical care solely for the purpose of AII.
   - In this case, the usual requirement to document attempts to transfer within 5 hours, and every 24 hours thereafter, and to contact the local health officer do not apply to this exception.

   Cal/OSHA Expectations: Managing COVID-19 Patients without an AIIR
   An employer who cannot transfer patients to an AIIR under the novel pathogen exception must:

- Ensure appropriate use of N95 respirators (or higher level) by employees when caring for COVID-19 residents; and
- Provide and document use of "other effective control measures" to reduce the risk of transmission to employees, such as:
  - Place HEPA filters of sufficient size in resident rooms to provide significant removal of contaminants.
  - Create temporary negative pressure areas by exhausting ventilation equipment such as HEPA filtration machines through temporary ducting to a window or other opening.

  Please note that the above noted exception does not apply to the requirements to conduct high-hazard procedures on airborne infectious disease (AirID) cases in AIIRs. High-hazard procedures must be done in AIIRs, and staff must wear powered air purifying respirators (PAPRs). N95s are not sufficient for high-hazard procedures. The only exception for high-hazard procedures is where an AIIR is not available and the delay of a procedure would be detrimental to the health of the patient.

3. **Q: Are nursing homes required to contact hospitals within and outside their jurisdiction to identify AIIR options for managing residents?**
   A: No, nursing homes are not required to contact hospitals if a COVID-19 patient does not need hospital-level care. Hospitals are unlikely to take patients that do not need hospital-level care. In this case, follow the local health officer recommendations and ATD requirements to prevent transmission within the facility.

4. **Q: What signage is necessary outside of COVID-19 rooms?**
   A: In terms of signage, Section 5199(e)(1)(A) requires that AII be consistent with the procedures in the CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health-Care Settings, and droplet and contact precautions be consistent with the CDC Guideline for Isolation Precautions. Both publications address the placement of signs to provide notification of isolation precautions in use. It would not be appropriate to place a "droplet precautions" sign on the room of a COVID-19 patient, because even though the patient room is not an AIIR, other provisions of AII apply, either required by Section 5199 or by these guidelines. These include, but are not limited to:
   - Use of NIOSH-approved respirators by employees who have been fit-tested when entering and while in the room, with respirator doffing after leaving the room.
   - Single occupancy rooms with the door closed (unless cohorting procedures are necessary and implemented).
   - Prior arrangement with receiving units, such as imaging, and determination of an appropriate route of travel to minimize exposures.
   - Respirator use by transporters if the patient is not masked.
   - Use of PAPRs or equivalent respirators for high-hazard procedures on COVID-19 or other AirID cases or suspected cases.
   - Use of respirators by employees who have been fit-tested when they enter the room after the patient has left, until the required clearance time has passed.

5. **Q: Is fit testing still required annually from Cal/OSHA?**
   A: Yes. There have been no changes to the required fit testing requirements.

I. Infection Prevention Training

Infection Preventionist Guidance	
CDPH AFL 20-84 IP Recommendations and Incorporation into the Quality and Accountability Supplemental Payment (QASP) Program (11/4/20)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-84.aspx
AB 2644 (Chapter 287, Statutes of 2020)	http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB2644
CDPH AFL 21-51: Assembly Bill 1585—Expansion of SNF IP Minimum Qualifications (12/13/21)	https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-51.aspx
CMS 483.95 Training Requirements	https://qsep.cms.gov/data/352/TrainingRequirements.pdf
CMS State Operations Manual: Appendix PP—Guidance to Surveyors for Long Term Care Facilities	https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

1. **Q: Are nursing homes required to have a full-time IP?**
   A: California nursing homes are required to have an IP 40 hours a week per AFL 20-52, AFL 20-84, AFL 21-51, and AB 2644. Effective January 1, 2021, SNFs are required to have a full-time, dedicated IP. The IP role may be filled either by one full-time IP staff member or by two staff members sharing the IP responsibilities, if the total time dedicated to the role equals at least the time of one full-time staff member. In original guidance, the IP must be filled by an RN or LVN; however, AFL 21-51 guidance distributed on December 13, 2021, expanded eligibility and minimum qualifications for a SNF's IP. The new guidance is that the IP must have primary professional training as a licensed nurse, medical technologist, microbiologist, epidemiologist, public health professional, or other healthcare-related field. The IP must be qualified by education, training, clinical or healthcare experience, or certification, and must have completed specialized training in IPC. The IP hours shall not be included in the calculation of 3.5 hours of direct patient care per day provided to residents. The IP must complete 10 hours of continuing education in the field of IPC on an annual basis (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-21-51.aspx).

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

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

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

- Examples of approved courses for initial IPC fundamentals training include:
  - CDPH IP Training for SNFs Online Course cdph.ca.gov/Programs/CHCQ/HAI/Pages/IP_TrainingForSNFs_OnlineCourse.aspx.
  - CDC Nursing Home IP Training Course https://www.cdc.gov/longtermcare/training.html.
- The IP should complete 10 hours of continuing education in the field of IPC on an annual basis. Facilities should provide encouragement and support for IP staff to stay abreast of current news and training sources through a nationally recognized IPC association. Examples of approved courses for annual IP training include:
  - CAHF AHCA IP Specialized Training (IPCO) https://www.cahf.org/Education-Events/QCHF-Education-Foundation/AHCA-Infection-Preventionist-Specialized-Training-IPCO.
  - CALTCM IP Orientation Program https://www.caltcm.org/infection-preventionist-orientation-program2.

3. **Q: What is F945—Infection Control Training?**
   A: F945 is a new CMS phase 3 requirement specific to infection control that was issued October 21, 2022, and became effective October 24, 2022. F945 requires that **nursing homes develop, implement, and permanently maintain an effective training program for all staff**, which includes training on the standards, policies, and procedures for the IPC program as described at §483.80(a)(2), that is appropriate and effective, and as determined by staff need.
   - For the purposes of this training requirement, staff includes all facility staff (direct and indirect care functions), contracted staff, and volunteers (training topics as appropriate to role).
   - Changes to the facility's resident population, community infection risk, national standards, staff turnover, the facility's physical environment, or facility assessment may necessitate ongoing revisions to the facility's training program for IPC.
   - All training should support current scope and standards of practice through curricula which detail learning objectives, performance standards, evaluation criteria, and address potential risks to residents, staff, and volunteers if procedures are not followed.
   - A process should be in place to track staff participation in and understanding of the required training.
   - Such infection control training must, at a minimum, include the following areas:
     - The facility's surveillance system designed to identify possible communicable diseases or infections before they can spread to other persons in the facility.
     - When and to whom possible incidents of communicable disease or infections in the facility should be reported.
     - How and when to use standard precautions, including proper hand hygiene practices and environmental cleaning and disinfection practices.
     - How and when to use transmission-based precautions for a resident, including but not limited to, the type and its duration of use depending upon the infectious agent or organism involved.
     - Occupational health policies, including the circumstances under which the facility must enforce work restrictions and when to self-report illness or exposures to potentially infectious materials.
     - Proper IPC practices when performing resident care activities as it pertains to particular staff roles, responsibilities, and situations.

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

4. **Q: What IP training programs are available to assist nursing homes in meeting the F945 staff IP training requirements?**
   A: Per F945, the below trainings will assist nursing homes in meeting the requirement to have all staff trained in IP practices.
   - CMS Targeted COVID-19 Training for Frontline Nursing Home Staff and Management Training
     - Accessible at qsep.cms.gov
     - 3-hour training for frontline staff
     - 4.5-hour training for management

- CDPH Project Firstline Training for SNF Certified Nursing Assistants (CNAs)
  - Eight 30-minute trainings
  - Contact ProjectFirstline@cdph.ca.gov
- CDC Project Firstline Infection Control Training (2-hour training accessible at www.train.org)

J. Other Questions

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

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

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

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

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

3. **Q: How often do vital signs need to be taken?**
   A: Vital signs guidance from CDPH is no longer in effect. CDPH AFL 20-25.2 Attachment, which included the vitals recommendations for SNF residents, is obsolete and no longer in effect. The vital signs guidance served a purpose early on in the pandemic when there was less clinical experience with COVID-19 and there was a concern that residents with COVID-19 could deteriorate rapidly without the facility recognizing. At this point, there is no longer a need for public health to direct clinical management. Moving forward, SNFs should monitor residents based upon best practice and clinical assessment of the resident's condition.

4. **Q: Do we still need to monitor for signs and symptoms of COVID-19 every shift for residents, since CDPH's vital signs COVID-19 guidance is no longer in effect (per question #3)?**
   A: SNFs should monitor residents for signs and symptoms of COVID-19 based upon best practice and clinical assessment of the resident's condition. If you see increased transmission of COVID-19 in your community, or if you are seeing cases of COVID-19 infection in your facility, it would be reasonable to follow previous guidance to:
   a. Monitor the vital signs daily for COVID-19 negative or recently recovered residents.
   b. Monitor the vital signs every shift, including pulse oximeter measurements, for COVID-19 exposed residents who are asymptomatic; monitoring every shift can be defined as either an 8- or 12-hour shift, (i.e., twice daily), allowing residents to get uninterrupted sleep.
   c. Monitor vital signs every 4 hours, including pulse oximeter measurements, for COVID-19 positive residents in isolation.

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

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

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

8. **Q: Are there any regulations about how often to change the tubing on an oxygen cylinder or concentrator when not visibly soiled or contaminated?**
   A: Tubing for an oxygen cylinder or concentrator should be changed between their use on different patients, when it is visibly soiled or mechanically malfunctioning. Follow published guidelines or the manufacturer's instructions for use (IFU) about specific products.
   - CDC MMWR: Guidelines for Preventing Health Care Associated Pneumonia, 2003—Recommendations of CDC and the Healthcare Infection Control Practices Advisory Committee https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5303a1.htm.

9. **Q: Could you give an update on safe administration of nebulizer treatments for bedbound SNF residents in multiple occupancy rooms who do not have COVID-19 or are COVID-19 recovered?**
   A: CDC no longer recommends implementing universal use of N95s for HCP during care for residents undergoing aerosol generating procedures.

10. **Q: Is there a way to get previous versions of the CDPH AFLs?**
    A: Yes, past AFL versions, as well as other federal and state guidance, can be found at Clear Pol, which is a free search engine designed to make compliance easier for long-term care professionals (https://app.clearpol.com/).

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

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

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

13. **Q: Are nursing homes required to report COVID-19 cases to residents and their representatives, and families?**
    A: No. Per CMS QSO-23-13-ALL, CMS relayed their concerns that the effort required to continue this reporting provision may outweigh the utility of the information provided. Therefore, CMS is exercising enforcement discretion and will not expect providers to meet this requirement at this time.

Acronym Definitions

Acronym	Definitions
AB	Assembly Bill
AFL	All Facilities Letter
AGP	aerosol-generating procedure
ATD	aerosol transmissible disease
BSI	bloodstream infection
CAHAN	California Health Alert Network
CAIR2	California Immunization Registry
Cal/OSHA	California Division of Occupational Safety and Health
CalREDIE	California Reportable Disease Information Exchange
CDC	Centers for Disease Control and Prevention
CDI	Clostridioides difficile infection
CDPH	California Department of Public Health
CLIA	Clinical Laboratory Improvement Amendment
CMP	civil money penalty
CMS	Centers for Medicare & Medicaid Services
CNA	certified nursing assistant
COVID-19	coronavirus disease 2019
DCVR	Digital COVID-19 Vaccine Record
ELR	Electronic Laboratory Reporting system
EMT	emergency medical technician
ER	emergency response
EUA	Emergency Use Authorization (FDA)
EVS	environmental services
FAQ	frequently asked question
FDA	U.S. Food and Drug Administration
HAI	healthcare-associated infection
HCP	healthcare personnel
HCW	healthcare worker
HR	human resources
HSAG	Health Services Advisory Group
IIS	Immunization Information System
IP	infection prevention or infection preventionist
IPC	infection prevention and control
IPCO	infection prevention control officer
L&C	Licensing and Certification
LHD	local health department

Acronym	Definitions
LVN	licensed vocational nurse
MDRO	multi-drug resistant organism
MHOAC	Medical Health Operational Area Coordinator
MMWR	Morbidity and Mortality Weekly Report (CDC)
NAAT	Nucleic Acid Amplification Test (viral diagnostic test)
NHSN	National Healthcare Safety Network (CDC)
NIOSH	National Institute for Occupational Safety & Health
OTC	over the counter
PCP	primary care physician
PCR	polymerase chain reaction (detects virus genetic material)
POC	point of care
PPE	personal protective equipment
QIIP	Quality Improvement Innovation Portal
QSO	Quality, Safety, and Oversight
RN	registered nurse
RSV	respiratory syncytial virus
SARS-CoV-2	severe acute respiratory syndrome coronavirus 2, the virus that causes COVID
SNF	skilled nursing facility
UTI	urinary tract infection

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