Interim Guidance:

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

UPDATED April 19, 2020

The following guidance was developed by the San Francisco Department of Public Health for use by local facilities, and will be posted at http://www.sfcdcp.org. This interim guidance may change as knowledge, community transmission, and availability of PPE and testing change. Please also check for recent related health orders at https://www.sfdph.org/dph/alerts/coronavirus-healthorders.asp.

AUDIENCE: Long-term care facilities (LTCF) that provide 24-hour medical care on site.

Summary of Changes to the Guidance as of 4/16/2020

Guidance has been updated to reflect recent guidance from CMS and CDC;
- Residents with known or suspected COVID-19 should be isolated in a private room with a dedicated bathroom. Airborne Infection Isolation Rooms (AIIRs) are not required.
- Symptom screening plus temperature checks for all staff, residents, and visitors.
- Universal masking of all staff and visitors while in the facility, and of residents while outside their rooms.
- Criteria for return to work for ill staff and removal of isolation for residents with COVID-19 increased to least 14 days after start of symptoms.
- Guidance on conserving respirators, facemasks and other PPE in short supply has been added.
- Guidance on cohorting and rooming residents with known or suspected COVID-19 has been added.

BACKGROUND: Given their congregate nature and the nature of the residents served (e.g., older adults often with underlying chronic medical conditions), LTCFs at the highest risk of being affected by COVID-19.

Once introduced into a facility, COVID-19 can spread rapidly. Recent experience with outbreaks in LTCFs has shown many people with COVID-19 may not experience symptoms or may be infectious before they develop symptoms. These unrecognized asymptomatic and pre-symptomatic infections likely contribute to the spread of infection.

Given the high risk of spread once COVID-19 enters a facility and the increased risk of serious illness in residents, facilities must take immediate action to protect residents and staff from severe infections, hospitalizations, and death.

Visitors and health care staff continue to be sources of introduction of COVID-19 into LTCFs. Aggressive efforts are needed to keep unrecognized COVID-19 from entering the facility, to identify infections early, and to prevent further spread, especially via asymptomatic transmission.

General measures to implement immediately

- **Continue to restrict all visitors** from entering the facility, except for certain compassionate care situations, such as end-of-life situations. Send letters or emails to families to notify them of this policy

- **Continue to limit all volunteers and non-essential health care personnel** as well as non-essential staff (e.g. barbers).
  - Use telehealth when possible.

Implement universal masking and face coverings

To help prevent transmission by asymptomatic or pre-symptomatic individuals,

- **All persons entering the facility should wear facemasks or cloth face coverings at all times while in the facility.** This includes all staff, any visitors, delivery people, vendors, etc. The only exception is EMS personnel responding to a 911 call**.** Facemasks are preferred for health care workers.

- **Residents should wear cloth face coverings or facemasks when they leave their room, including residents leaving the facility for dialysis or other procedures.** They should also wear cloth face coverings or facemasks in their room when staff or others are within 6 feet.

- Facemasks should be prioritized for health care personnel and residents with known or suspected COVID-19 infection. Others should use cloth face coverings.

  - If a visitor, resident, vendor or other person arrives at the facility without a cloth face covering, a facemask may be provided if supplies permit.

  - When supplies of facemasks are limited, refer to CDC guidelines on extended use and re-use of facemasks https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html.

- Cloth face coverings should not be used on anyone who has trouble breathing, or is asleep, unconscious, incapacitated or otherwise unable to remove the cover without assistance.

> **Facemasks vs. Cloth Face Coverings**
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> For the purpose of this guidance,
>
> - "Facemasks" refers to surgical masks or procedure masks. They are PPE and protect the person wearing them from sprays and splashes. They also keep the person wearing them from spreading respiratory secretions when talking, sneezing, or coughing.
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> - "Cloth face coverings" including cloth face masks, keep the person wearing them from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE, and it is uncertain whether cloth face coverings protect the wearer. **Cloth face coverings should not be worn when a facemask or respirator is indicated.**

Implement symptom screening and temperature checks for all persons entering the facility.

- Screen all persons entering the facility for symptoms of COVID-19 and check their temperature. All persons entering the facility should be checked, including staff, consultants, any visitors, vendors, etc. The only exception is EMS workers responding to 911 call.

- For the purpose of screening,
  - Fever is defined as temperature >100.0°F (37.8°C)
  - Symptoms: new or change in cough, sore throat, shortness of breath and muscle aches

- Document the temperature and absence or presence of shortness of breath, new or altered cough, sore throat, and muscle aches in a log.

- Health care workers and consultants who work at multiple facilities can be an important source of introduction of COVID-19 into a facility. When screening staff, ask about other health care facilities where they have worked in the last 14 days, and keep a daily log.

- Persons with fever or COVID-19 symptoms on screening should not be allowed inside the building. Staff with symptoms should keep their facemask on and immediately leave the workplace

- Facilities should limit access points and ensure that all accessible entrances have a screening station.

Prevent staff from working while ill.

In addition to screening staff upon arrival for work,

- Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill employees to stay home.

- Instruct all staff to check themselves for fever and symptoms at home BEFORE coming to work. If they are symptomatic, they should not report to work, and should notify their supervisor.

- If staff develop fever or symptoms while at work, they should keep their facemask on, notify their supervisor and leave the workplace.

  o Fever is a temperature >100.0°F (37.8°C) or subjective fever and may be intermittent. Symptoms of COVID-19 include cough, shortness of breath, fatigue, muscle aches, and decreased appetite. Less common symptoms are headache, confusion, sore throat, runny nose, vomiting and diarrhea.

- Instruct staff and consultants to notify the facility immediately if they have a work-related COVID-19 exposure at another site. If a staff reports a work-related exposure, refer to *SFDPH Interim Guidance: Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19 In the Setting of Community Transmission*, at http://www.sfcdcp.org/covid19hcp

  Notify SFDPH Communicable Disease Control (CD Control) at (415) 554-2830 of any staff, consultants or outside health care workers with fever or symptoms of COVID-19, whether they call in before their work shift**,** are detected during the facility entrance screening or develop symptoms at work. After hours, call 415-554-3613 to reach the on-call physician.

Return to Work Criteria for LTCF Staff with Respiratory or Influenza-like illness

LTCF staff should not work until

- At least 72 hours have passed since fever has resolved without the use of fever-reducing medications **and** since respiratory symptoms have improved **and**

- At least **14** days have passed since symptoms first appeared (*not 7 days as for health care workers in lower-risk settings)*. If a LTCF wishes to test staff for COVID-19, to allow staff with negative results to return to work sooner, the LTCF should consult first with SFDPH Communicable Disease Control.

After returning to work, staff should

- Wear a facemask (surgical or procedure mask) instead of a cloth face covering at all times while in the facility, until all symptoms are completely resolved. When a respirator is required for PPE, avoid using a respirator with an exhaust valve, as this may not protect the resident from infection by the health care worker.

- Self-monitor for symptoms, and seek re-evaluation if symptoms recur or worsen

See *SFDPH Return to Work Guidance for Healthcare Personnel With Potential COVID-19 Infection* at http://www.sfcdcp.org/covid19hcp

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Train and educate staff

Train and educate all staff on signs of COVID-19 and infection control, including universal masking and hand hygiene. Provide job-specific training on transmission-based precautions and appropriate use of PPE.

- Remind staff to practice social distancing in break rooms and common areas.

- Review recommendations for hand hygiene before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing personal protective equipment (PPE), including gloves. https://www.cdc.gov/handhygiene/providers/index.html

- The CDC webinar, "Preparing Nursing Homes and Assisted Living Facilities for COVID-19" covers updated recommendations. https://www.youtube.com/watch?v=p1FiVFx5O78

- Guidance on implementing recommended infection prevention practices is also available in CDC's free online course at https://www.cdc.gov/longtermcare/training.html, which includes resources and checklists for facilities and employees to use.

Ensure that health care staff demonstrate competency with putting on and removing PPE.
See CDC graphic https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf.

Ensure that adequate staff have been trained and fit-tested for N95 respirators. When fit-testing staff, reinforce procedures to prevent the inadvertent spread of infection, such as

- Screening of employees for symptoms or recent symptoms before fit testing them
- Thorough cleaning of any devices used between each participant

Prepare the facility for recommended infection control and prevention practices

Hand hygiene

- Put alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).

- Make sure that sinks are well-stocked with soap and paper towels for handwashing.

- Post signs encouraging hand hygiene and cough etiquette. A hand hygiene sign with multiple translations is available for download at http://eziz.org/assets/docs/IMM-825.pdf

- Have a process, such as regular Infection Prevention (IP) audits, to monitor staff adherence

Personal protective equipment (PPE).

- Post signs on the door or wall outside of the resident room that clearly describe the type of precautions needed and required PPE.

- Make necessary PPE available in areas where resident care is provided.

- Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback promoting appropriate use by staff.

- Position a trash can near the exit of each resident room to make it easy for employees to discard PPE.

Cleaning and disinfection of residents' rooms and common areas.

- Clean all surfaces at least daily more often as needed, especially "high-touch" surfaces, mobile medical equipment, and other shared resident care equipment. Use EPA-registered, healthcare-grade disinfectants that are effective against SARS-CoV-2, the coronavirus that causes COVID-19. https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

- Work with staff to identify high-touch surfaces such as door handles, bedrails, and bathroom fixtures. Commonly overlooked items include bed alarms which are often turned off with a gloved hand, PPE carts, light switches, and med carts.

Limit transmission between residents

- **Cancel group activities and communal dining**. All meals should be served in resident rooms.

- **Encourage residents to remain in their rooms.** IF a COVID-19 case is diagnosed in the facility, restrict residents to their rooms, to the extent possible, except for medically necessary purposes.

  - When residents leave their rooms, they should
    - wear a cloth face covering or facemask,
    - perform hand hygiene,
    - limit their movement in the facility, and
    - perform social distancing (stay at least 6 feet away from others).

- **Influenza Vaccination**
  Because influenza can cause a similar, severe respiratory illness in the elderly, influenza vaccination should be provided annually, routinely to all residents and healthcare personnel and staff of long-term care facilities. Vaccination can prevent influenza-related illness and death, especially among people at increased risk for severe influenza complications.

Establish processes now to anticipate COVID-19 cases in the facility

Practice Consistent Assignment (assigning the same staff to certain residents) as much as possible, regardless of the residents' COVID-19 status, to minimize the number of different staff interacting with residents. Staff should not work across units or floors as much as possible.

Identify an area of the facility to dedicate to care for residents with confirmed COVID-19. This could be a floor, unit, or wing in the facility or a group of rooms at the end of the unit to cohort residents with COVID-19. Create a staffing plan for that location and assign dedicated HCP to work only in this area of the facility.

Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Consider quarantining new admissions and readmissions in a private room or designated observation unit, with full PPE use by healthcare personnel, for 14 days after admission while monitoring for signs of COVID-19.

Establish a protocol to immediately notify SFDPH Communicable Disease Control (CD Control) of positive COVID-19 test results, suspected COVID-19 in staff or residents, and clusters of respiratory illness

Plan how to regularly communicate with families, residents, and staff if COVID-19 cases are identified in residents or staff.

Have a contingency staffing plan for increased employee absences and staffing shortages.

- Create a backup/on-call system if one is not already in place.
- Identify minimum staffing needs to continue essential services if on-site operations must be reduced.

PPE Supplies

- Implement a process to track and report available quantities of PPE as well as hand hygiene products, swabs and transport media for COVID-19 testing, EPA-approved disinfectants, and other items that may be in short supply.

- Monitor daily PPE use to identify when supplies will run low. CDC's PPE burn rate calculator may be helpful. https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/burn-calculator.html

- Implement strategies to optimize use of PPE now, before supplies are limited. These may include:

- Bundling resident care and treatment activities to minimize entries into resident room (e.g., having clinical staff clean and disinfect high-touch surfaces when in the room)
- Extended use of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift).
- Prioritizing gowns for activities where splashes and sprays are anticipated, aerosol generating procedures and high-contact resident care activities.
- Developing a process for decontamination and reuse of PPE such as face shields and goggles
- Develop a strategy for how allocate to PPE if supplies are limited.
- Develop a plan to address likely supply shortages, including alternative channels for procuring needed resources.

Testing

- **Have a mechanism to obtain specimens for COVID-19 tests on-site** and to transport specimens to the designated laboratory. *Residents should not be sent to the ED or an outside clinic for testing.*
- Maintain an adequate supply of swabs and transport media to collect specimens for all exposed/symptomatic residents and staff, if specimens will be collected by the facility staff

Special Considerations for Memory Care and Behavioral Units:

- Prioritize Memory Care units and behavioral units (locked units) for early, aggressive measures to prevent infection. These units can be challenging for infection control because PPE and cleaning supplies may need to be locked up, and ambulatory residents can sometimes be difficult to redirect. An outbreak on such a unit has the potential for rapid transmission.
- In addition to universal masking/face covers, hand hygiene and social distancing for both staff and residents. Consider the following:
  - Supervised hand hygiene for residents
  - Opening windows for ventilation when feasible.
  - Cohorting staff to the memory unit or behavioral unit alone.
  - Frequent Infection Control team spot checks for adherence on the unit
  - Cordoning off an area of the memory unit to use as an COVID-19 isolation/cohort area
  - Strategies to keep ambulatory residents out of the rooms of residents under isolation

Implement symptom screening and temperature/O2 saturation checks for all residents

Evaluate all residents on <u>admission, readmission after transfer for acute care</u> and <u>at least once daily</u>. Check for respiratory symptoms (new or altered cough, sore throat, shortness of breath, muscle aches). Check for fever using a thermometer and check heart rate and O2 saturation via pulse oximeter. A log should be kept.

  - If there are confirmed COVID-19 cases in the facility, all residents should be checked at least <u>twice</u> daily, or once per shift.
  - Consider screening potentially exposed residents <u>three</u> times a day, with temperature, pulse and O2 sat, including residents who
    - Regularly leave the facility for dialysis, infusions, or other complex care.
    - Were transferred or readmitted from an acute care setting in the last 14 days

- Have known exposure to COVID-19 (ex. roommate of a patient with COVID-19)

  o Screen for fever, cough, shortness of breath, and muscle aches. Also consider COVID-19 if other symptoms are reported including decreased appetite, fatigue, new or worsening malaise, headache, confusion, sore throat, runny nose, vomiting and diarrhea .

  o Elderly patients with COVID-19 infection may not be able to mount a fever, so any change from their usual (baseline) temperature should be brought to the attention of a provider.

  o Residents who are medically fragile and those with neurological or neurocognitive conditions may manifest atypical signs and symptoms of viral infection (e.g., confusion, behavior change) and may not exhibit fever. Astute clinical judgement and flexibility in applying the clinical definition should be used.

- **Place a face mask on residents with symptoms of COVID-19** ASAP, until they can be isolated.

If a resident has symptoms of COVID-19

Isolate symptomatic residents as soon as possible.

- Place symptomatic residents in a single-person room with the door closed. The room should have a private bathroom if possible. An Airborne Infection Isolation Room (AIIR) is not required and should be reserved for residents undergoing aerosol-generating procedures.

- Residents should leave their rooms only for medically essential purposes, and those who must leave should wear a facemask. If unable to tolerate a facemask, they should use tissues to cover their mouth and nose when sneezing or coughing.

- Ensure physical distancing for both residents and staff.

- Roommates of residents with suspected COVID-19 infection should be considered potentially exposed, placed in a private room with a private bathroom if possible, and full PPE used for any resident interaction.   See "Bed Placement of Residents" below for details of placement when private rooms are unavailable.

Contact SFDPH COVID-19 Communicable Disease Control to discuss the case.

> **SFDPH Communicable Disease Control (CD Control)**
> **(415) 554-2830**
> **After hours, call 415-554-3613 to reach the on-call physician**.
>
> Notify SFDPH CD Control immediately of
> - Suspected or lab-confirmed COVID-19 in residents or staff
> - Three (3) or more residents or staff with new-onset respiratory symptoms within 72 hours of each other
> - Residents with severe respiratory infection resulting in hospitalization or death

Implement appropriate PPE for resident care.

- SFDPH recommends the following PPE when caring for LTCF residents with COVID-19 or other respiratory illness.

PPE AND SOURCE CONTROL FOR PATIENT CARE INTERACTIONS

	Residents in isolation for suspected or known COVID-19 infection, exposure to COVID-19 *(including asymptomatic roommates and other close contacts of a case)*	Residents with respiratory symptoms and a negative COVID-19 test result*	Asymptomatic residents
Staff wears	Respirator (preferred) or facemask Goggles or face shield Gloves Gown, for ANY resident interaction	Facemask Goggles or face shield Gloves Gown, when there is a risk of exposure to blood or bodily fluids	Facemask (to be worn at all times in the facility) Other PPE as indicated
Resident wears	Facemask (surgical or procedure mask) if tolerated	Facemask if tolerated	Cloth face covering if tolerated

* These residents may still have influenza, RSV, or other respiratory pathogens that could spread through the facility.

- o **Respirator (or facemask)**

  A fit-tested N95 respirator or powered air purifying respirator (PAPR) is recommended if available. Facemasks are an acceptable alternative when respirators are in short supply,

  - When supplies of respirators are limited, they should be reserved for aerosol-generating procedures on residents with suspected or confirmed COVID-19 and for care of residents whose infections require airborne precautions (e.g., tuberculosis, measles).

  - When supplies are limited consider extended use, where staff continue to wear the same respirator or facemask and eye protection for the care of more than one resident, for example, a cohort of COVID-19 positive residents.

    - Staff should take care not to touch their eye protection, mask or respirator with their hands. If they do, they should immediately remove their gloves, perform hand hygiene, and put on a new pair of gloves.

    - Per CDC guidance, eye protection and respirator/facemask should still be changed when caring for residents with different respiratory pathogens or illnesses where the pathogen is unknown.

- o **Eye protection (goggles or face shield)** should cover the front and sides of the face. Personal eyeglasses and contact lenses are not considered adequate eye protection
- o **Gloves and gown** should be removed after each resident encounter, and immediately perform hand hygiene. If gowns are in short supply, they should be prioritized for:
  - aerosol-generating procedures
  - care activities where splashes and sprays are anticipated and
  - high-contact patient care activities where virus may be transferred to the clothing of the health care staff, such as dressing, bathing/showering, transferring, changing linens, changing briefs, toileting, wound care, and device care or use

- **Perform hand hygiene before and after each resident encounter.** Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands as PPE was removed.

- **As respirators and other PPE become more available, healthcare facilities should promptly resume standard practices**.

Test for COVID-19 and other respiratory infections.

- Collect a single swab for COVID-19 according to instructions published in the SFDPH at http://www.sfcdcp.org/covid19hcp, under "Clinical Testing and Guidance."

- Submit specimens for COVID-19 testing to a laboratory that has rapid turn-around time of results. SFDPH Public Health Laboratory is recommended for LTCFs to ensure faster turn-around time for results. Prior approval is no longer required for LTCF residents and staff. The lab requisition is at https://www.sfcdcp.org/public-health-lab/forms-specimen-culture-submission/

- Send a test concurrently for influenza and other respiratory pathogens. If possible, test for a full respiratory viral panel. Note that while commercial respiratory viral panels may test for other coronaviruses, they do not detect COVID-19.

Closely monitor the ill resident.

- Monitor symptomatic residents at least 3 times day, including symptom checks, vital signs, oxygen saturation via pulse oximetry, and respiratory exams.

- Clinicians should maintain a low threshold for obtaining a chest radiograph to exclude pneumonia or ARDS and refer for further evaluation and hospitalization if the resident exhibits clinical worsening.

Guidance on removing residents with suspected COVID-19 and asymptomatic residents exposed to COVID-19 from isolation

- If the resident with suspected COVID receives a negative COVID-19 test result, they may be removed from isolation for COVID-19. If they continue to have respiratory symptoms, the usual protocol for residents with respiratory symptoms should be followed.

- Residents who were exposed to COVID-19 and are asymptomatic, for example, roommates, may be removed from isolation after 14 days following the last exposure if they remain asymptomatic. If they develop symptoms, they should be tested and the criteria for residents with lab-confirmed or suspected COVID-19 should be followed.

Further steps if a resident or staff has a positive COVID-19 test result

- Presume widespread distribution of COVID-19 infection in the facility, and be prepared for additional cases. When visitors are restricted, residents are most likely to acquire COVID-19 from an infected health care worker. Given the time period for between infection and the onset of symptoms, as well as the risk of asymptomatic transmission, it is likely that if one resident is identified, multiple residents and staff have already been exposed.

- Continue to monitor the resident closely, at least 3 times a day.

- **Call SFDPH Communicable Disease Control (CD Control) <u>as soon as a confirmed COVID-19 case is identified</u> at (415) 554-2830** for management to limit further spread of COVID-19. After hours, call 415-554-3613 to reach the on-call physician. The following actions will be required in consultation with SFDPH:

  - Restrict admissions to the facility and transfers to any units with symptomatic residents

  - Isolate and monitor residents who were in contact with the case. Test symptomatic persons for COVID-19 and other respiratory pathogens.

  - Monitor employees who were in contact with the case per *SFDPH Interim Guidance: Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with COVID-19 In the Setting of Community Transmission*, located under "Healthcare Exposures" at http://www.sfcdcp.org/covid19hcp

  - Check all residents for COVID-19 symptoms, temperature, heart rate, and O2 saturation via pulse oximeter at least <u>twice daily</u>.

  - Notify external facilities and transport services prior to transferring <u>any</u> ill resident for further care.

  - For residents receiving dialysis outside of the facility, notify their dialysis center and request that they be dialyzed in "isolation".

  <u>For residents with a positive COVID-19 test:</u>

  - Record a log of all persons who care for or enter the room or care area of the ill resident

  - Maintain isolation of the ill resident with appropriate infection control precautions, including appropriate PPE use, following the *CDC Interim Infection Prevention and Control Recommendations for Patients with Confirmed COVID-19 or PUIs for COVID-19 in Healthcare Settings* guidance (https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html)

  - Minimize of the number of staff providing care for residents with COVID-19 infection. Restrict staff from floating to more than one unit. Staff in contact with ill residents/units should not work with well residents/units or in other health care facilities until no new cases have been identified for 28 days.

  Determine additional control measures and duration of implementation in consultation with SFDPH.

- **Guidance on removal from isolation for LTCF residents with lab-confirmed COVID-19**

  - Current criteria for removal from isolation for LTCF **r**esidents with lab-confirmed COVID-19 are:

    - At least 3 days (72 hours) have passed *since recovery*, defined as

- resolution of fever without the use of fever-reducing medications **and**

- improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**

  ▪ At least **14** days have passed since symptoms first appeared (*not 7 days as for patients in lower-risk settings)*.

  o If the resident meets criteria for removal from isolation but continues to have persistent symptoms (e.g., persistent cough), they should be remain in a private room, be restricted to their room, and wear a facemask or cloth face covering during care activities until all symptoms are completely resolved or until 14 days after illness onset, whichever is longer.

  o If the resident was diagnosed based on non-respiratory symptoms (e.g., lethargy or altered mental status) or is immunocompromised, consult with SFDPH prior to removal from isolation.

- *This guidance on when to discontinue transmission-based precautions may change as new information about COVID-19 becomes available.*

Cohorting Residents during an Outbreak

- Consider designating entire units or pods within the facility, and cohort staff to care for only for known or suspected COVID-19 residents during their shift. The ability to separately house suspect and confirmed will vary by facility, and this decision can be made on case-by-case basis in consultation with SFDPH.

  - Residents with different respiratory pathogens will likely housed on the same pod or unit, as it might not be possible to distinguish residents who have COVID-19 from residents with other respiratory viruses.

  - **Only residents with the same respiratory pathogen may be housed in the same room. For example, a resident with COVID-19 should not be housed in the same room as a resident with an undiagnosed respiratory infection.**

  - If there is a shortage of private rooms,
    ▪ Residents with confirmed COVID-19 may be housed in the same room.

    ▪ Asymptomatic residents without suspected or known exposure to COVID-19 may be housed in the same room.

    ▪ Persons exposed to COVID-19 and symptomatic residents without confirmed COVID-19 infection should be isolated in private rooms if possible.

    See "Bed Placement of Residents" below for detailed information.

  - Increase environmental cleaning throughout the facility to three (3) times a day, if possible, with emphasis on high touch surfaces, particularly in the unit where the resident was located.

Bed Placement of Residents

- **Residents with confirmed COVID-19** should ideally be cohorted together in a designated unit/area for residents with lab-confirmed COVID-19 infection. Otherwise, they should be roomed with other residents with lab-confirmed COVID-19 or isolated in a private room with their own bathroom.

- **Residents with suspected COVID-19 and test results pending** should be isolated in a private room with their own bathroom. If that is not possible, please discuss cohorting alternatives with SFDPH CD Control, as the goal is to minimize potential exposures among susceptible patients.

- **Asymptomatic roommates of residents with known or suspected COVID-19** should be considered potentially exposed to COVID-19. *Avoid placing exposed residents in a new room with residents who do not have known exposures to COVID-19.* They should be roomed as described below, in order of desirability.
    1. (Preferred) Move the exposed roommate to a private room, preferably with a private bathroom.
    2. (Alternative 1) Move the resident with known or suspected COVID-19. Keep the exposed roommate in the original room without a new roommate. This risks infection of the roommate from contaminated surfaces.
    3. (Alternative 2) If there are multiple residents with known or suspected COVID-19 at the facility, house their asymptomatic exposed roommates together
    4. If bed capacity, staffing availability, or other constraints prevent another of the first 3 placements, it is reasonable to keep the roommate in the same room as the suspect/known COVID-19 case. This is preferable to having the roommate share a room with residents who do not have known exposures to COVID-19.
       To mitigate potential ongoing risks of transmission to the roommate,
         - Place resident beds as far apart as possible
           Instruct mobile residents to socially distance (stay 6 feet away) from their roommate while in the room
         - Place a surgical mask on the resident with suspected or known COVID-19 resident, if tolerated
         - Use privacy curtains as possible barrier protection between the resident beds
         - Open windows for ventilation if feasible
         - Enhance/increase frequency of daily environmental cleaning of the room, focusing on shared bathroom and high-touch surfaces

- **Considerations for residents in Memory Care or Behavioral Units**

    o The benefits of transferring a resident with known or suspected COVID-19 infection from a Memory Care or Behavioral Unit to a designated COVID-19 or quarantine unit must be weighed with the risks of such transfers, especially if significant exposure has already occurred for other residents and staff in the locked unit. Such a transfer may have adverse effects, including potential falls, and can be extremely distressing and disorienting for the resident.

    o Transfers should be carefully controlled and planned to avoid unnecessary exposures when moving through the building. The ability of the receiving COVID-19 or observation unit to keep the resident from wandering after transfer should also be considered.

Transfers of Patients with COVID-19 to LTCFs

- Per CDPH, patients with COVID-19 may be transferred to skilled nursing facilities (SNFs) as long as they are clinically stable, even if they still require isolation/transmission-based precautions. .

- A checklist for LTCF to accept a resident with suspected or known COVID-19 is in development and will be posted at: https://www.sfcdcp.org/covid19hcp under Long-Term Care and Senior Care.

- In brief, the facility should have the following:

    o For lab-confirmed COVID-19 infection, placement in
        - designated unit or pod for residents with lab-confirmed COVID-19 infection

(preferred),
- • a room shared with another resident with lab-confirmed COVID-19 infection, or
- • a private room with a private bathroom.
  - o For suspected COVID-19, a private room with a private bathroom
  - o Adequate staffing and PPE to maintain transmission- based precautions. *Patients should not be accepted if the receiving facility cannot maintain transmission-based precautions.*

- • For new admissions and readmissions whose COVID-19 status is unknown, consider isolating the resident in a single-person room or in a designated observation area so the resident can be monitored for signs of COVID-19. Residents can be transferred out of the observation area and moved into a shared room if they remain afebrile and without symptoms for 14 days after admission.

Additional Resources

Stay informed. Information is changing rapidly. Updated CDC, local and state COVID-19 activity and recommendations can be found at

- o Centers for Disease Control and Prevention (CDC)

  - o Preparing for COVID-19: Long-term Care Facilities, Nursing Homes
    https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

  - o Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of COVID-19 in the United States
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