

This manual is only intended for use by staff from the Los Angeles County Department of Public Health.

Please check this webpage to view the current guidance:

<http://publichealth.lacounty.gov/acd/ncorona2019/b73covid/CongregateResidential/index.htm>

## **Congregate Residential Settings - Where People Reside Overnight (excluding: Jails, Settings Associated with People Experiencing Homelessness, Acute Care Facilities, and Skilled Nursing Facilities)**

### **Forms**

- COVID-19 Outbreak Form: Congregate Residential Settings [Form](#) (7-17-20)
- COVID-19 Line List for Congregate Residential Settings for Residents and Staff [Excel](#) (8-17-20)

### **REPORTING PROCEDURES**

#### **Outbreak Definitions:**

Under Title 17, Section 2500, *California Code of Regulations* all suspected outbreaks are reportable.

#### **High-Risk Caregiving Congregate Residential Setting** (See [below](#) for facility definition)

At least one or more laboratory confirmed cases (symptomatic or asymptomatic) of COVID-19 has been identified in a resident.

OR

At least two confirmed cases of symptomatic or asymptomatic COVID-19 in staff who have face to face contact with residents, within a 14-day period.

NOTE: If newly admitted residents (e.g. within 14 days of admission) are admitted to the quarantine area of the facility test positive for COVID-19, this is not considered an outbreak as it was acquired outside the facility.

#### **Caregiving Congregate Residential Setting** (See [below](#) for facility definition)

At least two confirmed cases of symptomatic or asymptomatic COVID-19 (including residents and/or staff who have face to face contact with residents), within a 14-day period.

NOTE: If newly admitted residents (e.g. within 14 days of admission) are admitted to the quarantine area of the facility test positive for COVID-19, this is not considered an outbreak as it was acquired outside the facility.

#### **Housing Facility** (Do not provide care-giving services - See [below](#) for facility definition)

At least three confirmed cases of symptomatic or asymptomatic COVID-19 (including residents and/or staff), within a 14-day period.

### **Epidemiologic Data for Outbreaks**

- a. Confirm etiology of outbreak using laboratory data (PCR, antigen test). All symptomatic residents or staff are recommended to be tested for COVID-19.
- b. Complete the line list that includes:
  - i. Names of cases
  - ii. Dates of onset
  - iii. Symptoms
  - iv. Dates of birth
  - v. Race/ethnicity
  - vi. Underlying medical conditions
  - vii. Days and shifts staff last worked
  - viii. Location of staff and residents
  - ix. Hospitalization status
  - x. Results of laboratory tests

- c. Maintain surveillance for new cases until no new cases for at least 2 weeks. Complete [Congregate Residential Settings](#) (Rev. 7.17.20) form at the conclusion of investigation (See Report Forms).
- d. Obtain site floor plan, if appropriate.
- e. Create an epi-curve, by date of onset (see CDC Quick Learn Lesson: [Create an Epi Curve](#) for guidance). Only put those that have suspected or confirmed COVID-19 on the epi-curve. (Optional)

### CONTROL OF CASES & CONTACTS

Investigation can be conducted over the phone. The frequency of follow-up with the facility for outbreak updates will be at least bi-weekly, but more frequently as needed and determined by Community and Field Services (CFS) MD.

Inform the facility that they will be included on a public outbreak notification list posted on the LAC Public Health website until the facility demonstrates that there are no new cases at the facility for at least 2 weeks and outbreak is resolved.

#### Additional Guidance and Resources:

- Congregate Living [Targeted Testing Guidance](#)
- [Guidance](#) for Congregate Living Facilities
- Bed Positioning [Guidance](#)
- [Guidelines](#) for Proper Grouping of Residents
- [Information for Health Facilities](#)

#### Cases

See detailed instructions below for case management of residents, as well as cases in facility staff.

#### Contacts

A close contact is a person with exposure to a confirmed or suspected case of COVID-19 during the period from 2 days before symptom onset until the case meets criteria for discontinuing isolation (see detailed instructions below for staff and residents). For asymptomatic cases, the date of collection of the specimen positive for SARS-CoV-2 can be used in place of onset date to determine period of isolation.

Exposures are defined as follows:

- a. Being within approximately 6 feet of a person with confirmed or suspected COVID-19 for a prolonged period of time (greater than 15 minutes) without a mask (surgical or higher level of protection such as N-95); OR
- b. In high risk settings such as a memory care unit, the duration of close contact is being approximately within 6 feet of a person with confirmed or suspected COVID-19 and >2 minutes, OR
- c. Having unprotected direct contact with infectious secretions or excretions of a person with confirmed or suspected COVID-19 (e.g., being coughed on, touching used tissues with a bare hand).

See detailed instructions below for staff contacts and resident contacts in care-giving facilities and housing facilities.

- **Caregivers:** All direct care-giving staff, whether licensed or unlicensed, should follow CDC and local guidelines for health care personnel. This includes nurses (RNs/LVNs), health aids and unlicensed caregivers.
- **Visitors:** Contact any visitors that may have been exposed to a suspected or confirmed case and instruct them to self-quarantine for 14 days after last exposure (see [Home Quarantine Instructions](#) for Close Contacts to COVID-19. Visitors should call their primary care provider to discuss testing options.

Note: CDC does not recommend testing, symptom monitoring or special management for people exposed to asymptomatic people with potential exposures to SARS-CoV-2 (i.e., “contacts of contacts;” these people are not considered exposed to SARS-CoV-2).

## CAREGIVING, HIGH-RISK CAREGIVING, AND HOUSING FACILITY DEFINITIONS

### Caregiving Congregate Residential Settings:

These are short- or long-term residential facilities that meet any one of the following descriptors:

- Residential facilities for adults licensed by the California Community Care Licensing Division (CCLD) including Residential Care Facilities for the Elderly (RCFEs) and Adult Residential Facilities (ARFs). For facility types see: [www.cdss.ca.gov/inforesources/community-care/ascp-centralized-application-units](http://www.cdss.ca.gov/inforesources/community-care/ascp-centralized-application-units).
- CCCLD-licensed residential facilities caring for minors age 6 through 17 and non-minor dependents age 18 through 21 in out-of-home care, including Short-Term Residential Therapeutic Programs and Transitional Shelter Care Program Facilities.
- Residential behavioral health treatment facilities, such as substance use or mental health treatment facilities.
- Group homes for adults not licensed by the State, which provide housing and assistance with activities of daily living or other need.

### High-Risk Caregiving Congregate Residential Facilities:

Facilities that provide caregiving services primarily to residents with at least two or more of the following:

- Residents older than 65 years of age.
- A memory care unit or at least 25% residents with dementia or severe mental illness diagnosis.
- Provide medical care to residents who are non-ambulatory .
- Serve residents that require regular direct on-site medical care.

### Housing Residential Facilities:

These include residential facilities that do not provide care-giving services and only provide shared housing such as dormitories, boarding homes, etc.

## ADMINISTRATIVE OUTBREAK CONTROL MEASURES IN ALL RESIDENTIAL CONGREGATE FACILITIES

1. Always encourage all staff and residents to follow physical distancing and adhere to hand hygiene guidance as much as possible.
  - a. Signage should be posted to reinforce frequent hand washing, cover your cough and maintain physical distancing.
  - b. Provide accurate and updated Public Health materials to facility- including posters, handouts, etc. available at <http://publichealth.lacounty.gov/acd/ncorona2019/printmaterials.htm>.
2. Ensure universal source control at the facility including staff, visitors and residents (cloth face covering at minimum for residents/visitors, or surgical mask or N-95 for caregivers).
  - a. Source control is required by all persons in all resident areas, common or shared areas, walkways, or where residents and/or staff congregate.
  - b. Staff working alone in closed areas do not need source control unless they are moving through common spaces where they may interact with other staff or residents.
  - c. Surgical masks, if available, should be reserved for caregivers or for any resident that is confirmed or suspected to have COVID-19.
  - d. All residents must wear cloth face coverings when outside their room. This includes residents who must regularly leave the facility for care (e.g. hemodialysis patients).

- e. Residents who, due to underlying cognitive or medical conditions, cannot wear face coverings outside their room should not be forcibly required to wear face coverings and should not be forcibly kept in their rooms. However, face coverings should be encouraged as much as possible.
  - f. When staff are in resident rooms, residents should cover their noses and mouths as much as possible. Residents can use tissues for this or cloth face coverings.
3. Increase environmental cleaning throughout the facility to 3 times a day (if possible) with emphasis on high touch surfaces and objects, such as doorknobs, bannisters, countertops, faucet handles, and phones. particularly in the unit where case(s) were located. Use [EPA-registered cleaning agents](#) and follow the label directions.
4. Identify a mechanism for the facility to obtain SARS CoV-2 samples and to send these specimens from the facility to a [commercial clinical laboratory](#). If a facility is unable to obtain DPH recommended SARS CoV-2 testing through a commercial laboratory or does not have clinical staff on site to administer the test, see Testing Recommendations in All Residential Settings below.
5. Recommend targeted testing for residents and staff, see LAC DPH testing guidance for congregate residential facilities. Refer to [Targeted Testing Guidance](#).
6. Plan for ways to continue essential services if on-site operations are reduced temporarily.
7. Plan for employee absences and create a back-up/on-call system..
8. Discontinue group activities, field trips, and communal dining (See [Table 1: Social Distancing Measures for Community Residential Congregate Settings](#)).
  - a. All meals are to be served within individual rooms.
  - b. Staff may eat together in staff breakrooms or a separate designated area, but physical distancing of six feet or more between persons must be enforced at all times while eating.
  - c. Residents should be encouraged to stay in their room and avoid communal and group activities as much as possible.
9. Immediately implement symptom screening for all staff, visitors, and, if feasible, residents—including temperature checks if possible. Residents in care giving facilities should have their temperature taken or self-monitor their temperature every 12 hours.
  - a. Every individual entering the residential congregate facility (including residents, staff, visitors, outside healthcare workers, vendors, etc.) regardless of reason, should be asked about COVID-19 symptoms and if possible, have their temperature checked. An exception to this is Emergency Medical Service (EMS) workers responding to an urgent medical need. They do not have to be screened, as they are typically screened separately.
  - b. Records are to be kept of staff and resident temperature checks.
  - c. Facilities should limit access points and ensure that all accessible entrances have a screening station.
  - d. Anyone with a fever (100.0° F or 38° C) or symptoms (fever, chills, cough, shortness of breath, new loss of taste or smell, muscle or body aches, headache, sore throat, congestion or runny nose, nausea or vomiting, diarrhea) may not be admitted entry.
10. Restrict all volunteers and non-essential personnel (e.g. barbers).
11. Post a notification letter at the entrance of the facility and community area.
12. Prohibit visitors from entering the facility unless compassionate care situations, such as end-of-life, or if there have been no new cases of COVID-19 identified in their facility for at least 14 days (See [www.publichealth.lacounty.gov/acd/docs/nCoVLTCHOOFAQ.pdf](http://www.publichealth.lacounty.gov/acd/docs/nCoVLTCHOOFAQ.pdf).)
  - a. Those with fever or symptoms should not be permitted to enter the facility at any time (even in end-of-life situations).
  - b. Post signs explaining visitor restrictions.
  - c. Set-up alternative methods of visitation such as through videoconferencing through Skype or FaceTime.

- d. Those visitors that are permitted, should be screened for fever and respiratory symptoms, must wear a face covering while in the building, and should restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene and to practice physical distancing while in the facility.
13. Provide education and job-specific training to staff regarding COVID-19, including:
  - a. Signs and symptoms.
  - b. Modes of transmission of infection.
  - c. Correct infection control practices and personnel protective equipment (PPE) use.
  - d. Staff sick leave policies and recommended actions for unprotected exposures (e.g., not using recommended PPE, an unrecognized infectious patient contact).
  - e. How and to whom COVID-19 cases should be reported.
14. Ensure that your facility has the capacity to isolate residents with COVID-19 and quarantine residents who are close contacts of a COVID-19 case.
15. Establish a COVID-19 area within the facility, if possible:
  - a. The COVID-19 area is for residents who have suspected or confirmed COVID-19 and must have a designated bathroom. The area must be physically separated from the area for those who do not have COVID-19.
  - b. All staff, equipment and common areas should be kept separate as much as possible.
  - c. LAC DPH does not recommend transferring patients to hospitals unless they require higher level of care and does not recommend transfer between facilities unless the facility is unable to isolate cases adequately.
16. Once the designated COVID care area is established, facility should accept back COVID+ patients ready to be discharged from acute care hospitals in accordance with transfer rules ([www.publichealth.lacounty.gov/acd/NCorona2019/InterfacilityTransferRules.htm](http://www.publichealth.lacounty.gov/acd/NCorona2019/InterfacilityTransferRules.htm)).
17. The facility to consult with the DPHN assigned to the facility regarding closure of the facility to new/returning admissions. Refer to [Interfacility Transfer Rules During COVID-19 Pandemic](#).
18. Have a resident and, in care-giving facilities, family notification process for when a case of COVID-19 is identified.
19. Have the ability to identify residents who could be discharged to home in the event of COVID-19 introduction to the building.
20. As much as possible, have employees work at only one facility in order to reduce interfacility spread of COVID-19.
21. For any transfers out of the building, notify EMS and the receiving facility of possible exposures.
22. Cancel and re-schedule all upcoming non-essential medical appointments or consider telemedicine routine care appointments when available.

#### **ADDITIONAL ADMINISTRATIVE CONTROL MEASURES IN FACILITIES THAT PROVIDE CAREGIVING SERVICES**

1. All care-giving staff that provide direct resident care in these facilities are considered similar to healthcare personnel (HCP).
2. All caregivers should ideally wear a facemask (or N-95) while they are in patient care areas, walkways, common or shared areas where residents and/or staff may congregate.
3. For all resident encounters, caregivers should at minimum wear a mask (surgical mask or higher). If resident is unable to cover nose/mouth (i.e. practice source control), caregivers should also use eye protection for that encounter. Full PPE (facemask or higher, gloves, gown and eye protection) is recommended while providing care to a resident suspected or confirmed to have COVID-19. For conservation of PPE, please refer to CDC guidance ([www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html](http://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html)).

Note: The rationale for mask and eye protection is to try to prevent caregiver exposure. Surgical masks can be worn for an extended period but should be discarded after they become saturated with moisture.

4. Review and follow the CDC's "[Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 \(COVID-19\) in Healthcare Settings](#)".
5. If unsafe for residents to eat unsupervised (e.g. prone to aspiration) or cannot feed themselves, or if staffing is insufficient to support one to one feeding, residents may eat outside their rooms as long as physical distancing guidelines can be followed.
6. Designate caregivers who will be responsible for caring for suspected or known COVID-19 residents. Ensure they are trained on the infection prevention and control recommendations for COVID-19 and the proper use of PPE.
7. If staffing scarcity requires staff to work with COVID-19 positive and negative residents, staff should be careful to change required PPE between patients, adhere to donning and doffing recommendations ([www.publichealth.lacounty.gov/acd/docs/CoVPPPoster.pdf](http://www.publichealth.lacounty.gov/acd/docs/CoVPPPoster.pdf)), though N95 and face shields may be worn throughout the day consistent with CDC PPE conservation contingency strategies ([www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html](http://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html)).

#### **OUTBREAK RESPONSE RECOMMENDATIONS FOR SUSPECT OR CONFIRMED CASES IN ALL RESIDENTIAL SETTINGS**

1. All ill persons (residents or staff) with symptoms suggestive of respiratory illness should be presumed to have COVID-19 and SARS-CoV2 testing should be recommended.
  - a. For suspect or confirmed residents, immediately mask and initiate isolation. Use face covering if mask is not available. If possible, initiate full contact and droplet precautions and eye protection (mask, gloves, face shield/goggles, disposable/washable gown).
  - b. Symptomatic/confirmed staff should be asked to go home immediately and/or seek care as appropriate. Immediately mask the staff and isolate in room with door closed if need to remain on premises.
  - c. In the case of two or more unknown respiratory cases in 72 hours at facility, encourage testing of routine respiratory pathogens including influenza testing if appropriate to establish alternative diagnosis.
2. Facilities should initiate contact investigation around each suspect or confirmed case (staff or resident) to identify all close contacts (staff and residents) during the infectious period of the case(s).
3. Document all staff and resident case and contacts on the [COVID-19 Line List for Congregate Residential Settings for Residents and Staff](#) (Excel).
4. Designate an area in your facility for the placement of suspect and confirmed residents. Define an isolation area around the suspect resident(s). Refer to [Guidelines for Proper Grouping of Residents](#).  
Note: The actual isolation area will depend on each building but define the area by your local workflow (e.g. the unit the resident is located would be a logical decision).
  - a. Case(s) should be isolated in single-person room(s). Move roommates into other rooms within the isolation area, if possible. Otherwise, cohort case(s) together in a separate room with the door closed and a dedicated restroom.
  - b. Cohort staff (keep the same, limited number of staff caring for the COVID-19 residents and ensure they do not interact with other non-quarantined residents).
  - c. Move suspect residents into the isolation area if suspicion for COVID-19 is high.
5. Designate a quarantine area, if possible, for residents who have been identified as contacts to case(s) at your facility.
  - . Residents should use masks or face coverings. If possible, initiate full contact, droplet, and eye protection precautions in the quarantine area.

- a. Place asymptomatic residents identified as close contacts in the quarantine area.
  - b. Post signage of your quarantine area.
  - c. Cohort staff as much as possible to minimize transmission.
6. Quarantined residents should:
- . Not be allowed visitors and should have limited contact with staff and other residents.
  - a. Stay in a separate room as much as possible and away from residents who are vulnerable to severe illness related to COVID-19. Individuals vulnerable to severe illness related to COVID-19 include those who are age 65 and above, or with underlying medical conditions such as chronic lung disease or moderate to severe asthma, chronic heart disease, diabetes, end stage kidney or liver disease or weakened immune systems such as cancer patients, those on immunosuppressive therapy and HIV/AIDS.
  - b. Use a separate bathroom.
7. Quarantine ends 14 days from the last day the resident was in contact with a symptomatic case. Refer to [Proper Grouping of Residents Guidelines](#).
8. If quarantined residents develop symptoms of respiratory illness (fever and cough or shortness of breath), then they should be moved to isolation area and SARS-CoV2 testing should be recommended.
9. If, during the quarantine period, there is contact with a person with suspected or confirmed COVID-19 (being within 6 feet for more than 15 minutes or touching body fluids or secretions without using the appropriate precautions) the 14-day quarantine period will have to restart. Body fluids or secretions include sweat, saliva, sputum, nasal mucus, vomit, urine, or diarrhea.
10. Continue to monitor all residents for fever and respiratory symptoms (i.e. cough, sore throat, shortness of breath) until 14-day after the last COVID-19 exposure at facility. Last COVID-19 exposure at facility is until the last COVID-19 case (staff or resident) is placed under isolation. Any breach in isolation of COVID-19 case would constitute an ongoing exposure at facility and monitoring period will need to be extended additional 14 days from that time.
11. **Special situations for facilities to consider:**
- . For residents receiving dialysis outside of the facility, notify their dialysis center and request that they be dialyzed in “isolation.”
  - a. Consider substituting nebulizers for metered dose inhalers.
12. Instruct the facility to notify District Public Health Nurse (DPHN) assigned to the facility immediately if any resident or staff report fever or respiratory symptoms.
13. Notify DPHN immediately if any caregivers or resident contact tests positive for COVID-19.

### Management of Caregiver Exposure in Caregiving Facilities

1. Identify all caregiver close contacts and assess their exposure. For guidance on management of caregiver contacts, refer to [LAC DPH Guidance for Monitoring Healthcare Personnel](#) and companion guidance, [CDC Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 \(Interim Guidance\)](#).
  - a. If caregiver was wearing only a face covering (and not a face mask or higher) during close contact, then they are considered exposed. Otherwise, assess exposure risk according to [CDC Interim Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19](#).
  - b. Instruct exposed caregiver to self-quarantine for 14 days after last exposure (see [Home Quarantine Instructions](#)).
  - c. Instruct exposed caregiver to notify all other employers of the type and nature of their exposure.
2. If caregiver must remain on site to mitigate critical staffing shortage, asymptomatic exposed contacts can continue to work under the following conditions:

- a. They must wear a mask during the 14-day quarantine period.
  - b. Monitor for symptoms twice daily.
  - c. If caregiver becomes symptomatic, staff must immediately be sent home for self-isolation (see [Home Isolation Instructions](#)).
3. Document all caregiver contacts on the [COVID-19 Line List for Congregate Residential Settings](#) (Excel) (See [Report Forms](#) section).
4. Monitor and follow-up caregiver contacts for symptoms during, or at the end of monitoring period, to check-in and respond to concerns, if possible.
5. For confirmed caregiver cases who are symptomatic, ensure the caregiver self-isolates for at least 10 days AND 3 days since recovery (fever has resolved without the use of antipyretics and symptoms have improved). Caregivers with high risk exposures (exposure to high-hazard aerosol-generating procedure without mask or eye protection) to COVID-19 should be excluded from work for 14 days. Caregivers can return to work after 14 days if they have never had symptoms.
  - a. If possible, identify facility staff who can monitor sick staff with daily “check-ins” using telephone calls, emails, and/or texts.

### Management of Staff Exposure in All Congregate Residential Facilities

1. Identify all staff who had close contact with resident within 48 hours before the onset of symptoms and assess potential exposure. If staff was wearing a cloth face covering during close contact, they are considered exposed. If wearing a face mask, and not directly exposed to body secretions of the case, they are not considered exposed.
  - a. Instruct exposed staff to self-quarantine for 14 days after last exposure (see [Home Quarantine Guidance](#)).
  - b. Instruct exposed staff to notify all other employers of the type and nature of their exposure.
2. If staff must remain on site to mitigate critical staffing shortage, asymptomatic exposed staff can continue to work under the following conditions:
  - a. They must wear a mask during the 14-day quarantine period.
  - b. Monitor for symptoms twice daily.
  - c. If staff becomes symptomatic, staff must immediately be sent home for self-isolation (see [Home Isolation Instructions](#)).
3. Document all staff contacts on the [COVID-19 Line List for Congregate Residential Settings](#) (Excel) (See [Report Forms](#) section).
4. Monitor and follow-up staff contacts for symptoms during, or at the end of monitoring period, to check-in and respond to concerns.
5. Monitor all staff (regardless of contact with a case) for fever, cough, and shortness of breath. Symptomatic staff may not work.

### TESTING RECOMMENDATIONS IN ALL RESIDENTIAL SETTINGS

1. DPH testing recommendations should be communicated to the facility administrator/manager or medical director.
  - a. Targeted testing is recommended for close contacts in all residential congregate settings, see [Targeted Testing Guidance](#).
  - b. Wider testing for early intervention may be considered in certain circumstances to help identify additional cases at a point in time and determine scope of outbreak at the facility. These include:
    - i. In high-risk congregate residential settings.
    - ii. Identification of contacts cannot be reliably conducted such that all residents are considered exposed (e.g. in a memory care unit).

- iii. AMD or designee determines broader testing is required after performing a transmission risk and infection control assessment.
2. More than 10% of residents have been identified as suspected or confirmed cases of COVID-19. A new 10% should be chosen for every round of testing. California Department of Social Services Provider Information Notice: PIN (CDSS PIN) 20-23-ASC recommends that when COVID-19 positive individuals (resident or staff) are identified, testing of all residents (excluding independent Continuing Care Retirement Communities-unless they have been in communal settings with other residents) and staff should be done every 14 days. Testing of all residents and staff may be discontinued after 2 rounds of negative testing. Facilities can then revert back to surveillance testing of 10% of staff every 14 days.
3. Facilities should conduct their own testing if they can do so. The facility should first be referred to the [DHS reference guide](#) or the [California Testing Taskforce](#) to find a lab – there are resources that provide onsite collection services. If the facility is unable to find a lab to do testing within 1 week, despite attempting to do so, facilities should be referred to DPH community testing (strike) team.
4. For symptomatic caregivers, ensure they are not working and recommend the following:
  - a. Testing is recommended through their Primary Care Provider or through Los Angeles County <https://covid19.lacounty.gov/testing/>.
5. Requests for DPH strike team testing can be requested if facilities are unable to conduct targeted or wider testing on their own. However, requests will be prioritized by ACDC in communication with CFS based on risk and scope of outbreak, and consensus that testing will change management as well DPH capacity and resources for testing supplies and staff. Decisions for testing through DPH will be made on a case-by-case basis with the CFS MD. Retesting will be done by the facility when indicated.
  - a. For an urgent need for testing outside of the priority, the request must come from the CFS Area Medical Director (AMD).
6. Surveillance Testing: Per [California Department of Social Services Provider Information Notice: PIN 20-23-ASC](#), facilities that currently do not have any diagnosed COVID-19 cases in residents or staff should conduct surveillance testing of 10 percent of all staff every 14 days (e.g. choose different staff to test every 14 days).

## DISCONTINUATION OF TRANSMISSION-BASED PRECAUTIONS AND DISPOSITION OF PATIENTS WITH COVID-19 IN CAREGIVING FACILITIES

For more details, refer to [CDC Discontinuation of Transmission-Based Precautions and Disposition of Patients with COVID-19 in Healthcare Settings](#).

1. If discontinuing isolation for symptomatic suspect cases, facilities are advised to do the following:
  - a. Residents should be tested 2 times at least 24 hours apart given the high false-negative rate of testing. Once the negative test results are received, discontinue isolation unless an alternative diagnosis requires transmission-based precautions.
  - b. If testing is not available or not tested:
    - i. At least 24 hours have passed since recovery defined as resolution of fever without the use of antipyretic medications; **AND**,
    - ii. Improvement in symptoms (e.g., cough, shortness of breath); **AND**,
    - iii. At least 10 days have passed since symptoms first appeared.
2. If discontinuing isolation for **confirmed symptomatic patients with COVID-19**, facilities are advised to do the following:
  - a. Symptomatic-based strategy:
    - i. At least 1 day (24 hours) has passed since recovery defined as resolution of fever without the use of antipyretic medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); **AND**,

- ii. At least 14 days have passed since symptoms first appeared if the patient has not been hospitalized and is not immunosuppressed.
    - iii. At least 20 days have passed since symptoms first appeared if the patient has been hospitalized or is immunosuppressed (actively receiving chemotherapy for cancer, HIV with CD4 count <200, immunodeficiency disorder, prednisone dose >20mg/day for more than 14 days, receipt of immunosuppressive medications [biologic agents, etc.] for treatment of autoimmune disease, or other cause of immunosuppression as determined by the patient's primary physician).
  - b. Test-based strategy is not currently recommended and may be considered for severely immunocompromised patients in consultation with an Infectious Disease expert.
3. If discontinuing isolation for **asymptomatic laboratory-confirmed patients with COVID-19**, facilities are advised to do the following:
  - a. Time-based strategy:
    - i. At least 14 days have passed since the date of testing for patients who are not immunosuppressed.
    - ii. If the patient is immunosuppressed (actively receiving chemotherapy for cancer, HIV with CD4 count <200, immunodeficiency disorder, prednisone dose >20mg/day for more than 14 days, receipt of immunosuppressive medications [biologic agents, etc.] for treatment of autoimmune disease, or other cause of immunosuppression as determined by the patient's primary physician), the patient should be isolated for 20 days.
  - b. Test-based strategy is currently not recommended.
4. Transmission-Based Precautions have been discontinued, but the resident has persistent symptoms from COVID-19 (e.g., persistent cough), they should be placed in a single room, be restricted to their room, and wear a facemask (if tolerated) during care activities until all symptoms are completely resolved or at baseline.

### Transfers from Hospital to Community Congregate Residential Settings

Refer to [Interfacility Transfer Rules During COVID-19 Pandemic](#).

Interfacility transfers should be limited as much as possible, while still maintaining appropriate levels of care for all patients.

Patients/residents should not be sent to the Emergency Department (ED) to obtain SARS CoV-2 testing.

1. For residents not needing hospital admission: Refer to [Return-to-Facility Discharge Rules for Patients in the Emergency Department](#).
2. Residents who developed symptoms of COVID-19 in the facility and are transferred to acute care hospital may return to the facility of origin once clinically stable if staffing levels in the facility are adequate. They should be placed in COVID-19 dedicated area within the facility.
3. New COVID-negative admissions to the facility should be restricted based on the assessment of the AMD or AMD delegated physician and depends upon the layout of the facility and the capacity for the facility to separate COVID-positive residents from negative residents and whether there is evidence of ongoing transmission (i.e., new symptomatic cases) in the facility.
  - a. For high risk facilities, new admissions or transfers should be placed in quarantine for 14 days and tested at admission and at the end of the 14 days prior to clearance to the general population.

### Transfers between Community Congregate Residential Settings

LAC DPH does not recommend transferring residents to hospitals unless they require higher level of care and does not recommend transfers between community congregate residential facilities unless the facility is unable

to isolate the resident adequately. Refer to [Interfacility Transfer Rules During COVID-19 Pandemic](#). If the facility is a dedicated COVID receiving facility, they may accept transfers of COVID+ residents from other facilities.

### Outbreak Closure Criteria

Outbreak can be closed once closure criteria is met:

At least 14 days have passed since last exposure to a confirmed or symptomatic case in a staff and resident.

1. PHN uploads all documents into IRIS and documents in IRIS per protocol.
2. PHN or PHNS can close COVID-19 outbreak in IRIS after approval by AMD or AMD delegated physician. Closure letter will be signed by AMD or AMD delegate and placed in IRIS under the filing cabinet.

### Death Reporting

DPHN must be notified of a death and the facilities will need to complete and submit a death report form to ACDC.

**Table 1: Social Distancing Measures for Residential Congregate Settings**

|                         |  |
|-------------------------|--|
| Sleeping Arrangements   | <ul style="list-style-type: none"> <li>• Increase spacing so beds are at least 6 feet apart</li> <li>• Arrange beds so that individuals lay head to toe, or use neutral barriers (curtains) to create barriers in between the beds</li> <li>• Move symptomatic resident into a designated area, preferable with closed doors, and provide separate bathroom if applicable</li> <li>• If only shared rooms are available, consider housing the case in a room with the fewest possible number of residents</li> <li>• Avoid housing residents with underlying conditions in the same area as symptomatic resident</li> <li>• For additional guidance, see <a href="#">Bed Positioning Infographic</a>.</li> </ul> |
| Mealtimes               | <ul style="list-style-type: none"> <li>• Stagger mealtimes to reduce crowding in shared eating facilities</li> <li>• Stagger the schedule for use of common/shared kitchens</li> <li>• Serve meals “to go” if possible</li> <li>• Serve meals in resident rooms, if possible</li> <li>• Stagger dining times to decrease the size of the groups</li> </ul>   |
| Bathrooms/Bathing       | <ul style="list-style-type: none"> <li>• Create a staggered bathing schedule to reduce the amount of people using the facilities at the same time</li> </ul>   |
| Recreation/Common areas | <ul style="list-style-type: none"> <li>• Create a schedule for using common space</li> <li>• Reduce activities that congregate any resident at once</li> <li>• If smaller group activities are necessary, keep the same group together to decrease the risk for virus spread</li> <li>• If symptomatic residents need to move through areas with asymptomatic residents, they should wear a mask, and minimize the time in these areas</li> </ul>  |
| Communication           | <ul style="list-style-type: none"> <li>• Reduce the amount of face-to-face interactions with residents for simple informational purposes</li> <li>• Consider using alternative methods of communication: Bulletin boards, signs, posters, phone, sliding information under doorway</li> </ul>  |
| Staff Activities        | <ul style="list-style-type: none"> <li>• Reduce unnecessary assembly of staff (e.g., large meetings where information can be communicated otherwise)</li> </ul>  |