COVID-19 PREVENTION TOOLKIT FOR LONG-TERM CARE FACILITIES

(NURSING HOMES, SKILLED NURSING FACILITIES, AND ASSISTED LIVING FACILITIES)

Stanislaus County HEALTH SERVICES AGENCY

HEALTH SERVICES AGENCY

Long Term Care Facility Toolkit

Dear Colleague,

Stanislaus County Public Health is asking for your assistance to help slow the spread of the disease caused by the novel (new) coronavirus (COVID-19) in Stanislaus County. All Long Term Care Facilities (LTCF) in Stanislaus County need to be prepared for patients with suspected or confirmed COVID-19. Older adults and people who have severe underlying medical conditions like heart or lung disease or diabetes seem to be at higher risk for developing more serious complications from COVID-19 illness. That is why it is so important to put in place practices that protect residents and staff.

The general strategies the Centers for Disease Control and Prevention (CDC) recommend for preventing the spread for COVID-19 are the same strategies long-term care facilities use every day to detect and prevent the spread of other respiratory viruses, like influenza. These guidelines provide specifications you should take to help slow the spread of COVID-19.
We ask that you ensure that your staff is trained, equipped, and capable of practices needed to:

- prevent the spread of respiratory viruses including Sars-cov-2 within the facility
- promptly identify and isolate patients with possible COVID-19 and inform the correct facility staff and public health authorities
- care for patients with known or suspected COVID-19 as part of routine operations and as well as an escalating outbreak
- monitor and manage any healthcare personnel that might be exposed to COVID-19
- communicate effectively within the facility and plan for appropriate external communication related to COVID-19.

The attached documents are designed to help your facility implement changes to mitigate the spread of COVID-19 in your facility. For additional resources and information please visit http://schsa.org/corona-virus/healthcare-professionals/
Additionally, California Department of Public Health will be hosting weekly calls to discuss COVID-19 updates starting **May 7, 2020**. We encourage you attend these calls to stay up to date on new recommendations. The teleconference details are as follows:

- Time: Thursdays, 12:00 P.M. – 1:00 P.M.
- Dial-in: 1-877-226-8163
- Access Code: 513711

Please contact Stanislaus County Public Health at (209) 558-5678 if you have any questions.

Sincerely,

Dr. Thea Papasozomenos
Assistant Public Health Officer
Stanislaus County Public Health

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1. Preparing for COVID-19 in California Skilled Nursing Facilities

The California Department of Health (CDPH) strongly recommends skilled nursing facilities (SNF) prepare for novel coronavirus disease (COVID-19). Elderly persons and those with chronic medical conditions may be at higher risk for severe illness and death from COVID-19. All California SNFs should take steps to:

1) Prevent introduction of COVID-19 into their facility
2) Detect COVID-19 in their facility
3) Prepare to receive residents with suspected or confirmed COVID-19 infection
4) Prepare to care for residents with suspected or confirmed COVID-19 infection
5) Prevent spread of COVID-19 within their facility

1) Prevent Introduction of COVID-19 into your Facility

Ill visitors and healthcare personnel (HCP) are the most likely sources of introduction of COVID-19 into a SNF.

Visitors:

- ☐ Restrict all nonessential visitors.
  - o Screen essential visitors for travel within the prior 14 days to areas with COVID-19 transmission and for signs or symptoms of a respiratory infection (e.g., fever, cough, or sore throat) or contact with someone with suspected or confirmed COVID-19 infection (see the CDC COVID-19 travel website for updated travel information).
  - o If a visitor meets any of these criteria, facilities should restrict their entry to the facility until he or she is no longer potentially infectious [for example, 72 hours after resolution of fever without antipyretic medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath)].
- ☐ Post signs at the entry, reception area, and throughout the facility to help visitors self-identify relevant symptoms and travel history.
- ☐ Limit visitor movement within the facility and avoid common areas.
- ☐ Before visitors enter a resident's room, provide instructions for hand hygiene, limiting surfaces touched, and appropriate use of personal protective equipment (PPE).
- ☐ Educate visitors on basic infection control measures for respiratory infections, including hand hygiene, respiratory hygiene and cough etiquette (sneeze/cough into tissue or elbow, place used tissues in a waste receptacle and wash hands immediately after using tissues).
- ☐ Facilitate remote communication between the resident and visitors (for example, video-call applications on cell phones or tablets), and develop policies addressing when and how visitors might still be allowed to enter the facility (such as, end of life situations).
- ☐ See also AFL 20-22.

Healthcare personnel:

- ☐ Instruct healthcare personnel (HCP) to not report to work if they are symptomatic with fever or respiratory symptoms. Ill HCP must report symptoms to their supervisor.
- ☐ Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that allow ill HCP to stay home.
- ☐ Instruct HCP who develop signs and symptoms of a respiratory infection while at work to immediately stop work, put on a facemask, alert their supervisor, leave the facility, and self-isolate at home.
- ☐ Educate HCP on basic infection control measures for respiratory infections, including hand hygiene, respiratory hygiene and cough etiquette.
- ☐ Restrict nonessential HCP, for example, volunteers.

2) Detect COVID-19 in your Facility

Perform surveillance to detect respiratory infections, including COVID-19.

- ☐ Implement a protocol for daily (or more frequent) monitoring for acute respiratory illness (fever, cough, shortness of breath) among residents and HCP.
- ☐ Track suspected and confirmed respiratory infections using a line list; see the CDC's Long Term Care Respiratory Surveillance Line List (PDF) for further details.
- ☐ Assess incoming residents with acute respiratory illness upon admission for travel to areaswith COVID-19 transmission in the 14 days prior to illness onset, or contact with persons with confirmed COVID-19 infection.
- ☐ Report identification of a resident with severe respiratory infection, or three or more residentswith acute respiratory illness over 72 hours, to your local public health department. Do not wait for COVID-19 results to report.
- ☐ Alert your local health department if you identify a resident who has COVID-19.
- ☐ Notify other facilities prior to transferring a resident with acute respiratory illness, including suspected or confirmed COVID-19 infection.
- ☐ Notify residents'family members or the resident's representative, if there is a COVID-19 positive health care worker or resident in their facility.

3) Prepare to Receive Residents with Suspected or Confirmed COVID-19 Infection

Although COVID-19 infection can be severe and require inpatient care, some infections may be mild and not require medical care in an acute care facility. Hospitalized patients with COVID-19 infection may be medically stable for discharge prior to discontinuation of Transmission-based precautions.
Therefore, SNFs should prepare to accept such residents and institute the appropriate precautions to prevent spread of infection to HCP and other patients.

- ☐ Ensure all HCP are familiar with Standard and Transmission-based precautions.
- ☐ Verify all HCP are familiar with proper PPE donning and doffing procedures by demonstrating competency.

- ☐ Identify dedicated HCP to care for residents with COVID-19 and ensure they are N95 respirator fit- tested.
- ☐ Ensure the facility has an adequate supply of facemasks, N95 respirators, face shields orgoggles for eye protection, gowns and gloves; place supplies in all areas where patient care isprovided.
- ☐ Ensure the facility has adequate supply of alcohol-based hand rub and that it is easily accessible in every resident room (ideally both inside and outside the room and in otherresident care areas).

4) Prepare to Care for Residents with Suspected or Confirmed COVID-19 Infection

Most SNFs do not have airborne infection isolation rooms (AIIR) for placement of residents with COVID-19 infection.

- ☐ Place residents with suspected or confirmed COVID-19 infection in single occupancy rooms (or cohorted in multi-occupancy rooms with other residents with confirmed COVID-19 infection), with the door closed.
- ☐ Symptomatic residents and exposed roommates must limit movement outside their room; if they need to leave the room, they should wear a facemask.
- ☐ HCP dedicated to care for residents with suspected or confirmed COVID-19 infection should use an N95 respirator wherever available (if unavailable, a facemask), eye protection (face shield or goggles), gloves, and gown.
- ☐ Clean and disinfect high touch surfaces and shared resident care equipment with EPA-registered, healthcare-grade disinfectants. See the EPA Pesticide Registration List N: Disinfectants for Use Against SARS-CoV-2 (PDF) for list of products with label claims against COVID-19.

5) Prevent Spread of COVID-19 within your Facility

- ☐ Cohort residents with suspected or confirmed COVID-19 infection on the same unit, wing, or building.
- ☐ Use single-use equipment for residents with COVID-19 infection whenever possible; otherwise, dedicate re-useable medical equipment to residents with COVID-19 infection (e.g., thermometers, stethoscopes, etc.) and clean and disinfect between use.
- ☐ Minimize the number of HCP assigned to patient care activities for residents with COVID-19.
- ☐ Suspend large group activities and close communal dining areas.

Additional Resources:

- CDPH COVID-19 Guidance for California SNF webinar recording
- CDPH COVID-19 webpage
- CDC Preparing for COVID-19: Long-term Care Facilities, Nursing Homes
- CDC Nursing Homes and Assisted Living (Long-term Care Facilities [LTCFs]) Infection Prevention Training modules

2. Assessment of California Skilled Nursing Facilities to Receive Patients with Confirmed COVID-19 Infection

California is experiencing increasing numbers of COVID-19 cases and hospitalizations, and there is an urgent need to ensure hospital capacity to be able to meet the demand for patients with COVID-19 requiring acute care. Although COVID-19 infection can be severe and require inpatient care, some infections may not require care in an acute care facility. Hospitalized patients with COVID-19 infection may be medically stable for discharge prior to discontinuation of Transmission-based precautions. Skilled nursing facilities (SNF) can be expected to accept a resident diagnosed with COVID-19 and who is still requiring transmission-based precautions for COVID-19 as long as the facility can follow Centers for Disease Control and Prevention (CDC) infection prevention and control recommendations for the care of COVID-19 patients, including adequate supplies of personal protective equipment (PPE). Some SNF will be designated by state and/or local authorities as entirely or partially dedicated to care for residents with COVID-19 infection who either do not require acute care hospitalization or are medically stable for hospital discharge.

CDPH All Facilities Letter (AFL) 20-33 provides interim guidance for transfer of residents with suspected or confirmed COVID-19. Patients with confirmed or suspected COVID-19 should not be sent to a SNF via hospital discharge, inter-facility transfer, or readmission after hospitalization without first consulting the local health department (LHD). LHD may direct placement of the patient at a facility that has already cared for COVID-19 cases, or that has a specific unit designated to care for COVID-19 residents.

Considerations for public health evaluation of SNF infection prevention and control preparations to receive and care for residents with suspected or confirmed COVID-19 infection:

Space

- ✓ Review facility plans for a designated location (unit, wing, or building) to care for residents with confirmed COVID-19, separate from other residents.
    - Residents with confirmed COVID-19 infection may be placed in single occupancy rooms (or in multi-occupancy rooms with other residents with confirmed COVID-19 infection), with the door closed; symptomatic residents with suspected COVID-19 infection may remain in their room (if multi-occupancy room, with 6ft, or as far as possible, between beds and curtains closed) while testing is pending.
    - Facilities should develop plans for placement and monitoring of new admissions and readmissions with unknown COVID-19 status, such as single rooms or a separate observation unit, wing or building.
    - Most SNF do not have airborne infection isolation rooms (AIIR); if present, AIIR should be reserved for residents requiring aerosol-generating procedures. If the facility uses common shower room, residents in the COVID-19 cohort should have their own shower room or should receive in-room bed baths.
- ✓ Assess facility procedures for cleaning and disinfection of high touch surfaces and shared resident care equipment with EPA-registered, healthcare-grade disinfectants. See List N: Disinfectants for Use Against SARS-CoV-2 for list of products with label claims against COVID-19.
    - High-touch surfaces in resident rooms, staff break rooms and work areas should be frequently cleaned and disinfected (e.g., each shift).

Staff

- ✓ Review facility plans for dedicated healthcare personnel (HCP) to care for residents with suspected or confirmed COVID-19 infection. Dedicated HCP should not care for non-COVID-19 residents, if present in the facility, and should have a separate entrance, restroom and break room, if possible.
    - All HCP must be familiar with standard and transmission-based precautions and proper PPE donning and doffing procedures by demonstrating competency, and ensure they are N95 respirator fit-tested.
    - Dedicated HCP should use an N95 respirator wherever available (if unavailable, a facemask), eye protection (face shield or goggles), gloves, and gown while providing patient care.
    - Dedicated HCP should understand processes for extended use of facemasks and eye protection or prioritization of gowns for certain resident care activities; see the CDC's Strategies to Optimize the Supply of PPE and Equipment.
    - Dedicated HCP should perform cleaning/disinfection of high-touch surfaces etc. when in the room for resident care activities, to limit potential exposure of non-dedicated environmental services personnel.
    - All HCP should wear a facemask at all times while in the facility.
    - HCP must be instructed to not report to work if they are symptomatic with fever or respiratory symptoms. Ill HCP must report symptoms to their supervisor. HCP who develop signs and symptoms of a respiratory infection while at work must immediately stop work, put on a facemask (if not already wearing), alert their supervisor, leave the facility, and self-isolate at home.

- ✓ Review facility plans for maintaining adequate staffing, processes for obtaining staffing support if needed, and return to work policies for HCP with suspected or confirmed COVID-19 infection.

Supplies

- ✓ Assess the facility's current supply of personal protective equipment (PPE) and other critical materials (e.g., alcohol-based hand rub, EPA-registered disinfectants, tissues).
    - Record the number of full boxes of each type of PPE in stock, then use a burn rate calculator to estimate the remaining supply based on the average consumption rate. Determine how many days supply the facility has of the following PPE and alcohol-based hand rub (ABHR):
        - Facemasks:_____
        - N-95 or higher-level respirators:_____
        - Isolation gowns:_____
        - Eye protection:_____
        - Gloves:_____
        - ABHR:_____
    - ABHR must be easily accessible in every resident room (ideally both inside and outside the room and in other resident care areas), PPE supplies should be placed in all areas where patient care is provided, and trash cans accessible upon exiting resident rooms for appropriate doffing of PPE.
- ✓ Review facility's procedures for use of single-use equipment for residents with COVID-19 infection whenever possible; otherwise, dedicate re-useable medical equipment to residents with COVID-19 infection (for example, thermometers, stethoscopes, etc.) and clean and disinfect between use.

Strategies

- ✓ Review facility plans for preventing spread of COVID-19 within the facility
    - Symptomatic residents and exposed roommates must limit movement outside their room; if they need to leave the room, they should wear a facemask. Residents with cognitive deficits or psychiatric illness may need frequent reminders to stay in their room and supervision when leaving the room.
    - Suspend large group activities and close communal dining areas.
    - Restrict all nonessential visitors. Screen essential visitors for signs or symptoms of a respiratory infection (e.g., fever, cough, or sore throat) or contact with someone with suspected or confirmed COVID-19 infection. Limit visitor movement within the facility and avoid common areas.
    - Restrict nonessential HCP, for example, volunteers.
- ✓ Ensure facility has plans for facilitating remote communication between residents and family/visitors (for example, video-call applications on cell phones or tablets), and develop policies addressing when and how visitors might still be allowed to enter the facility (such as, end of life situations).
- ✓ Review facility processes for monitoring vital signs (including pulse oximetry) every shift for all residents and every 4 hours for residents with COVID-19 infection.
- ✓ Review facility processes for conducting surveillance to detect respiratory and other infections, including COVID-19.
    - Protocol for daily (or more frequent) monitoring for acute respiratory illness (fever, cough, shortness of breath) among all residents and HCP.
    - Track suspected and confirmed respiratory infections using a line list (PDF).
- ✓ Discuss facility procedures for notifying other facilities prior to transferring a resident with acute respiratory illness, including suspected or confirmed COVID-19 infection.

Resources for LHD:

- *CDPH surveyors are available to conduct site visits and provide LHD notification of whether a facility is ready.*
- *CDPH AFL 20-25.2 Preparing for Coronavirus Disease 2019 (COVID-19) in California Skilled Nursing Facilities*
- *CDC guidance for long-term care facilities preparing for COVID-19*

3. Detection and Management of COVID-19 Cases in Long Term Care Facilities

Ill residents in facility?

YES → **Resident with fever/respiratory illness identified**

NO

No residents with fever/respiratory illness in facility

- Actively monitor each resident daily for fever, cough, shortness of breath*
- If COVID-19 cases in community, conduct fever and respiratory symptoms screening of visitors and healthcare personnel

1 or more residents with fever/respiratory illness in facility

- Actively monitor each resident daily (or more frequently) for fever >100.4F, cough, shortness of breath*
- Isolate ill residents in their room; roommates (if any) can remain in the same room with 6ft (or as far as possible) between beds and curtains closed
- Limit movement of ill residents outside their room unless clinically necessary
- Cease communal/group activities
- Restrict nonessential visitors and contracted services
- Conduct fever and respiratory symptoms screening of essential visitors and healthcare personnel (HCP) upon start of their shift
- Consider use of facemasks by all HCP while in facility, if sufficient supplies
- Notify local health department (LHD); notify families/advocates and potentially exposed HCP
- Seek guidance for COVID-19 testing from LHD; also test for influenza for first 2-3 symptomatic residents
- If there are no new cases in facility and no community transmission x 14 days, consult with LHD about relaxing restrictions

Ill residents remain in facility while ill?

NO → If resident(s) are moved elsewhere or transported, continue above control and monitoring measures.

YES

When Ill residents remain in the facility during their illness

- Cohort all residents with suspected or confirmed COVID-19 on one wing/unit or floor, if possible
- Designate dedicated HCP to provide care to residents with suspected or confirmed COVID-19; dedicated HCP should not care for non-COVID-19 residents
- Group care tasks to limit frequent staff entrance to resident rooms and minimize numbers of exposed HCP
- HCP caring for COVID-19 residents should use recommended personal protective equipment (PPE) including N95 respirator (preferred) or facemask, faceshield or goggles, gown, gloves
- Consider expanding HCP use of recommended PPE for the care of all residents in the facility, and implement extended use and limited reuse strategies to conserve PPE supplies
- Monitor clinically stable residents twice daily for signs of worsening condition
- Continue isolation precautions and recommended PPE until:
  - 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 7 days have passed since symptoms first appeared.

If a resident's condition worsens and needs a higher level of care

- Notify family/advocate
- Arrange transport
- Keep in room
- Use recommended PPE

* Symptoms of COVID-19 might also include sore throat, nausea, vomiting, diarrhea, muscle aches, fatigue; elderly people might not develop fever.

4. Infection Control Guidance for Local Public Health Response to Congregate Living Facilities with Suspected or Confirmed COVID-19 Cases

Elderly persons and those with chronic medical conditions are at higher risk for severe illness and death from COVID-19. The California Department of Social Services Community Care Licensing Division PIN 20-07-ASC (PDF) provides guidance to Adult and Senior Care (ASC) licensees on prevention, containment, and mitigation measures for COVID-19 and for the implementation of a statewide waiver for certain licensing statutes and regulations.

Local public health department staff responding to suspected or confirmed cases of COVID-19 in assisted living or other congregate living facilities should ensure facilities:

1. **Implement protocols for screening and management of facility residents and staff.**

Residents:

- ✓ Implement a protocol for daily (or more frequent) monitoring of residents for acute respiratory illness (fever, cough, shortness of breath). (Fever is considered to be a temperature of **100.4°F/38°C or higher)**
- ✓ Ask independent residents to self-monitor for fever, cough, shortness of breath; provide instructions for residents who develop symptoms to stay home or in their room, limit contact with others, report their illness to the facility administrator. The facility should seek advice by telephone from a healthcare provider or their local health department to determine whether medical evaluation is needed.
- ✓ For residents who are not independent, depending on facility layout, designate one staff per floor or wing to conduct screening (including temperature measurement) wearing a facemask, goggles/face shield, and gloves; staff should change gloves and perform hand hygiene between residents.
- ✓ Notify the local public health department of new cases of respiratory illness with fever among residents and/or any clusters of respiratory illness in residents or staff.

Staff:

- ✓ Instruct staff not to report to work if they are symptomatic with fever or respiratory symptoms. Ill staff must report symptoms to their supervisor.
- ✓ Perform daily screening prior to start of shift for acute respiratory illness (fever, cough, shortness of breath) and keep a log.
- ✓ Instruct HCP who develop signs and symptoms of a respiratory infection while at work to immediately stop work, put on a facemask, alert their supervisor, leave the facility, and self-isolate at home.
- ✓ Educate HCP on basic infection control measures for respiratory infections, including hand hygiene, respiratory hygiene, and cough etiquette.
- ✓ Coordinate with local public health for testing of symptomatic staff.
- ✓ Staff exposed to COVID-19 positive residents can continue to work as long as they are asymptomatic and wearing a surgical mask for 14 days after the last exposure.

2. Encourage source control and social distancing.

- ✓ If there are cases of respiratory illness in the facility, cease all group activities. If there are no cases of respiratory illness in the facility, cease all communal/group activities that are unable to be conducted with 6-foot social distancing.
- ✓ Meals should be served to residents in their rooms, if possible. If this is not possible, meal service should maintain 6-foot social distancing and avoid shared utensils.

- ✓ Teach residents respiratory hygiene and cough etiquette
- ✓ Consider using a sitter or other dedicated staff to enforce social distancing for residents with mental health challenges or dementia.
- ✓ Identify all contracted services and restrict any non-essential contracted services (for example, barber); for essential contracted services, ensure contracted service employers educate and screen their employees.
- ✓ Limit nonessential visitors; ask residents to strongly encourage their family members and friends not to visit and discuss alternative methods of communication.

3. Provide safe placement of residents with acute respiratory illness or confirmed COVID-19.

- ✓ Isolate each resident with acute respiratory illness or confirmed COVID-19 in a private room with a closed door and private bathroom.
- ✓ Provide a facemask for symptomatic residents who must leave their room for essential services, such as dialysis.
- ✓ House all residents with suspected or confirmed COVID-19 on one wing/floor if possible; for group homes with two or more individuals in a room, keep persons with confirmed COVID-19 together.
- ✓ Designate staff members to provide care and assistance to residents with suspected or confirmed COVID-19; group care tasks to limit frequent staff entrance to resident rooms and minimize numbers of potentially exposed staff.

4. Ensure hand hygiene supplies are readily available and monitor hand hygiene adherence.

- ✓ Designate an area for staff to perform hand hygiene (handwashing with soap and water, or use of alcohol-based hand rub) upon facility entry.
- ✓ Ensure staff understand when and how to perform hand hygiene; consider monitoring adherence when new hand hygiene protocols differ from routine operations.
- ✓ Identify how staff will perform hand hygiene when going from room to room; consider use of hand wipes or towelettes if liquid/gel alcohol-based hand rub is not available.
- ✓ Place alcohol-based hand rub dispensers inside and outside the patient room; if not feasible, such as in memory care units, provide individual bottles of alcohol-based hand rub to staff.
- ✓ Consider scheduling hand hygiene at regular intervals during the day, such as every 2 hours, for residents.

5. Use recommended personal protective equipment (PPE).

- ✓ For providing direct care for residents with suspected or confirmed COVID-19, wear a respirator (if not available, facemask), face shield (if not available, goggles), gown, and gloves. If supply shortages, select PPE accordingly:
  - 1st preference: N95 respirator, face shield or goggles, gown, and gloves.
  - 2nd preference: any respirator (expired, non-medical, or not fit tested), face shield or goggles, gown, and gloves.
- ✓ 3rd preference: facemask, face shield or goggles, gown, gloves; place facemask on resident as possible. For interactions with residents who have respiratory symptoms (but not suspected or confirmed COVID-19): place a facemask on the resident and wear mask, face shield (if not available, goggles), gowns, gloves.
- ✓ Ensure staff understand to perform hand hygiene before donning PPE, and how to safely remove PPE to prevent self-contamination, removing PPE in the following order: gloves and gown inside the room, face shield or goggles and respirator/mask outside the room. Perform hand hygiene between each step.

- ✓ Assess PPE supply and utilize optimization strategies (CDC Strategies to Optimize the Supply of PPE and Equipment); request supplies through local Medical Health Operational Area Coordinator (MHOAC).
- ✓ If supply shortages, consider extended use of facemask/respirator (CDC Strategies for Optimizing the Supply of N95 Respirators) and eye protection when the caregiver goes from room to room of residents with respiratory illness, changing gloves, and gown after each resident and performing hand hygiene before donning new gloves.

6. Clean and Disinfect the Environment

Continue to use routine practices for handling waste and linen; non-disposable dishes and silverware may be used and washed according to routine procedures.

- ✓ Clean and disinfect frequently touched surfaces in resident rooms, staff areas and public areas at least daily.
- ✓ Increase frequency of cleaning and disinfection for shared bathrooms.
- ✓ Use hospital-grade EPA-approved cleaning/disinfectant product effective against coronavirus (CDC List N) or with emerging viral pathogens claim.
- ✓ Follow wet contact time on the disinfectant label and other manufacturer instructions for use.
- ✓ Dedicate medical equipment/devices (such as stethoscopes, thermometers, blood pressure cuffs) to the resident's room; any shared patient care equipment/device must be properly cleaned and disinfected between patients.

7. Prepare to receive residents discharged from a hospital

- ✓ When residents who likely acquired COVID-19 while in your facility are discharged from the hospital, consult with local public health regarding the return of these patients to your facility.
- ✓ When determining whether to admit a new resident with COVID-19 from a hospital: If your facility has not housed other positive COVID-19 residents, identify if alternate care site is available; if no alternative site is available, consult with local public health to determine if your facility should accept the resident.

5. Inter-facility Infection Control Transfer Form

This form must be filled out for transfer to accepting facility with information communicated prior to or with transfer.

Please attach copies of latest culture reports with susceptibilities if available.

Sending Healthcare Facility:

Patient/Resident Last Name	First Name	Date of Birth	Medical Record Number

Name/Address of Sending Facility	Sending Unit	Sending Facility Phone

Sending Facility Contacts	Contact Name	Phone	E-mail
Transferring RN/Unit			
Transferring physician			
Case Manager/Admin/SW			
Infection Preventionist			

Does the person* currently have an infection, colonization OR a history of positive culture of a multidrug-resistant organism (MDRO) or other potentially transmissible infectious organism?	Colonization or history (*Check if YES*)	Active infection on Treatment (*Check if YES*)
Methicillin-resistant *Staphylococcus aureus* (MRSA)	☐ Yes	☐ Yes
Vancomycin-resistant *Enterococcus* (VRE)	☐ Yes	☐ Yes
Clostridioides difficile	☐ Yes	☐ Yes
Acinetobacter, multidrug-resistant	☐ Yes	☐ Yes
Enterobacteriaceae (e.g., *E. coli, Klebsiella, Proteus*) producing-Extended Spectrum Beta-Lactamase (ESBL)	☐ Yes	☐ Yes
Carbapenem-resistant Enterobacteriaceae (CRE)	☐ Yes	☐ Yes
Pseudomonas aeruginosa, multidrug-resistant	☐ Yes	☐ Yes
Candida auris	☐ Yes	☐ Yes
Other, specify (e.g., lice, scabies, norovirus, influenza):	☐ Yes	☐ Yes

Does the person* currently have any of the following? (Check here ☐ if none apply)

- ☐ Cough or requires suctioning
- ☐ Diarrhea
- ☐ Vomiting
- ☐ Incontinent of urine or stool
- ☐ Open wounds or wounds requiring dressing change
- ☐ Drainage (source):
- ☐ Central line/PICC (Approx. date inserted)
- ☐ Hemodialysis catheter
- ☐ Urinary catheter (Approx. date inserted)
- ☐ Suprapubic catheter
- ☐ Percutaneous gastrostomy tube
- ☐ Tracheostomy

Inter-facility Infection Control Transfer Form

Is the person* currently in Transmission-Based Precautions? NO YES

Type of Precautions (check all that apply) Contact Droplet Airborne

Other:

Reason for Precautions:

Is the person* currently on antibiotics? **NO** **YES (current use)**

Antibiotic, dose, route, freq.	Treatment for:	Start date	Anticipated stop date	Date/time last dose

Vaccine	Date administered (If known)	Lot and Brand (If known)	Year administered (If exact date not known)	Does the person* self-report receiving vaccine?
Influenza (seasonal)				Yes No
Pneumococcal (PPSV23)				Yes No
Pneumococcal (PCV13)				Yes No
Other:				Yes No

*Refers to patient or resident depending on transferring facility

Name of staff completing form (print):

Signature: **Date :**

If information communicated prior to transfer:

Name of individual at receiving facility:

Phone of individual at receiving facility:

SAVE PRINT

Title 17, California Code of Regulations (CCR) §2500, §2593, §2641.5-2643.20, and §2800-2812 requires that healthcare providers report known or suspected cases of disease or conditions, listed below, to the jurisdiction in which the patient resides

REPORT IMMEDIATELY BY PHONE
During business hours 209-558-5678 After Hours 209-664-6032

- Anthrax, human or animal
- Botulism (Foodborne, Infant, Wound, Other)
- Brucellosis, human
- Cholera
- Ciguatera Fish Poisoning
- Coronavirus 2019 (COVID-19)
- Diphtheria
- Domoic Acid Poisoning (Amnesic Shellfish Poisoning)
- Flavivirus Infection of undetermined species
- Hemolytic Uremic Syndrome
- Influenza due to Novel Strains (human)
- Measles (Rubeola)
- Meningococcal Infections
- Middle East Respiratory Syndrome (MERS)
- Novel Coronavirus Infection
- Novel Virus with Pandemic Potential
- Paralytic Shellfish Poisoning
- Plague, human or animal
- Rabies, human or animal
- Scombroid Fish Poisoning
- Shiga toxin (detected in feces)
- Smallpox (Variola)
- Tularemia, human
- Viral Hemorrhagic Fevers, human or animal (Crimean-Congo, Ebola, Lassa and Marburg Viruses)
- Occurrence of ANY Unusual Disease
- Outbreak of ANY disease (including diseases not listed in §2500)

REPORT WITHIN ONE WORKING DAY
BY PHONE, FAX, MAIL or CalREDIE
BY PHONE: 209-558-5678 BY FAX:209-558-7531

- Babesiosis
- Campylobacteriosis
- Chickenpox (Varicella) (outbreaks, hospitalizations and deaths)
- Chikungunya Virus Infection
- Cryptosporidiosis
- Dengue Virus Infection
- Encephalitis, specify etiology (viral, bacterial, fungal, parasitic)
- *Escherichia coli:* Shiga Toxin producing E. Coli (STEC) including *E. coli* 0157
- Foodborne Disease
- *Haemophilus influenzae*, invasive disease (only in persons less than 5 years of age)
- Hantavirus Infections
- Hepatitis A, acute infection
- Listeriosis
- Malaria
- Meningitis, specify etiology (viral, bacterial, fungal, parasitic)
- Paratyphoid Fever
- Pertussis (Whooping Cough)
- Poliovirus Infection
- Psittacosis
- Q Fever
- Relapsing Fever
- Salmonellosis (other than Typhoid Fever)
- Shigellosis
- Syphilis (all stages, including congenital)
- Trichinosis
- Tuberculosis (TB)
- Typhoid Fever, cases and carriers
- Vibrio Infections
- West Nile Virus (WNV) Infections
- Yellow Fever
- Yersiniosis
- Zika Virus Infection

REPORT BY PHONE, FAX, MAIL or CalREDIE WITHIN 7 CALENDAR DAYS
BY PHONE: 209-558-5678 BY FAX: 209-558-7531

- Anaplasmosis
- Brucellosis, animal (except *Brucella canis)*
- Chancroid
- Coccidioidomycosis
- Creutzfeldt-Jakob Disease (CJD) and other Transmissible Spongiform Encephalopathies (TSE)
- Cyclosporiasis
- Cysticercosis or Taeniasis
- Ehrlichiosis
- Giardiasis
- Gonococcal Infections
- Hepatitis B (specify acute, chronic, or Perinatal)
- Hepatitis C (specify acute, chronic or perinatal)
- Hepatitis D (Delta) (specify acute or chronic)
- Hepatitis E, acute infection
- Human Immunodeficiency Virus (HIV) infection, any stage including progression to stage 3 (AIDS)
- Influenza-associated deaths in laboratory-confirmed cases less than 18 years of age
- Legionellosis
- Leprosy (Hansen Disease)
- Leptospirosis
- Lyme Disease
- Mumps
- Respiratory Syncytial Virus (RSV)-associated deaths in laboratory confirmed cases less than five years of age
- Rickettsial Disease (non-Rocky Mountain Spotted Fever), including Typhus and Typhus-Like Illnesses
- Rocky Mountain Spotted Fever
- Rubella (German Measles)
- Rubella Syndrome, Congenital
- Tetanus
- Tularemia, animal

REPORT BY PHONE, TRACEABLE MAIL OR ELECTRONICALLY WITHIN 7 CALENDAR DAYS 209-558-8052
(see detailed reporting requirements below)

- Human Immunodeficiency Virus (HIV), acute infection
- Human Immunodeficiency Virus (HIV) infection, any stage, including progression to stage 3 (AIDS)

HIV REPORTING BY HEALTH CARE PROVIDERS §2641.30-2643.20 Human Immunodeficiency Virus (HIV) infection at all stages is reportable by traceable mail, person- to-person transfer, or electronically within seven calendar days. For complete HIV-specific reporting requirements, see Title 17, CCR, §2641.30-2643.20 and the California Department of Public Health's HIV Surveillance and Case Reporting Resource page

REPORTABLE NON-COMMUNICABLE DISEASE AND CONDITIONS §2800-2812 AND §2593 (B)

- Animal Bites
- Disorders Characterized by Lapses of Consciousness (§2800-2801)
- Pesticide-Related Illness or Injury (known or suspected cases)

CalREDIE California Reportable Disease Information Exchange

CDPH California Department of Public Health

For access to CalREDIE reporting, complete the account request form. Return via fax to (209)558-7531

Reporter/Provider Account Request Form

Links to CMR reporting forms can be found here:

* Confidential Morbidity Report for all conditions EXCEPT TB and conditions reportable to DMV
* Confidential Morbidity Report form for TB
* Confidential Morbidity Report form for conditions reportable to DMV
* Adult HIV-AIDS Confidential Case Report

***** The Confidential Morbidity Report (CMR) is designed for health care providers to report those diseases mandated by Title 17, California Code of Regulations (CCR). Failure to report is a misdemeanor (Health & Safety Code §120295) and is a citable offense under the Medical Board of California Citation and Fine Program (Title 16, CCR, §1364.10 and 1364.11).

****** Failure to report is a citable offense and subject to civil penalty ($250) (Health and Safety Code §105200).

******* The Confidential Physician Cancer Reporting Form may also be used.

See Physician Reporting Requirements for Cancer Reporting in CA at:

Revised 03/13/2020

Stanislaus County HEALTH SERVICES AGENCY

CALIFORNIA CANCER REGISTRY

Stanislaus County HSA
Public Health Division
Attn: Morbidity
820 Scenic Drive
Modesto, Ca 95350

CONFIDENTIAL MORBIDITY REPORT

PLEASE NOTE: Only use this form for reporting COVID-19. Report to Stanislaus County Public Health within one working day.

DISEASE BEING REPORTED: COVID-19 **Please write all dates as (mm/dd/yyyy)**

Patient Name - Last Name | ***First Name*** | ***MI***

Home Address: Number, Street | ***Apt./Unit No.***

City | ***State*** | ***ZIP Code***

Home Telephone Number | ***Cell Telephone Number*** | ***Work Telephone Number***

Email Address | ***Primary Language*** ☐ English ☐ Spanish ☐ Other: _____

Birth Date *(mm/dd/yyyy)* | ***Age*** ☐ Years ☐ Months ☐ Days | ***Gender*** ☐ Male ☐ Female ☐ M to F Transgender ☐ F to M Transgender ☐ Other: _____

Pregnant? ☐ Yes ☐ No ☐ Unknown

If yes, Estimated Delivery Date (mm/dd/yyyy):

Country of Birth

Occupation or Job Title:

☐ *Health Care Worker (check if yes)*

☐ *In Health Care Setting (check if yes)*

Close contact with a laboratory confirmed COVID-19 case?
☐ Yes ☐ No ☐ Unknown
☐ Household contact ☐ Community contact
☐ Healthcare setting contact ☐ Non-healthcare workplace

Housing Status
☐ *Stably Housed*
☐ *Unstably housed*
☐ *Unknown*

_____ ***Date of Diagnosis***

_____ ***Date of Death*** *(if applies)*

Ethnicity (check one)
☐ Hispanic/Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Race (check all that apply)
☐ African-American/Black
☐ American Indian/Alaska Native
☐ Asian *(check all that apply)*
☐ Asian Indian ☐ Hmong ☐ Thai
☐ Cambodian ☐ Japanese ☐ Vietnamese
☐ Chinese ☐ Korean ☐ Other *(specify)*: _____
☐ Filipino ☐ Laotian
☐ Pacific Islander *(check all that apply)*
☐ Native Hawaiian ☐ Samoan
☐ Guamanian ☐ Other *(specify)*: _____
☐ White
☐ Other *(specify)*: _____ ☐ Unknown

Congregate Setting *(check if applies)* ☐ Staff ☐ Resident ☐ Unknown
☐ Assisted Living Facility ☐ Skilled Nursing Facility ☐ Shelter
☐ Correctional Facility ☐ Hospital-Based Facility
☐ Other _____

Name and City of Congregate Setting (s), if applies:

Reporting Health Care Provider | ***Reporting Health Care Facility***

Address: Number, Street | ***Suite/Unit No.***

City | ***State*** | ***ZIP Code***

Telephone Number | ***Fax Number***

Email Address: | ***Date Submitted***

REPORT TO:

(Obtain additional forms from your local health department.)

Laboratory Name | ***City*** | ***State*** | ***ZIP Code***

COVID-19: Hospitalization Status and Diagnostic Testing

Status at Time of Report
☐ Hospitalized, ICU
☐ Intubated
☐ Not Intubated
☐ Hospitalized, non-ICU
☐ Not Hospitalized

Complete dates where applies
_____ Date Hospitalized (if ever hospitalized)
_____ Date Discharged (if previously hospitalized)
_____ Date Intubated (if ever intubated)

Status History

Ever Hospitalized?	☐ Yes	☐ No
Ever in ICU?	☐ Yes	☐ No
Ever Intubated?	☐ Yes	☐ No
Ever Placed on ECMO?	☐ Yes	☐ No

Respiratory Complications

Clinical or Radiologic Evidence of Pneumonia *(check all that apply)*	***Clinical or Radiologic Evidence of ARDS*** *(check all that apply)*
☐ None	☐ None
☐ Clinical	☐ Clinical
☐ Radiologic	☐ Radiologic

Imaging performed *(check all that apply)*
☐ *Chest X-Ray* _____ *Date Performed*
☐ *Chest CT Scan* _____ *Date Performed*
☐ *Other Chest Imaging Study* _____ *Date Performed*

COVID-19 Testing (Complete all that apply)

☐ **Nasopharyngeal PCR swab**
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
_____ Date Collected _____ Date Resulted

☐ **Oropharyngeal PCR Swab**
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
_____ Date Collected _____ Date Resulted

☐ **Serology** **Test Name** _____
FDA/EUA approved ☐ Yes ☐ No ☐ Unknown
☐ IgM only ☐ IgG only ☐ IgM/IgG ☐ Unknown
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
_____ Date Collected _____ Date Resulted

☐ **Other** _____
Result: ☐ Positive ☐ Negative ☐ Indeterminate ☐ Pending
_____ Date Collected _____ Date Resulted

Clinical Information

COVID-19 Symptoms (Check all that apply)

☐ None	☐ Fever >100.4F, 38C	☐ Subjective fever
☐ Cough	☐ Sore throat	☐ Runny nose (Rhinorrhea)
☐ Shortness of breath	☐ Difficulty breathing	☐ Chills
☐ Rigors	☐ Headache	☐ Muscle aches (myalgias)
☐ Loss of smell	☐ Loss of taste	
☐ Nausea	☐ Abdominal pain	☐ Vomiting
☐ Other *(specify)*: _____		☐ Diarrhea

Date of first symptom onset _____

Travel to COVID-19 impacted area within 14 days of symptom onset?
☐ Yes ☐ No ☐ Unknown *If yes, destination(s):* _____

Other diagnosis or etiology for respiratory condition?
☐ Yes *(specify)*: _____ ☐ No

Chronic Conditions (Check all that apply)

☐ None	☐ Unknown	☐ Diabetes
☐ Cardiovascular disease	☐ Hypertension	☐ Chronic lung disease
☐ Chronic kidney disease	☐ Chronic liver diease	☐ Immuno-compromised
☐ Asthma	☐ Neurological/neuro-developments	☐ Cancer
☐ Obesity	☐ Current smoker	☐ Stroke

☐ Other *(specify)*: _____

COVID-19 Specific Treatment (s)

Drug, Dosage, Route	Date Initiated
_____	_____
_____	_____

For more information, please contact Stanislaus County Public Health at **(209) 558-5678**

CERTIFIED CLEANING/DECONTAMINATION SERVICES

ACT - Advanced Chemical Transport Enviro
265 Riggs Ave., Merced, CA, 95341
Phone: 209-722-4228
Phone: 209-628-8032
Web: actenviro.com
Contact: Bruce Wescott, Henry DeSousa
Email: cvcsr@actenviro.com

Coit Cleaning and Restoration
4210 Kiernan Ave.
Modesto, Ca 95356
209-353-8012
Email: info@coit.com

Clean Harbors
1745 Cebrian St., , W. Sacramento, CA, 95691
Phone: 916-520-3620
Phone: 707-410-8242
Web: cleanharbors.com
Contact: Scott Murtishaw
Email: Murtishaw.Scott@cleanharbors.com

Parc Environmental
2864 E. Dorothy Ave., Fresno, CA 95838
Primary Phone: 559-233-7216
Alternate Phone:
Hotline: 800-955-7761
Fax: 559-233-4284
Web: parcenvironmental.com
Contact: Jeff Davis
Email: info@parcenvironmental.com

Patriot Environmental Services
3318 Howard Ave., McClellen, CA, 95652
Primary Phone: 916-256-4914
Alternate Phone: 916-317-0144
Hotline: 800-624-9136
Fax:
Web: patriotenvironmental.com
Contact: Joe McGuffin, Steve Nigro
Email: jmcguffinpatriotenvironmental.com; snigro@patriotenvironmental.com

Stericycle
11855 White Rock Rd., Rancho Cordova, CA, 95742
Phone: 844-667-5780
Phone: 707-748-3040
Web: stericycle.com
Email: customercare@stericycle.com

Stanislaus County Resource Request Procedure

In order to process resource request for your facility you will need to complete these two documents to submit to the Medical Health Operational Area Coordinator (MHOAC). This is the process for medical health mutual aid in the State of CA. Please read all the directions before filling out the form

Documentation directions

- ICS 213 focus on sections 1,2,4,5,6.
- COVID-19 questionnaire, focus on date, facility, Type of PPE in the shaded fields. All questions in white fields. One questionnaire for each line item requested.

Required fields 213:

Section 1: COVID19 Response

Section 2: Date Submitted

Section 4: Qty please indicate ea. (each) or cs (case) If no quantity or "any" is listed it will be returned.

Section 4: Kind-mask, gown, etc.

Section 4: Detailed description, P/N is fine with the understanding we may have no choice, but it helps when there are options

Section 5: Facility name, address, POC and phone number of the delivery location to coordinate with logistics for delivery

Section 6: Please add to every order "Expired resources are acceptable as are substitutes", a State request

Any missing or incorrect fields will be returned to requestor for correction. This will delay the order. They will then be reviewed, all documentation must be provided or the request will not be processed pending complete documentation. Once reviewed the order will be forwarded to Logistics for allocation and fulfillment. Based on scarcity of resources there is no guaranty of 100% fulfillment. Once an order is shipped it is considered complete; there are no backorders at this time. Hand sanitizer is considered a medical/health resource.

When completed please submit to: MHOAC@stanoes.com
cc request to: EOCLogistics@stanoes.com

Please keep in mind, PPE and supplies are scarce. The process is to try to fill locally and if unable to fill, push the request to the Region and then to State and finally to Feds. Lead times can be up to 2 weeks if the order must go to the State as an example.

Logistics will contact the point of contact (POC) from the 213 at the phone number listed to arrange delivery.

FILL OUT YELLOW HIGHLIGHTED AREAS. EXPECT TWO WEEK LEAD TIME WITH NO GUARANTEE THAT REQUEST CAN BE FILLED. IF FILLED, FACILITY WILL BE REQUIRED TO PICK UP FROM COUNTY WAREHOUSE LOCATION (TO BE PROVIDED). SUBMIT COMPLETED FORM TO: MHOAC@stanoes.com and cc: EOCLogistics@stanoes.com

RESOURCE REQUEST MESSAGE (ICS 213 RR)

1. Incident Name:	2. Date/Time	3. Resource Request Number:

Requestor

4. Order (Use additional forms when requesting different resource sources of supply.):

Qty.	Kind	Type	Detailed Item Description: (Vital characteristics, brand, specs, experience, size, etc.)	Arrival Date and Time		Cost
				Requested	Estimated	

5. Requested Delivery/Reporting Location:

6. Suitable Substitutes and/or Suggested Sources:

7. Requested by Name/Position:	8. Priority: ☐ Urgent ☐ Routine ☐ Low	9. Section Chief Approval:

Logistics

10. Logistics Order Number:	11. Supplier Phone/Fax/Email:
12. Name of Supplier/POC:	
13. Notes:	
14. Approval Signature of Auth Logistics Rep:	15. Date/Time:

16. Order placed by (check box): ☐ SPUL ☐ PROC

Finance

17. Reply/Comments from Finance:	
18. Finance Section Signature:	19. Date/Time:

Region IV COVID-19 Response –questionnaire for distribution of PPE based on priority of needs:

SUBMITTOR: Please submit answers to the questions below for any entities submitting requests for PPE in your operational area (OA). **MUST Complete one (1) of these questionnaires for each type of PPE being requested.**
MHOAC: Please submit one Med-Health Resource Request (RR) form for your OA (https://www.cdph.ca.gov/Programs/EPO/Pages/Resource_Publications.aspx) accompanied by the completed questionnaires.

Date:	**Facility/Agency:**	**County/Requesting OA:**	**Completed by:**
Type of PPE being requested (N95s, procedure masks, isolation gowns, etc):			

Question from MAC Guidance	**Directions to Respondent**	**Answer:**
Will alternate style, or expired PPE (in accordance with Cal-OSHA guidance) be accepted:	Yes/No	
Current stock on-hand	Total # (individual count, not boxes or cases)	
Estimated 2-week burn rate	Total # per 2-weeks	
What use is the PPE needed for:		
Screening of respiratory patients	Yes/No	
Routine Healthcare Isolation Procedures (non-COVID-19)	Yes/No	
Contact with quarantined, high-risk individuals	# of individuals at this time	
Contact with PUIs (patients awaiting test results)	# of individuals at this time	
Contact with COVID-19 positive cases	# of individuals at this time	
Other	Describe use	

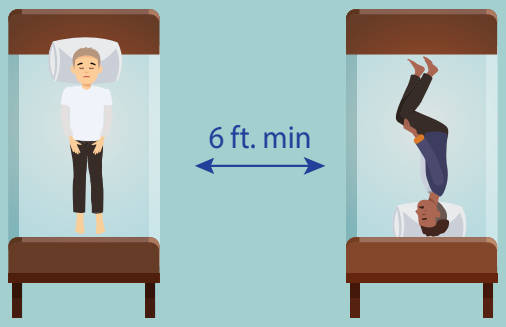
SOCIAL DISTANCING AND BED POSITION FOR RESIDENTIAL AND CONGREGATE SETTINGS

Social Distancing involves establishing ways to increase physical distance between individuals in settings where people commonly come into close contact with one another. Due to close proximity of staff and residents, residential and congregate settings can be vulnerable to the spread of COVID-19.

To ensure the safety of patients in residential and congregate settings and reduce the spread of COVID-19 transmission, below are instructions for bed positioning on all open sides of bed.

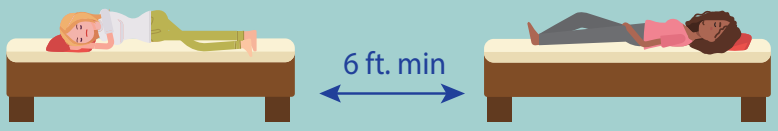
For single beds positioned next to each other (side-to side):

- At least 6 feet apart AND patient's laying position is head to toe



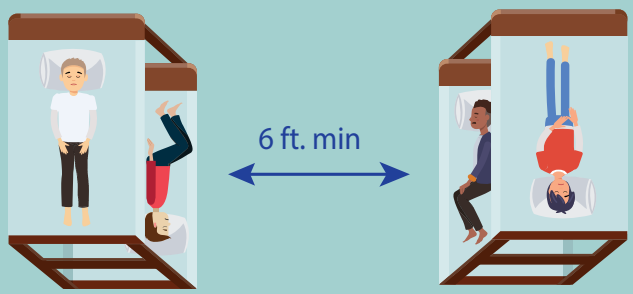
For beds positioned across from one another (end-to-end)

- Feet of beds are at least 6 feet apart AND patient's laying position is toe to toe.



For bunkbeds that are positioned next to each other or across from one another:

- Position beds at least 6 feet apart.
- Ensure the patient's laying position is head to toe **on each separate bunk bed**, so positioning allows for the least transmission risk as possible. This includes laying position that is head to toe with adjacent bunks.

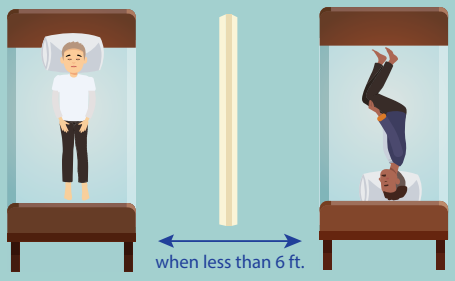


Stanislaus County HEALTH SERVICES AGENCY
County of Los Angeles Public Health

Placement When Positioning Beds 6 feet or more is **NOT** Possible:

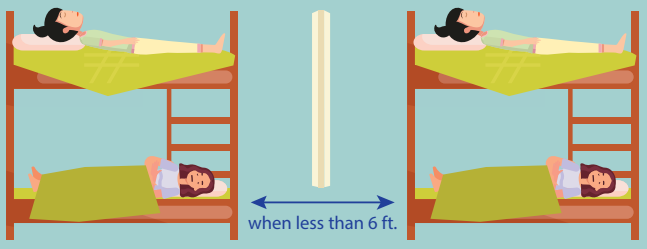
For single beds:

- Position beds at least 3 feet apart.
- Consider placing partitions (e.g., nailing string from wall-to-wall and hanging sheets or blanket, using dressers or cardboard boxes as a barrier, etc) between beds.
- Ensure patient's laying position is head to toe.



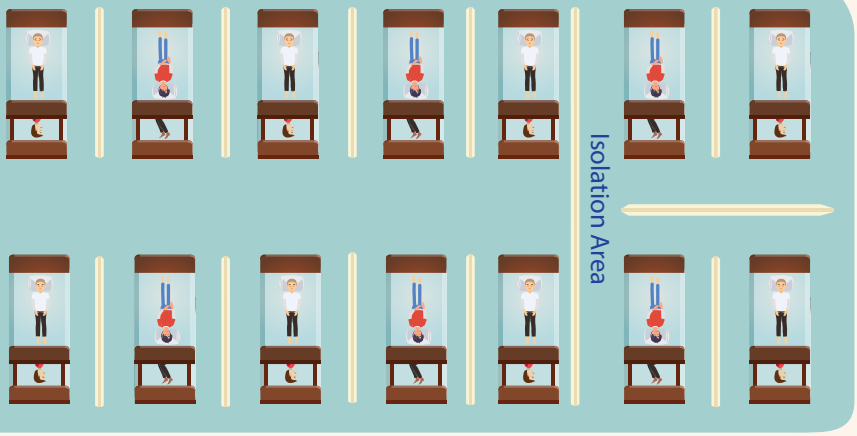
For bunkbeds:

- Position beds at least 3 feet apart.
- Consider placing partitions (e.g., nailing string from wall-to-wall and hanging sheets or blanket, using dressers or cardboard boxes as a barrier, etc) between beds.
- Ensure the patient's laying position is head to toe on **each separate bunk bed**, including positioned head to toe on adjacent bunks.



For rooms with more than 10 beds:

- Include partitions to separate beds to the fullest extent possible.



IMPORTANT!

If patient has been diagnosed with or shows symptoms of COVID-19 (e.g., fever, cough, shortness of breath), follow specific guidance available on DPH coronavirus website to appropriately isolate individuals and prevent intermingling with non-symptomatic individuals. This includes having clear signs indicating when people are entering and leaving isolation areas, requiring that symptomatic individuals wear surgical masks when leaving isolation areas, having separate bathrooms and meal areas, maximally separating or partitioning sleeping and common areas, and taking appropriate cleaning and disinfecting precautions.

Stanislaus County HEALTH SERVICES AGENCY
County of Los Angeles Public Health

Quarantine vs Isolation

	Quarantine		Isolation
Symptoms	**No symptoms** • Residents who have been exposed but have no symptoms.		**COVID-19 symptoms** • fever, cough, shortness of breath, etc.
Separation Details	**Clients** ● In residential or congregate settings, clients who require quarantine should be separated from others for 14 days. ● In nonresidential or non-congregate settings, clients should be sent home with QUARANTINE instructions and offered telehealth or telephone services, as available.	**Staff** ● Home QUARANTINE for 14 days. ● For critical shortages of essential workers, non-symptomatic staff may work with a mask during 14-day quarantine period **AND** self-monitor for fever and symptoms every 12 hours (including while at work).	**Clients** ● In residential or congregate settings, clients should be separated from those who have no symptoms or exposure until at least 10 days AND no fever for at least 3 days (72 hours) after recovery, defined as: - No fever without the use of fever-reducing medications; AND - Improvement in respiratory symptoms; AND - At least 10 days have passed since symptoms first appeared. ● In nonresidential or non-congregate settings, clients should be sent home with ISOLATION instructions and offered telehealth or telephone services, as available.	**Staff** ● Home ISOLATION for at least 10 days AND no fever for at least 3 days (72 hours) after recovery, defined as: - No fever without the use of fever-reducing medications; AND - Improvement in respiratory symptoms; AND - At least 10 days have passed since symptoms first appeared.

Cohorting in Residential/Congregate Settings

*Cohorting describes the practice of grouping individuals together who have similar characteristics or levels of risk. Symptomatic/sick people can and should be cohorted with other symptomatic/sick people. People who are not sick and non-symptomatic but have been exposed to or in close contact with symptomatic/sick person(s) should be also be cohorted with other exposed but non-symptomatic. This protects others from getting sick in case the exposed person develops symptoms. Cohorting reduces transmission risks.

Separated Residents
(confirmed COVID-19 lab tested (+), COVID-19 symptoms, and exposed residents)

MINIMUM separation procedure

Non-Separated Residents
(not symptomatic and not exposed)

Symptomatic
(COVID-19 lab tested (+) and symptomatic residents)

Exposed
(exposed residents without symptoms)

GOOD separation procedure

General Population

High Risk
(> age 65, chronic medical conditions, pregnancy)

Symptomatic and COVID-19 lab tested (+)

Symptomatic and Not Tested

Exposed
(exposed residents without symptoms)

BEST PRACTICE separation procedure

Stanislaus County HEALTH SERVICES AGENCY
County of Los Angeles Public Health

Filtering out Confusion:
Frequently Asked Questions about Respiratory Protection

User Seal Check

Over 3 million United States employees in approximately 1.3 million workplaces are required to wear respiratory protection. The Occupational Safety and Health Administration (OSHA) (29 CFR 1910.134) requires an annual fit test to confirm the fit of any respirator that forms a tight seal on the wearer's face before it is used in the workplace.1 Once a fit test has been done to determine the best respirator model and size for a particular user, **a user seal check** should be done every time the respirator is to be worn to ensure an adequate seal is achieved.

What is a User Seal Check?

A user seal check is a procedure conducted by the respirator wearer to determine if the respirator is being proper-ly worn. The user seal check can either be a positive pressure or negative pressure check.

During a **positive pressure user seal check**, the respirator user **exhales** gently while blocking the paths for air to exit the facepiece. A successful check is when the facepiece is slightly pressurized before increased pressure causes outward leakage.

During a **negative pressure user seal check**, the respirator user **inhales** sharply while blocking the paths for air to enter the facepiece. A successful check is when the facepiece collapses slightly under the negative pressure that is created with this procedure.

A user seal check is sometimes referred to as a fit check. A user seal check should be completed each time the respirator is donned (put on). It is only applicable when a respirator has already been successfully fit tested on the individual.

How do I do a User Seal Check while Wearing a Filtering Facepiece Respirator?

Not every respirator can be checked using both positive and negative pressure. Refer to the manufacturer's in-structions for conducting user seal checks on any specific respirator. This information can be found on the box or individual respirator packaging.

The following positive and negative user seal check procedures for filtering facepiece respirators are provided as examples of how to perform these procedures.

Centers for Disease Control and Prevention
National Institute for Occupational Safety and Health

Stanislaus County HEALTH SERVICES AGENCY

How to do a positive pressure user seal check

Once the particulate respirator is properly donned, place your hands over the facepiece, covering as much surface area as possible. Exhale gently into the facepiece. The face fit is considered satisfactory if a slight positive pressure is being built up inside the facepiece without any evidence of outward leakage of air at the seal. Examples of such evidence would be the feeling of air movement on your face along the seal of the facepiece, fogging of your glass-es, or a lack of pressure being built up inside the facepiece.

If the particulate respirator has an exhalation valve, then performing a positive pressure check may be impossible. In such cases, a negative pressure check should be performed.

How to do a negative pressure user seal check

Negative pressure seal checks are typically conducted on particulate respirators that have exhalation valves. To conduct a negative pressure user seal check, cover the filter surface with your hands as much as pos-sible and then inhale. The facepiece should collapse on your face and you should not feel air passing between your face and the facepiece.

In the case of either type of seal check, if air leaks around the nose, use both hands to readjust the nosepiece by placing your fingertips at the top of the metal nose clip. Slide your fingertips down both sides of the metal strip to more efficiently mold the nose area to the shape of your nose. Readjust the straps along the sides of your head until a proper seal is achieved.2

If you cannot achieve a proper seal due to air leakage, you may need to be fit tested for a different respirator model or size.

Can a user seal check be considered a substitute for a fit testing?

No. The user seal check does not have the sensitivity and specificity to replace either fit test methods, qualitative or quantitative, that are accepted by OSHA (29 CFR 1910.134). A user should only wear respirator models with which they have achieved a successful fit test within the last year. NIOSH data suggests that the added care from performing a user seal check leads to higher quality donnings (e.g., reduces the chances of a donning with a poor fit).3

Where can I Find More Information?

This information and more is available on the NIOSH Respirator Trusted-Source webpage.

References
1. OSHA [1998]. Respiratory Protection. 29 CFR 1910.134. Final rule. Fed Regist *63*:1152-1300.
2. NIOSH [2010]. How to properly put on and take off a disposable respirator. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Insitute for Occupational Safety and Health, DHHS (NIOSH) Publication No. 2010-133 https://www.cdc.gov/niosh/docs/2010-133/pdfs/2010-133.pdf
3. Viscusi DJ, Bergman MS, Zhuang Z, and Shaffer RE [2012]. Evaluation of the benefits of the user seal check on N95 filtering facepiece respirator fit. J Occup and Evironl Hyg. *9*(6):408-416.
Photos courtesy of NIOSH

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DHHS (NIOSH) Publication No. 2018-130

To receive NIOSH documents or more information about occupational safety and health topics, please contact NIOSH:
Telephone: 1–800–CDC–INFO (1–800–232–4636) TTY: 1–888–232–6348 CDC INFO: www.cdc.gov/info or visit the NIOSH Web site at www.cdc.gov/NIOSH.
For a monthly update on news at NIOSH, subscribe to NIOSH eNews by visiting www.cdc.gov/niosh/eNews.

Coping with a Disaster or Traumatic Event

After a disaster, it is important to take care of your emotional health. Pay attention to how you and your family members are feeling and acting.

Taking care of your emotional health will help you think clearly and react to urgent needs to protect yourself and your loved ones.

Follow these tips to help you and your family recover or find support.

Steps to Care for Yourself

- Take Care of Your Body
  - » Try to eat healthy, exercise regularly, get plenty of sleep, and avoid alcohol and other drugs.
- Connect
  - » Share your feelings with a friend or family member. Maintain relationships and rely on your support system.
- Take Breaks
  - » Make time to unwind. Try to return to activities that you enjoy.
- Stay Informed
  - » Watch for news updates from reliable officials.
- Avoid
  - » Avoid excessive exposure to media coverage of the event.
- Ask for Help
  - » Talk to a clergy member, counselor, or doctor or contact the SAMHSA helpline helpline at 1-800-985-5990 or text TalkWithUs to 66746.

How to Help Your Children

- Talk with them.
  - » Share age-appropriate information.
  - » Reassure them.
  - » Address rumors.
  - » Answer questions.
- Set a good example by taking care of yourself.
- Limit exposure to media and social media coverage of the event.

Common Signs of Distress

- Feelings of shock, numbness, or disbelief
- Change in energy or activity levels
- Difficulty concentrating
- Changes in appetite
- Sleeping problems or nightmares
- Feeling anxious, fearful, or angry
- Headaches, body pain, or skin rashes
- Chronic health problems get worse
- Increased use of alcohol, tobacco, or other drugs

Seek help from your healthcare provider if these stress reactions interfere with your daily activities for several days in a row.

HEALTH SERVICES AGENCY

CDC

Substance Abuse and Mental Health Services Administration's (SAMHSA's) Disaster Distress Hotline: 1-800-985-5990 or text TalkWithUs to 66746.

People with deafness or hearing loss can use their preferred relay service to call 1-800-985-5990.

CS283563A

LET'S STAY CONNECTED

As we work on preventing the spread of COVID-19, we want to assure you that we are taking steps to protect our residents. While we have restricted visitation in our facility, staying away doesn't mean losing contact. Below are some tips on how you can keep in touch from a distance:

- Phone calls are still an option to be able to talk to your loved one.
- Video calling like FaceTime, WhatsApp, Messenger, Skype, Zoom
- Sending cards and letters to your loved ones is another way to show them that you are thinking of them.
- Arrange with the facility a regular time to get in touch with your relative
- Order some flowers to be sent to the home, with your personal message, to help brighten up the day of your relative (and the staff!)
- Mail some photographs, old and recent, to your relative to help them stay connected to you
- Alert staff of upcoming milestone dates, like birthdays, wedding anniversaries, or anniversaries of deaths which may affect your relative. Ask care staff to ensure you are able to contact your relative on those dates

Stanislaus County HEALTH SERVICES AGENCY

Stanislaus County Public Health
Visitor and Patient Poster 5.4.2020

HELP PROTECT OUR PATIENTS AND STAFF

Novel Coronavirus

VISITORS

If You Have Fever, a Cold, or Flu-like Symptoms,

Please Postpone Your Visit.

Together We Can STOP The Spead

Stanislaus County HEALTH SERVICES AGENCY

Stanislaus County Public Health
Visitor and Patient Poster 3.18.2020

LET'S PROTECT EACH OTHER

Novel Coronavirus

If you have symptoms, take the same precautions you would to avoid colds and flu.

Wash Hands

Cover Your Cough

Stay Home

Stanislaus County Public Health
Visitor and Patient Poster 3.18.2020
Adapted from Los Angeles County Department of Public Health

NUHW
NATIONAL UNION OF HEALTHCARE WORKERS

NUHW.org/covid-19

COVID-19 HEALTHCARE WORKERS' BILL OF RIGHTS

1 PERSONAL PROTECTIVE EQUIPMENT

All healthcare workers have a right to appropriate Personal Protective Equipment (PPE). If healthcare facilities do not have enough PPE, they must work to secure an adequate supply. This includes demanding that local, state, and federal officials increase acquisition and production of PPE.

2 TESTING FOR COVID-19

To reduce the spread of COVID-19 and ensure appropriate staffing levels, healthcare facilities must provide healthcare workers with guaranteed access to rapid, point-of-care testing whether they have COVID-19 symptoms or not.

3 SAFE WORK ENVIRONMENT

Healthcare facilities must protect workers and patients by requiring that all visitors and workers wear masks and adhere to social distancing measures, and ensuring that engineering controls, like ventilation systems, meet necessary standards for preventing the spread of COVID-19.

4 SAFE STAFFING

The influx of COVID-19 patients combined with the number of healthcare workers becoming sick creates a strain on staffing. Healthcare facilities must ensure staffing levels that keep healthcare workers and patients safe.

5 PROPER TRAINING

Healthcare facilities must provide training on all COVID-19 protocols for the safe and effective execution of healthcare workers' duties.
New training or refreshers should be immediately provided if protocols are changed or added.

6 MENTAL HEALTH CARE

Healthcare workers are confronting intense pressure, stress, uncertainty, and trauma in the workplace as well as a high risk for infection. To help workers facing these conditions, healthcare facilities must provide access to high-quality mental healthcare services to employees at no cost.

7 TEMPORARY HOUSING

Healthcare facilities need to provide safe, high-quality nearby housing accommodations for healthcare workers who choose not to return home in order to limit exposure to their family members — including some who may be at higher risk of severe illness from COVID-19.

8 WORK FROM HOME

When it will not compromise patient care, healthcare workers should be allowed to work from home, and healthcare facilities should arrange for the equipment and technology needed to do so effectively. This includes mental health workers, who are needed now more than ever.

9 INPUT AND ACCOUNTABILITY

Healthcare workers should have input in decisions on staffing, PPE, infection control protocols, surge planning, and any other changes that impact their work. And workers should never be disciplined for blowing the whistle on hospital failures.

10 CARE FOR CAREGIVERS

Healthcare workers need additional paid time off to care for themselves or their families, presumptive eligibility for workers compensation for COVID-19 illness, and childcare support to continue working during the COVID-19 pandemic.

For more information on NUHW's COVID-19 policy recommendations, please visit

NUHW.org/covid-19

CONTACTS FOR ADDITIONAL INFORMATION

Non-emergency needs and general inquiries:
MHOAC@stanoes.com

Requests for PPE and additional resources:
MHOAC@stanoes.com
Cc: EOCLogistics@stanoes.com

Reporting Title 17 and COVID-19 Cases:

Staffing issues or other urgent needs, contact MHOAC:
Daytime Hours (Weekdays 8am to 5pm) – (209) 353 5501
After Hours (After 5pm on Weekdays and Weekends) – (800) 945 2273

Stanislaus County HEALTH SERVICES AGENCY