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

Definition of Outbreak:
1. At least one or more laboratory confirmed case (symptomatic or asymptomatic) of COVID-19 in a SNF resident who has resided in the facility for at least 14 days
   a. If newly admitted residents who are admitted to the YELLOW quarantine cohort test positive for COVID-19, this is not considered an outbreak as it was acquired outside the SNF.
2. A sudden increase of acute febrile respiratory illness (e.g. Fever measured or reported as >100.0° F and either a cough, sore throat, or shortness of breath) in the setting of community transmission of COVID-19—a minimum of 2 Persons Under Investigation (PUI) in residents within 72 hours. Facilities should test PUI immediately.
3. In facilities that have an outbreak of COVID-19 and are conducting weekly response testing, the outbreak is considered open until all mass testing is negative for 2 weekly rounds of testing. If additional positive residents (regardless of symptoms) are identified after 2 negative rounds of testing, a new outbreak should be opened.

   NOTE: a positive case of COVID-19 in a healthcare provider (HCP) should prompt mass testing in the SNF but is not considered an outbreak until there are identified cases among residents.

EPIDEMIOLOGIC DATA FOR OUTBREAKS
a. Establish a case definition (i.e., fever [measured or reported] and either cough, sore throat, or stuffy nose): include pertinent clinical symptoms and laboratory data.
b. Confirm etiology of outbreak using laboratory data.
c. Create a line list and contact information following the COVID-19 line list template above.
d. Maintain surveillance for new cases until no new cases for at least 2 weeks.
e. Create an epi-curve, by date of onset (see CDC Quick Learn Lesson: Create an Epi Curve for guidance). Only put those that meet the case definition on the epi-curve. (Optional)

CONTROL OF CASE, CONTACTS & CARRIERS
Case
See detailed instructions below for single cases and multiple cases in residents, as well as cases in facility staff.

CONTACTS
Contacts are defined as HCWs or residents who have:

a. Been within approximately 6 feet of a person with COVID-19 for a prolonged period (greater than 2 minutes) per CDC criteria (including roommates of a case); OR
b. Had unprotected direct contact with infectious secretions or excretions of the resident (e.g., coughed on, touched used tissues with a bare hand).
Healthcare Personnel (HCP):
Facility to identify all close contact HCP (includes clinical and ancillary staff), and determine risk status using the guide outlined in LAC DPH Guidance for Monitoring Healthcare Personnel and a companion guidance, CDC Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance). Document the contacts on the COVID-19 Line List template (see Report Forms section) and submit it to DPH as requested by DPH.

Visitors:
Visitors are currently limited in SNFs based upon CMS guidance. Facility to identify any close contact visitors that may have been exposed to a confirmed case and instruct to self-quarantine and self-monitor for symptoms for 14 days after last exposure.
Visitors should call their primary care provider to discuss testing options and guidance.
Facilities should be encouraged to maintain daily visitor log with date and time of visit as a regular practice.

COVID-19 Testing
Interim Guidelines for COVID-19 Antigen Testing in Skilled Nursing Facilities Guidelines (8-14-20)
Below are recommendations for testing and cohorting in SNFs based upon California Department of Public Health (CDPH) requirements outlined in recent CDPH AFLs:

- AFL 20-52 Coronavirus Disease 2019 (COVID-19) Mitigation Plan Implementation and Submission Requirements for Skilled Nursing Facilities (SNF) and Infection Control Guidance for Health Care Personnel (HCP) (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-52.aspx)

General requirements
1. Establish a relationship with a commercial lab to do rapid PCR testing (turn-around time of 48 hours or less) for COVID-19. Refer to the DHS reference guide or the California Testing Taskforce for laboratory resources.
2. Establish cohorting plan as part of CDPH-required COVID mitigation plan.
3. Report weekly to Public Health the number of staff and residents tested each week for COVID-19, the number who are asymptomatic and test positive, and the number who are symptomatic and test positive, as per the May 26, 2020 Board of Supervisors Motion.

Response testing plan See Figure 1 Testing Regime.
Response testing is required of all SNFs by CDPH (https://www.cdph.ca.gov/Programs/CHCQ/LCP/Pages/AFL-20-53.aspx). Asymptomatic patients or staff members who have previously tested positive for SARS-CoV-2 (by PCR) and recovered should not be re-tested for 3 months after the onset of the initial COVID-19 illness (or date of first positive PCR test if they never had symptoms). Patients or staff who develop new symptoms of COVID-19 should be retested regardless of previous infection.

1. Baseline. The CDPH AFL requires all facilities, regardless of outbreak status, to do one-time direct virus detection (i.e., PCR) testing of all residents and staff.
2. Testing of all admissions and readmissions. All newly admitted residents or readmissions should be tested upon admission. These patients should follow transfer rules (http://publichealth.lacounty.gov/acd/NCorona2019/InterfacilityTransferRules.htm). Lack of testing at discharge/transfer is not a reason to deny admissions of patients.
   a. All newly admitted and readmitted patients who test negative should be placed in quarantine (Yellow Cohort) for 14 days, monitored for symptoms and signs of COVID-19, and retested at the end of
quarantine. A negative post-quarantine result permits their transfer to the non-COVID-19 cohort (Green Cohort).

b. A positive test should initiate isolation in Red Cohort for 14 days from the positive test date for asymptomatic patients, or for 20 days for symptomatic patients.

3. **Testing of symptomatic residents or staff.** Every staff member or resident with symptoms of COVID-19 should be tested as soon as possible. Any staff or resident testing positive in the facility should then prompt response testing. All symptomatic staff must be immediately restricted from working (see Healthcare Personnel Monitoring and Return to Work sections below). All symptomatic residents should be presumed infectious pending test results and transferred immediately to a single room in the Yellow Cohort area. Symptomatic residents that test negative will need a second negative PCR test at least 24 hours later before they can be returned to their non-COVID (Green) cohort. If there is an alternative diagnosis (i.e. UTI, cellulitis, etc.) for symptoms, one negative test for COVID-19 is sufficient to transfer the patient back to their normal bed.

4. **Response testing.** If a single positive COVID-19 case is identified among either staff or residents, the SNF must conduct comprehensive testing of all residents and staff to identify potential asymptomatic infections. If testing capacity is limited, the SNF may test staff who worked in the same area (e.g., nursing station, floor, etc.) as the COVID positive individual. Any contacts of confirmed COVID-19 cases will need to be quarantined accordingly in the Yellow Cohort. All residents and staff who test negative will need to be tested weekly until there are at least 2 rounds with no additional infections identified. After 2 negative rounds of testing, the facility should restart the weekly surveillance testing as outlined below.

5. **Surveillance testing of staff and residents.** Surveillance testing is initiated when either no cases were identified at baseline testing OR after no new cases are identified from two sequential rounds of response testing.
   a. **Staff:** Every SNF must test 25% of their staff weekly to complete testing of 100% of all staff each month.
   b. **Residents:** SNFs must test a random sample of 10% of all residents (regardless of facility size) weekly.
   c. If any resident or staff tests positive, the SNF must report the positive case to LAC DPH and proceed with outbreak/response testing as described above.

**Figure 1. Testing regime**


**Cohorting**

Facilities should have 3 separate cohorting areas as described below and shown in **Figure 2**.

1. **Red Cohort (Isolation).** This area is only for patients who have laboratory-confirmed COVID-19. Symptomatic residents who test positive for COVID-19 should be kept in the Red Cohort for 20 days after the date of onset
of symptoms AND until after 24 hours have passed since their last fever AND their symptoms have improved. Asymptomatic patients who test positive should stay in the Red Cohort until 14 days have passed since the date of their first positive PCR test. Once patients have completed the required duration in the Red Cohort, they may be admitted to the Green Cohort (Non-COVID-19 patient care area).

2. **Yellow Cohort (Mixed-Quarantine & Symptomatic).** This area is for the following residents: those who have been in close contact with known cases of COVID-19; newly admitted or re-admitted residents; dialysis patients; those who have symptoms of possible COVID-19 pending test results; and for residents with indeterminate tests. Patients in this area should be placed in private rooms, if possible. If private rooms are not available for all residents in the Yellow Cohort, they should be prioritized for symptomatic patients, close contacts, and those with indeterminate test results as they have a higher probability of infection. If single rooms are not available, use strategies to reduce exposures between residents such as placement of curtains between residents; put residents with similar risk profiles in the same room (e.g., group low risk admissions in the same room); and change gowns and gloves and perform hand hygiene between each patient contact in this area.

Residents may leave the Yellow Cohort under these circumstances:

a. If their test result is positive for COVID-19, they should be moved into the Red Cohort.

b. Newly admitted and readmitted patients must stay in quarantine in the Yellow Cohort for 14 days. They must be tested on admission and again at the end of quarantine. A negative post quarantine result permits the residents to be transferred to the Green Cohort (Non-COVID-19) cohort.

c. Close contacts to confirmed cases must stay in quarantine in the Yellow Cohort for 14 days. They should be tested on admission and again at the end of quarantine. Negative post-quarantine result permits the residents to be transferred to the Green Cohort.

d. Symptomatic patients must have two negative PCR tests at least 24 hours apart before they can move into the Green Cohort unless an alternate diagnosis is made (e.g., URI, cellulitis), in which case a single negative test is sufficient.

e. Residents with indeterminate test results should remain in the Yellow Cohort until they either have a positive test or once they have 2 negative tests at least 24 hours apart.

f. Residents who regularly leave the facility for dialysis treatments should be housed in the Yellow Cohort together.

3. **Green Cohort (Non-COVID-19 patient care area).** This area is reserved for residents who do not have COVID-19. To be in this area, patient must have either completed quarantine, cleared isolation, or have tested negative and remained asymptomatic after initial negative baseline testing.

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**Figure 2. Cohorting**

![Diagram of Cohorting](image-url)
Special staffing considerations in cohort areas
1. Staff assigned to the Red Cohort should not care for patients in other cohorts if possible. If staff must care for residents in multiple cohorts, they should visit the Red Cohort last and should don and doff PPE and perform hand hygiene prior to moving between cohorts.
2. With prior approval from Public Health, asymptomatic staff with lab-confirmed COVID-19 infection may be allowed to work in the Red Cohort. They will need to be able to keep separated from uninfected staff. This includes having dedicated breakrooms and bathrooms until they are no longer considered infectious (10 days after the date of collection of their initial positive test).
3. All staff in the facility should adhere to physical distancing of at least 6 feet while in break rooms and should wear masks while in the facility.

Special PPE considerations in cohort areas
1. Gloves should be changed between every patient encounter. Hand hygiene should be performed before donning and after doffing gloves.
2. Gowns should ideally be changed between patients if adequate supplies are available. The same gown may be worn in the Red Cohort as long as there are no other contact pathogens (C. difficile, CRE, Candida auris, etc.) that require changing between patients.
3. In the Yellow Cohort, contact and droplet precautions, with gown and glove changes between each patient is required. Hand hygiene must be performed between all patients in Yellow Cohort. Gowns may be prioritized for care activities that may result in exposure to body fluids.
4. The same gowns should never be worn for care of both COVID-19 positive and negative patients.
5. In the Green Cohort, standard precautions and universal source control are sufficient to provide care to patients. If there is evidence of ongoing COVID-19 transmission in the facility, then standard, contact, droplet plus eye protection is recommended for all patients.
6. In Yellow and Green Cohorts, eye protection is recommended for close contact with patients (within 6ft), especially if the patient cannot reliably wear a face covering.

COVID-19 Prevention - General and Administrative Practices
1. Conduct symptom and temperature screening
   a. At entry for all persons
i. All persons should be screened for symptoms including a temperature check before entering the facility. This includes residents, staff, essential visitors, outside healthcare workers, etc. Symptoms include, but are not limited to the following: 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, or not feeling well.

ii. 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.

iii. Anyone with fever or symptoms may not be admitted entry.

b. Twice daily for all staff and patients/residents
   i. All staff should be checked for symptoms and fever twice daily, once prior to coming to work and the second at the end of the shifts (see Healthcare Personnel Monitoring section below.)
   ii. Patients/residents should be assessed for symptoms and have their temperature checked at least every 12 hours.
   iii. Records should be kept of these staff and resident symptom and temperature checks.

2. Reinforce physical distancing, hand hygiene, and universal source control.
   a. Residents should remain in their room as much as possible and should be encouraged to wear a face covering if they leave. Remind residents to practice physical distancing and perform frequent hand hygiene. Residents who have underlying cognitive conditions should not be forcibly kept in their rooms nor forced to wear a face covering.

   a. Non-punitive sick leave policies to support staff to stay home when sick or when caring for sick household members. Make sure staff are aware of the non-punitive sick leave policy.

4. Enhanced environmental disinfection with EPA-approved healthcare disinfectants should be performed on high touch surfaces (e.g., bed rails, doorknobs, handrails, etc.).

5. Facilities must demonstrate that they have contracted with suppliers to order a 2-week supply of PPE and other infection prevention and control supplies
   a. PPE and other infection prevention and control supplies (e.g., surgical masks, respirators, gowns, gloves, goggles, hand hygiene supplies) that would be used for both HCP protection and source control for infected patients (e.g., facemask on the patient) should be readily accessible for use.

OUTBREAK RESPONSE MEASURES

1. Once an outbreak has been identified, facilities should immediately implement the following measures.
   a. Immediately initiate standard, contact, and droplet precautions, plus eye protection for all suspect or confirmed residents with fever and/or respiratory symptoms.
   b. Increase environmental cleaning throughout the facility to 3 times a day (if possible) with emphasis on high touch surfaces particularly in the unit where the resident was located.
   c. If you have not already done so, ensure that you are using an approved cleaning agent: List N: Disinfectants for Use Against SARS-CoV-2.

2. Discontinue all group activities and communal dining. Serve meals in resident rooms, if possible or stagger dining times to decrease the size of the groups. If smaller group activities are necessary, keep the same group together to decrease the risk of exposure. All group activities that must still be continued should adhere to social distancing and universal source control.

3. For any transfers out of the building, notify EMS and the receiving facility of possible exposures.

4. Consider discharge of any patients that can be cared for in the home setting.

5. Continue to restrict visitors.
6. 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 case has recovered.

7. **Lab testing** of symptomatic residents should be done through a commercial lab, if possible.

8. Response testing should be done as described in testing section above.

9. If the facility is not able to do testing on their own, they will be placed in a prioritization scheme by ACDC. Testing requests to ACDC will not be honored unless the Area Medical Director (AMD) believes there is an urgent need for testing outside of the priority.

10. Hold admissions to units where ongoing transmission of COVID may be occurring. If the SNF has separate floors or buildings that do not have evidence of COVID transmission after response testing, AMD may elect to resume admissions to the facility.

11. Re-admissions to the facility of residents who developed symptoms of COVID and tested positive for COVID after transfer to a hospital should be readmitted to the COVID cohort unit. Implement a line listing of all HCP, residents, and visitors with symptoms.

12. Notify all HCPs who were exposed to the resident within 48 hours before the onset of symptoms regarding the potential for exposure and instruct them to self-monitor for fever and respiratory symptoms twice a day for 14 days. Refer to LAC DPH Guidance for Monitoring Healthcare Personnel (www.publichealth.lacounty.gov/acz/docs/HCWMonitoring.pdf) a companion guidance, CDC Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)

13. Monitor all HCP (regardless of contact with a case) for fever, cough, and shortness of breath. Symptomatic HCP may not work.

14. 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.

15. Notify DPHN immediately if any HCP contact tests positive for COVID-19.

16. For symptomatic HCPs, ensure they are not working and recommend the following:
   a. Testing should be performed through the SNF testing plan. If the SNF is unable to perform testing, testing through the PHL may be arranged if approved by the AMD.
   b. Instruct the facility to notify DPHN to arrange for testing.

17. Check all HCPs for fever (>100.0° F) and respiratory symptoms at least at the beginning of the shift. For confirmed HCP cases who are symptomatic, ensure the HCP self-isolates for at least 10 days have passed since symptoms first appeared AND at least 24 hours have passed since last fever without the use of fever-reducing medications AND symptoms (e.g., cough, short of breath) have improved. HCP 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. HCP can return to work after 14 days if they have never had symptoms. Refer to LAC DPH Guidance for Monitoring Healthcare Personnel and a companion guidance, CDC Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance).

For asymptomatic confirmed HCW cases, Refer to LAC DPH Guidance for Monitoring Healthcare Personnel.

**COMMON SCENARIOS**

**Single confirmed COVID-19 RESIDENT case in a SNF**

1. Immediately transfer COVID positive resident to the **RED (COVID positive) cohort**.
2. Identify any close contacts or exposures to the COVID positive resident and place them in the **YELLOW (mixed quarantine) cohort** for 14 days.
3. If the resident testing positive was in the **YELLOW (mixed quarantine) cohort** because of recent admission or known exposure, this should not be opened as an outbreak and outbreak measures may not be necessary for the SNF. However, if a resident from the **GREEN (Non-COVID-19) cohort** tests positive, this suggests transmission within the SNF and warrants opening an outbreak in the facility and the facility should initiate an outbreak response.
Confirmed COVID-19 HCP case in a SNF
1. If a HCP is identified as positive either as result of being symptomatic or due to weekly testing of asymptomatic staff, the HCP should be excluded from work if symptomatic, but may continue to work only with COVID positive patients if there is a staffing shortage in the facility. While CDC does allow asymptomatic COVID positive staff to work with COVID negative patients under certain circumstances, this should be done only after approval from the AMD.
2. Positive COVID test results in a HCP should trigger response testing as described above, but does not meet the outbreak definition.
3. SNFs may continue to admit new residents unless a resident not previously in the quarantine cohort tests positive, suggesting widespread transmission of COVID in the facility.

Two or More Unknown Respiratory Cases within 72 Hours in LTCF
1. Residents who have possible symptoms of COVID should be transferred to the YELLOW (mixed quarantine) cohort immediately and tested. They should be placed in single rooms if possible, or cohorted together until testing is performed.
2. Residents who test positive should be transferred to the RED (COVID positive) cohort for 14 days from the time of symptom onset, or 3 days after the last fever, whichever is longer.
3. Residents may be moved back into the GREEN (Non-COVID-19) cohort if they test negative twice at least 24 hours apart. Residents who test negative for COVID should be tested for influenza and other respiratory pathogens prior to transfer back to the GREEN (Non-COVID-19) cohort.
4. Any positive COVID tests of residents in the GREEN (Non-COVID-19) cohort should trigger response testing of the residents and HCP of the facility, should be identified as an outbreak and should warrant outbreak response measures.

Special situations for long-term care facilities to consider:
1. For residents receiving dialysis outside of the facility, notify their dialysis center and request that they be dialyzed in “isolation.” Dialysis residents should be placed in the yellow zone.
2. Consider substituting metered dose inhalers for nebulizers to reduce the risk of aerosolization.

Discontinuing Transmission Based Precautions for Patients with Suspected or Laboratory Confirmed COVID-19
1. Suspect cases (cases with symptoms of possible COVID). Facilities should use one the following criteria to discontinue transmission-based precautions and return the patient to the Green Cohort:
   a. Residents should be tested 2 times with a direct virus detection test (i.e. PCR) at least 24 hours apart given the high false-negative rate of testing.
   b. If testing is not available or patient is not tested:
      i. After at least 20 days since symptom onset and at least 24 hours afebrile (< 100.0° F) without the use of antipyretic medications and improvement of symptoms.
      ii. For patients who have an alternative diagnosis (e.g., UTI, cellulitis), one negative PCR test is sufficient to remove from quarantine.
2. Laboratory-confirmed symptomatic patients with COVID-19. The symptom-based strategy is recommended to discontinue transmission-based precautions. The test-based strategy is no longer recommended because patients can shed non-infectious viral RNA for an extended period of time. The test-based strategy can be considered for patients who are severely immunocompromised or for atypical situations if used in consultation with infectious disease experts.
   a. Symptom-based strategy patients:
      i. At least 20 days have passed since symptoms first appeared; and,
      ii. At least 24 hours have passed since last fever without the use of antipyretic medications and
      iii. Improvement in symptoms (e.g., cough, shortness of breath).
b. Test-based strategy (only for severely immunocompromised residents as described above):
   i. Resolution of fever without the use of fever-reducing medications, and
   ii. Improvement in symptoms (e.g., cough, shortness of breath), and
   iii. Negative results of at least two consecutive respiratory specimens (e.g., nasopharyngeal swab) collected ≥24 hours apart (total of two negative specimens).

3. Asymptomatic (non-immunosuppressed patients) laboratory-confirmed patients with COVID-19. Facilities may discontinue transmission-based precautions using the following time-based strategy:
   a. 14 days have passed since the date of their first positive COVID-19 diagnostic test without the development of symptoms of COVID-19.
   b. If they develop symptoms during this 14-day period, the isolation period should be restarted from the onset of symptoms per the symptom-based criteria outlined above.

4. Asymptomatic severely immunosuppressed patients should be isolated for at least 20 days from the date of their first positive COVID-19 diagnostic test. The following patients are considered severely 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 [biologics, etc.] for treatment of autoimmune disease, or other form of immunosuppression as determined by the patient’s primary physician).

**TRANSFERS**

Interfacility transfer from hospital to LTCF and Transmission-Based Precautions

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.

a. For residents not needing hospital admission: Refer to Return-to-Facility Discharge Rules for Patients in the Emergency Department.

b. Residents who developed symptoms of COVID-19 in the LTCF and are transferred to acute care hospital may return to the facility of origin once clinically stable if staffing levels in the SNF are adequate. They should be placed in COVID-19 dedicated area within the SNF.

c. New COVID-negative admissions to the SNF should be tested upon admission and admitted to the quarantine area for 14 days. Repeat testing should be performed on or after day 12 of quarantine and if negative, the resident may return to the non-COVID cohort.

Transfers from one LTCF to another LTCF or to other Group Settings:

LAC DPH does not recommend transferring residents to hospitals unless they require higher level of care and does not recommend transfers between LTCFs 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 LTCFs.

**CLOSURE CRITERIA**

Outbreak can be closed once closure criteria is met:

consecutive weekly rounds of response testing in residents have been negative; OR

1. 14 days from the last onset of a symptomatic case if response testing is not being performed based upon the assessment of the AMD; OR

2. Upon the discretion of the AMD or MD designee.

3. Prior to closure, all the following documents must be completed:
   a. PPHN uploads all documents into IRIS and completes all required documents in IRIS per protocol.
   b. PHNS reviews and forwards to AMD.
c. 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.

Exceptions to routine closure:
1. If the facility becomes a COVID-designated facility upon approval by ACDC, outbreak can be closed after consultation with AMD.
2. If baseline/mass testing is delayed and is done in a facility after the facility meets other closure criteria, the outbreak may be closed and any asymptomatic positive cases found during baseline/mass testing should be isolated, but the outbreak should not be re-opened unless there are additional symptomatic or confirmed cases in residents.

GUIDELINES FOR OPENING A NEW OUTBREAK AFTER CLOSURE
For facilities that are conducting weekly response driven testing
1. The outbreak cannot be closed until two rounds of testing are completed, demonstrating no additional transmission.
2. If a single new case in a resident is identified after two rounds of negative testing, the facility should be opened as a new outbreak.
   o Once the NEW outbreak has been opened under a NEW outbreak number, PHN can manage the facility with the following abbreviated procedures:
     i. Contact the facility to reinforce infection control recommendations.
     ii. Determine if there are any infection control barriers or deficiencies with cohorting, staffing, PPE, etc.
     iii. Ensure facility is able to conduct response testing.
     iv. Monitor site for new cases weekly until investigation can be closed.
     v. Documentation to include the epi form, line list, and clearance letter. The notification letter and HOO are optional upon the discretion of the MD assigned to the investigation.
   o NOTE: A facility with a single case can accept new admissions if there are no infection control barriers/challenges, if the facility is able to properly cohort residents, if the facility has an adequate quarantine area to receive the patient, and is compliant with response testing requirements.
   o If ≥2 cases are identified at the facility or if the facility admits to substantial infection control barriers or deficiencies, then consider managing the OB with standard OB procedures, including daily check-ins and onsite/virtual visits as appropriate.

RESTRICTING ADMISSIONS TO SNFS DURING AN OUTBREAK
1. In an outbreak situation, all new admissions may be held based on the assessment of the AMD or AMD delegated physician.
2. The decision to allow admissions should be recommended based upon a number of factors. Consider allowing admissions if the following criteria are met:
   a. Dedicated quarantine unit to place new admissions
   b. Dedicated COVID, quarantine and non-COVID areas in the facility
   c. Ability to cohort residents per protocol
   d. Demonstration of good infection control practices as evidenced by a virtual or on-site infection control visit
   e. No evidence of transmission with 1 round of response testing of residents and staff
   f. Adequate supply of PPE
   g. No staffing shortages reported
DEATH REPORTING
DPHN must be notified of a death and the facilities will need to complete and submit a death report form to ACDC.

Healthcare Personnel Monitoring and Return to Work Monitoring
1. All HCP should self-monitor twice daily, once prior to coming to work and the second, ideally timed approximately 12 hours later for fever or symptoms consistent with COVID-19.
2. If HCP have symptoms, they should stay home from work and contact the health care facility (HCF) immediately to arrange for medical evaluation and/or testing as soon as possible.
3. HCF should inquire about symptoms of COVID and do temperature checks of all HCP prior to the start of working their shifts AND at the end of the shift.
4. Identify staff who can monitor sick staff with daily “check-ins” using telephone calls, emails, and texts. Refer to the LAC DPH Guidance for Monitoring Health Care Personnel for more detailed information including management of possible workplace exposures.

Return to Work
1. Symptomatic HCP with mild to moderate illness who are not severely immunocompromised may return to work when the following conditions are met:
   a. At least 10 days* have passed since symptoms first appeared; and,
   b. At least 24 hours have passed since last fever without the use of fever-reducing medications and
   c. Improvement in symptoms (e.g., cough, shortness of breath).
   *HCP with severe to critical illness or who are severely immunocompromised should be excluded from work for at least 20 days from illness onset.
2. Asymptomatic HCP who are not severely immunocompromised with laboratory-confirmed COVID-19 should be excluded from work until 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test. If the HCP is severely immunocompromised, then they should be excluded from work until at least 20 days after first positive diagnostic test. In a setting of severe worker shortage, asymptomatic staff may be permitted to work with COVID-19 positive patients only.
3. After returning to work they should:
   a. Wear a facemask for source control at all times while in the facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding universal source control.
      ▪ A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
      ▪ Of note, N95 or other respirators with an exhaust valve do not provide source control and should not be used in healthcare settings.
   b. Self-monitor for symptoms and seek re-evaluation from occupational health if symptoms recur or worsen.

See CDC Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance) and LAC DPH Guidance for Monitoring Health Care Personnel for more information.