**California Department of Public Health**
**Weekly Facility COVID-19 Update Call**
**March 9, 2021**
**8:00 am – 9:00 am**

**AT&T Meeting Recording: 1 (866) 207-1041**
**Access Code: 5980422**
**Available after 12 Noon 03/9/2021**

I. **Welcome / Introduction** **Heidi Steinecker**

II. **Overview** **Dr. Kathleen Jacobson**

- None Provided

III. **Laboratory Update** **Dr. Carol Glaser**

I will review variants of concern (VOC) which are those proven to have epidemiologic or clinical significance while other variants that I will be discussing have theoretical concerns but not yet shown to have epidemiologic and clinical significance. SARS-CoV-19 virus is constantly mutating so we expect to see variants. For VOI, we do not know clinical or epi significance but are following closely.

**B.1.1.7**
This is the variant that was first identified in the UK and has now been detected in 70 countries. It is more infectious and likely to higher morbidity/mortality per UK report. This is also the variant that CDC had predicted would become the predominant strain in the US by the end of March. Publication March 5 in International Journal Infectious Disease B117 produces higher viral load than other strains (CT value 15.8 vs 16.9) and its RNA persists longer (16-day vs 14 day).
https://www.ijidonline.com/article/S1201-9712(21)00210-1/fulltext

As of March 8, 2021: **3037 cases in 49 states, 262 in CA**
For comparison, March 1, 2021: 2400 cases in 46 states (206 in CA), Feb 22-1661 cases in 44 states (195 in CA), Feb 15-173 cases in US in 40 states (186 in CA)

**B.1.351**
This is the variant that was first identified in South Africa. In addition to concerns about increased infectiousness there are concerns about vaccine effectiveness.
(other names 501.V2 20C/ variants). (Key mutations: K417N, E484K, N501Y and D614G).

As of March 8, 2021: **81 cases in 20 states, 3 in CA** (same as before in CA)
For comparison, March 1, 2021: 53 cases in 16 states, , Feb 22-22 cases in 10 states, Feb 15: 17 cases in 8 states (for the 3 in CA, international travel, appropriate isolation)

**P.1**
This is the variant that was first identified in Brazil. Similar to B.1.351 there are concerns about increased infectiousness and vaccine effectiveness. (total of 12 mutations including E484K, K417N/T, N501Y, D614G),

As of March 8, 2021: **15 in 9 states, Zero in CA**
For comparison March 1; 10 in 5 states, Feb 22: 5 cases in 4 states, Feb 15; 3 cases detected in the US

Nature article published this week
https://www.nature.com/articles/s41591-021-01294-w.pdf
found moderate to substantial decrease in neutralization of these variants.

**Other variant of Interest**
**B.1.526 variant**
Mentioned last week, that researchers from Columbia in New York reported B.1.526 variant which has emerged there. https://www.medrxiv.org/content/10.1101/2021.02.23.21252259v1
This variant shares some of the concerning mutations VOC particularly as it pertains to vaccine effectiveness. Lineage first detected in late November 2020 and are increasing in detection in NY area and now represent at least one-quarter of their cases. Most cases NY and New Jersey. We have seen a handful of such variants in CA.

**B.1. 429 and B.1.427** , Western US variant, **CAL.20C, West Coast variant**)

For the past several weeks mentioned two closely related variants B.1.429 and B.1.427. Both of these variants have a mutation in spike protein and have the potential for increase transmission and immune evasion.

Accumulating data showing that B.1.427/B.1.429 are common in California now representing 60% of what is sequenced.
Mentioned a study last week from UCSF on these "West Coast variants" which showed mildly higher transmission rates comparted to other but no higher morbidity/mortality and no increase viral loads. This study now in preprint and will be included meeting notes.
https://doi.org/10.1101/2021.03.01.21252705

**SEQUENCING efforts**
The variants underscore the importance of WGS. CDPH continues to expand their whole genome sequencing (WGS) efforts and in past few weeks, additional samples have been sequenced the goal is to test representative samples from diverse populations and wide geographic range over time at least 2% of all positive samples.

**Other**
Abbott announced this week that BinaxNOW COVID-Ag cards is extending expiration date of these cards. Extending 3 months (e.g. 3-month extension on most kits).

IV. **Healthcare Associated Infections** **Dr. Erin Epson**

Yesterday CDC released new Interim Public Health Recommendations for Fully Vaccinated People. Healthcare facilities need to understand, however, that these new CDC recommendations do not apply to healthcare settings; CDC indicated that an analogous set of recommendations for healthcare settings is in progress but hasn't yet been finalized. In the meantime, however, yesterday CDPH released AFL 20-22.6 which includes updated CDPH guidance for visitation in SNF, including expanded opportunities for indoor, in-room visitation and physical touch as well as considerations for fully vaccinated residents and visitors. I'll highlight a few of the areas that have changed:

The updated AFL states that facilities shall allow indoor in-room visitation for:

- Fully vaccinated residents (e.g., individual residents who are ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine) in "green" (unexposed or recovered) or "yellow" (exposed or observation status ) areas, regardless of the county tier (including Tier 1, Purple) under Blueprint for a Safer Economy
- Unvaccinated or partially vaccinated residents in "green" (unexposed or recovered) or "yellow" (exposed or observation status) areas for facilities in Tier 2 (Red), 3 (Orange), or 4 (Yellow) counties.
- Visitors in Tier 1 (Purple) counties for fully vaccinated residents must test negative on a POC antigen test or PCR test on a sample taken within the prior two days, regardless of the visitor's vaccination status. Facilities may offer POC antigen testing.
- All visitors and residents should wear appropriate facial covering during their visit and should maintain 6-ft physical distancing. Fully vaccinated visitors of fully vaccinated residents may have brief, limited physical contact with the resident (e.g., a brief hug, holding hands, assisting with feeding or grooming).
- Visits for residents who share a room should be conducted in a separate indoor space or with the roommate not present in the room (if possible), regardless of the roommate's vaccination status.
- Full PPE must be worn for yellow zone visitation.

So to summarize what's changed, in-room visitation is now permitted in SNF in the Purple tier, but limited to fully vaccinated residents. In addition, in-room visitation is now permitted for residents in the "yellow" (exposed or observation status) areas, with visitors wearing personal protective equipment. And now, physical contact is permitted during visits between fully vaccinated residents and fully vaccinated visitors.

In addition, non-essential personnel/contractors (e.g., barbers, manicurists/pedicurists) who comply with the same screening testing and universal facemask use required of the facility HCP may enter the facility and provide services to residents in appropriate spaces (outdoors, if feasible, or indoors in a well-ventilated area where at least 6-ft distancing can be maintained between residents); non-essential personnel/contractors who enter the facility should be encouraged to seek COVID-19 vaccination through the resources available in their community including the local health department.

V. **Monoclonal Antibody Update** **Dr. Sohrab Sidhu**

**Topics for discussion:**

- Updates re: etesevimab and the direct ordering process
- New NIH COVID-19 Treatment Guidelines re: tocilizumab

**Monoclonal Antibody Overview**
To summarize, three investigational monoclonal antibody products have received an emergency use authorization (EUA) for the treatment of mild-to-moderate COVID-19 in non-hospitalized adult and pediatric patients who are at high risk for progression to severe disease. These products are:

1. Bamlanivimab (Eli Lilly, November EUA)
2. Casirivimab + Imdevimab (Regeneron, November EUA)
3. Etesevimab (Eli Lilly, February EUA)

Clinical trial data in outpatients have shown that these products may reduce COVID-19-related hospitalization or emergency room visits in patients who are treated early and who are at high risk for progression to severe disease. The EUAs for these therapies are only to treat symptomatic outpatients. Note that etesevimab is only authorized to be given in combination with bamlanivimab.

**Monoclonal Antibody Direct Ordering**
The federal government is now making these monoclonal antibody products – including the newly authorized bamlanivimab plus etesevimab combination – available through direct ordering only. **All treatment sites must now order these products directly from AmerisourceBergen Corporation (ABC), the drugs' sole distributor.** The products remain free of charge to requesting sites. Treatment sites should review the direct ordering process guide and place orders directly with ABC at this site. Should you have any questions or concerns regarding the direct order process for COVID-19 monoclonal antibodies, you may contact HHS/ASPR at COVID19Therapeutics@hhs.gov or ABC at C19therapies@amerisourcebergen.com.

For facilities and healthcare providers interested in setting up infusions for high-risk patients with COVID-19, ASPR has many resources available. This includes free digital content that your facility can use on social media platforms to help educate providers and patients. HHS has also provided CombatCovid.HHS.gov as a resource for your patients.

**In addition to the above direct ordering process, both bamlanivimab as monotherapy and casirivimab/imdevimab are readily available from CDPH. Contact your county's Medical and Health Operational Area Coordinator (MHOAC) to request either of these products from CDPH.**

**New NIH COVID-19 Treatment Guidelines re: tocilizumab**
Tocilizumab is an IL-6 inhibitor FDA-approved for the treatment of rheumatological conditions. It is hypothesized that modulating levels of pro-inflammatory IL-6 may improve the course of COVID-19. To date, no IL-6 inhibitor is FDA-approved or authorized for the treatment of COVID-19.

On March 5th, the NIH COVID-19 Treatment Guidelines Panel updated its recommendation regarding the use of tocilizumab for the treatment of COVID-19. Based on newly available data, the Panel's recommendations now states:

- The Panel recommends the use of **tocilizumab in combination with dexamethasone** in certain hospitalized patients who are exhibiting rapid respiratory decompensation due to COVID-19. This recommendation applies to:
    - (1) recently hospitalized patients who have been admitted to an intensive care unit (ICU) within the prior 24 hours and who require invasive mechanical ventilation, noninvasive mechanical ventilation (NIV), or high-flow nasal canula (HFNC) oxygen, and

- (2) recently hospitalized patients (not in an ICU) with rapidly increasing oxygen needs who require NIV or HFNC and have significantly increased markers of inflammation.

- In hospitalized patients with hypoxemia who require conventional oxygen therapy, the Panel recommends using one of the following options: **remdesivir**, **dexamethasone plus remdesivir**, or **dexamethasone alone**. There is insufficient evidence to specify which of these patients would benefit from the addition of tocilizumab. Some Panel members would also give tocilizumab to patients who are exhibiting rapidly increasing oxygen needs while on dexamethasone and have a C-reactive protein level ≥75 mg/L but who do not yet require NIV or HFNC.

Use of tocilizumab for the treatment of COVID-19 may affect supplies for other indications such as certain rheumatic diseases. Health systems are encouraged to ensure an adequate supply of tocilizumab for patients who need the drug for the FDA-approved indications.

Read the full statement: Statement on Tocilizumab | COVID-19 Treatment Guidelines (nih.gov)

**Additional Resources**

**Bamlanivimab**:
- Bamlanivimab Distribution Fact Sheet (ca.gov)
- Fact sheet for healthcare providers: https://www.fda.gov/media/143603/download
- Fact sheet for patients, parents, and caregivers: https://www.fda.gov/media/143604/download
- FDA FAQ: https://www.fda.gov/media/143605/download
- Eli Lilly video for bamlanivimab preparation/administration: https://www.kaltura.com/index.php/extwidget/preview/partner_id/1759891/uiconf_id/30232671/entry_id/1_i3nkvs7k/embed/dynamic?
    - Complete video transcript and more info: https://www.covid19.lilly.com/bamlanivimab/hcp/dosing-administration#dosing-and-administration

**Bamlanivimab/Etesevimab**
- Bamlanivimab and Etesevimab EUA Letter of Authorization February 9 2021 (fda.gov)
    - FDA press release
    - FAQ

**Casirivimab / Imdevimab**:
- Casirivimab and Imdevimab Distribution Fact Sheet
- Fact sheet for health care providers: https://www.fda.gov/media/143892/download
- Fact sheet for patients, parents, and caregivers: https://www.fda.gov/media/143893/download
- FDA FAQ: https://www.fda.gov/media/143894/download

**Remdesivir:**
- Frequently Asked Questions for Veklury (remdesivir) (fda.gov)

**MHOAC County Contact Information:** https://emsa.ca.gov/medical-health-operational-area-coordinator/

**NIH COVID-19 Treatment Guidelines**: https://www.covid19treatmentguidelines.nih.gov/whats-new/

**IDSA COVID-19 Treatment Guidelines**: https://www.idsociety.org/practice-guideline/covid-19-guideline-treatment-and-management/

VI. **Vaccine Update** **Dr.Caterina Lui**

- **Three** COVID-19 vaccines have received FDA emergency use authorization: Pfizer, Moderna, and Janssen
- Blue Shield of California is California's Third Party Administrator to build an enhanced vaccine network, and a transition to the new allocation process will occur over the next few weeks. Providers interested in becoming part of the vaccine network should contact Blue Shield at CovidVaccineNetwork@blueshieldca.com.
- Doses/allocation
    - As of 3/8/21, 13,345,790 doses of COVID-19 vaccine have been delivered to LHJs and other provider sites, including the LTC facility sites participating in the federal pharmacy partnership program. To date, 10,512,860 doses have been administered. The CDPH vaccine dashboard has been posted and is updated daily. The link to the dashboard is in the meeting notes: https://covid19.ca.gov/vaccines/#California-vaccines-dashboard.
    - As of 3/8/21, 773,299 total long-term care doses have been administered in California. 479,906 individuals have had at least one dose of Pfizer vaccine, and 289,641 have had 2 doses of Pfizer vaccine. Data on doses delivered to the Federal Pharmacy Partnership for LTC Program can be found on the CDC website: https://covid.cdc.gov/covid-data-tracker/#vaccinations-ltc
- Vaccination in long-term care facilities continues with the CDC-Pharmacy Partnership program. Both CVS and Walgreens will give dose #1 at clinic #3. If you are having problems with specific facilities, please contact CVS/Walgreens. If you are still having problems, reach out to your local health department. Links and contact information are provided in the meeting notes.
    - CVS / Omnicare: https://www.omnicare.com/covid-19-vaccine-resource/
    - Walgreens: https://www.walgreens.com/topic/findcare/long-term-care-facility-covid-vaccine.jsp
- The CDC Federal Retail Pharmacy Program includes CVS, Rite Aid, Walgreens, and Albertson's. The pharmacies are receiving federal allocations of Moderna, Pfizer, and Janssen vaccine. Eligible persons can make appointments at the pharmacies' individual websites.
- Clinical considerations for vaccines The CDC clinical considerations website is updated with the most recent information about all three vaccines. Please refer to the link in the meeting notes for additional information: https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
- Prioritization
    - CDPH's guidance on vaccine prioritization has not changed since 2/13/21, and is linked in the meeting notes: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/VaccineAllocationGuidelines.aspx
    - Individuals eligible for COVID-19 vaccines under the current guidance include:
        - Phase 1a, all tiers
        - Phase 1b, tier 1:
            - Persons 65 years of age and older
            - Essential workforce sector populations with risk of exposure: Education and Childcare** , Emergency Services*** , Food and Agriculture***.

- Beginning March 15, healthcare providers may use their clinical judgement to vaccinate individuals age 16-64 who are deemed to be at the very highest risk for morbidity and mortality from COVID-19 as a direct result of one or more of the severe health conditions included in this provider bulletin

**Additional resources:**

- Useful contacts
  - MyTurn: myturninfo@cdph.ca.gov
  - MyTurn onboarding: https://eziz.org/covid/myturn/
- CDC communications toolkit: https://www.cdc.gov/coronavirus/2019-ncov/communication/toolkits/index.html
- Link to COVID vaccine resources: https://eziz.org/covid/vaccine-administration/
- The CDC website is updated with the most recent information about both the Pfizer and Moderna vaccines.
  - Main landing page: https://www.cdc.gov/vaccines/covid-19/hcp/index.html
- Authorized Vaccinators: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Authorized-Licensees.aspx
- How to report inventory in Vaccine Finder.
- Link to the essential workforce list: https://covid19.ca.gov/essential-workforce/

VII. **Questions and Answers**

**Q:** Regarding the visitation AFL, it says that you can use a POC antigen test for visitors. Do we need a physician order? Where do we report the results and what obligations do we have, if any, if they are positive as far as counseling them on their results?
**A:** Many facilities are already doing that. No you do not need a physician order. It's not a requirement that you include that in the data survey for testing. We don't have a column in there for visitors but you do need to let a Local Public Health know that there was a positive so they can track that.
**Q:** It says if you are in purple tier and both the visitor and the resident are fully vaccinated, and it's been at least two weeks since their last vaccination, is there an end point? Is it just for up to three months? Is there any particular "how far out" requirements for the vaccinations that we have?
**A:** That's a great question. At this time we did not place that in there because we believe that CDC will continue to update that as they get more information. We will continue to track that and see what the CDC guidance and see what research is out there before we make any adjustments to that.
**Q:** Do you think it will change at all as we learn more about the variants?
**A:** It possibly could. At this point we are continuing to do exactly what you are talking about as we learn more about the variants seen and what the efficacy rates of the vaccine. That's why we urge that source controls should be used even if you're fully vaccinated.

**Q:** You had mentioned for PPE in the yellow zone. I couldn't find that in the AFL or understand what you were outlining as to who needs to wear the full PPE. I'm assuming it's the visitors in the yellow zone and under what condition. Also the ALF speaks of maintaining six foot of distancing with brief hugs, handholding, grooming and feeding. Grooming and feeding aren't really a brief distance issue. Those are more-long term so I would like to get some clarification on that if you could please.
**A:** You need to have source control in the yellow zone. You need to wear a facemask. We are more concerned about the visitor in that case then we are the residents. The resident was exposed and is under observation. It's more of a concern for the visitor coming in and making sure that they're protected and they don't acquire something in the facility and then go out to the community. As far as

the brief contact, you make a good point. We want it to be clear that in general it's best practice to keep your social distancing. We also know the effects of not having human touch and not having those who may have been caregivers before or helpful before for feeding etcetera. We wanted to provide that option. When in doubt, we just say please keep you distance but of course they're welcome to have human touch. We understand that feeding is a little bit more than a six-foot distance for a while. We wanted to provide that openness for people to have that option in those spaces where that's something that's critical for the mental and emotional health of the resident as well.
**Q:** Do you have a guidance on the number of persons per square foot once we're putting individuals in a room?
**A:** I'll bring that back to our HAI team to see if they've got thoughts on recommendations we may be able to provide on Wednesday's or Thursday's call. In general what we were looking though is when you can keep it to individual rooms, that would be best but we understand that many have roommates. Again be mindful of that and your time and duration there when you have roommate situations. We didn't put a specific number because you're right, it's going to be dependent on the ventilation, size of the room and the makeup of the room.
**Q:** I was thinking of things like dining room and activity rooms where you may have several residents and several family members.
**A:** We will take that back and see what we are thinking in terms of communal spaces.
**Q:** My understanding is that the organization is not required to provide testing for visitors, is that accurate?
**A:** That is accurate.
**Q:** My next question is based on that is related to PCR and turnaround testing. I can tell you that we've never met what the Testing Taskforce says is the turnaround time. We are not even on a two-day turnaround time in our areas. So for visitors to come and be able to provide a test before visiting is probably going to be very difficult because I don't see how they're going to turnaround on a test with a two-day timeframe.
**A:** We can discuss that offline and we can help you with that. I think that the antigen test kits may be a solution to help you with that. The state has worked to try to decrease turnaround time for PCR tests by using the Valencia Branch Laboratory by establishing a period or network. It reaches most of the state and most of the samples are arriving and turning around in less than two days. We can discuss potential solutions for improving testing for you.
**Q:** Related to where people can get together to potentially have some food and beverage with six-foot distancing, what is the size of that kind of a group that we should be limiting to?
**A:** I would stick with the guidance of three household. I think the critical thing is making sure you always have six-foot distance especially when food is involved. Once food is involved, masks are usually off or not on consistently. Luckily the weather right now is hopefully getting better where there's more outdoor options which are always the safest.

**Q:** Are the surveyors allowed to write up a facility? Can you point me to the specific regulation?
**A:** Anytime there is a discrepancy and you don't know why, I would say first and foremost, talk with the surveyor while they are on site. If that doesn't get you the outcome you were hoping for, then contact the district office to walk through that. Any kind of citation or deficiency that's noted it always goes through an internal approval process of the district office as well. By reaching out to the supervisor or manager at the district office you can talk through if there was a mistake or if there was not a mistake. It's an opportunity for the education of what regulation or tag that was used then you would have that

understanding. I would say definitely gain a relationship with your local district office as much as you possibly can.
**Q:** Are they expected also to follow the rules? We are not supposed to see PPE in the hallway but some of the regulators that come are wearing PPE all over and the staff are hesitant to call that to their attention because we're scared of retaliation.
**A:** All surveyors follow the CDC and CDPH guidance for PPE. They do wear and have PPE. They also have testing at the same cadence as the healthcare workers. Sometimes it's weekly or if it's a higher tier where there is more cadence then that's a twice a week testing and all of our surveyors also have been vaccinated. They follow the same rules and guidelines and are expected to as the rest of the healthcare workers in the facility as well.

**Q:** There are situations where we want to get genomic sequencing done. I've been having some difficulty getting through and getting some clarity about how to order the genomic sequencing. How long does the Valencia Lab hold specimens and the other question is what is the process for getting the sequencing? Often this will happen during the evening or on weekends. It seems like this will be coming up more often and would like to have a clearer understanding of how to get these sequenced.
**A:** Valencia Lab holds on to those types. If we are notified then we'll have to backtrack and try to find it but we are doing a lot of our surveillance sequencing from those specimens. If things are going to Valencia, we should be fine as far as the specimen not being tossed.
**Q:** How do we go about requesting the sequencing?
**A:** If you reach out to somebody in the virus lab, they can help you with that.

**Q:** I have a question about the updated 20-22 AFL. In the CMS QSO they indicate that the building needs to be outbreak free for 14 days. Is that just an underlying premise for the AFL that is a given? I didn't see anything about how long we needed to be completely COVID free in the building before we could extend these types of visitations.
**A:** CMS has not updated their visitation guidance since last early fall or late summer. We are moving ahead rather than waiting for CMS or CDC. California is moving ahead to just state "In California facilities, this is what you are able to do so if you choose". Since we are also contracted with CMS, CMS teams will also follow the CDPH AFL. As soon as we have more guidance that's updated from CMS or CDC, we will certainly update that and put it in here. You are right that the CMS pieces wouldn't match up at this point.
**Q:** So that same response would likely apply to the other statement in their QSO where residents who are on transmission-based precautions can only have virtual visits, visits through windows or compassionate care visits?
**A:** Yes.

**Q:** On the visitation guidance, it asks for visitor to be vaccinated. What evidence can we accept? Will the white vaccine cards do? What should we look for?
**A:** If they have their vaccine card with them, that's fine. I don't think you need to do any tracking or record keeping.
**Q:** Let's say the visitor is vaccinated however the resident is not. They would still be limited to an in-room with PPE correct with no physical contact is that correct?
**A:** That is correct. It also depends what tier your facility is in. It depends on the spread rate of your county, of what the options are.

**Q:** What do we do if the visitor can't provide documentation on their vaccination? We can't take their word for it I'm assuming?
**A:** There is no regulatory rule on this. These are all guidances. I really leave that up to you at the facility but you're probably right. You're probably best not to. What I would say is that in the AFL there is also a link to a table and hopefully that's helpful to be used as a generic guidance.

**Q:** I just want to get a clarification. I just wanted to make sure that I heard correctly, that for healthcare facilities, that a visitor policy update is coming. I think we've heard that for a couple of weeks and just wanted to ensure that that's upcoming. Number two, was there any specific guidance with recent revisions in regards to vaccinations for volunteers in a healthcare facility?
**A:** We did release the updated guidance for skilled nursing facilities yesterday. Are you looking for general acute care hospitals?
**Q:** Yes I am.
**A:** We hope to have our general acute care hospital visitation up by either the end of this week or early next week before next week's call so we can have that out there and discuss it fully during our Tuesday meeting. About the volunteers, we will include in the AFL. In many cases even in our skilled nursing facility guidance, we added some of the other ancillary, whether that be students, people coming in that would do hair and nails etcetera. We are adding in a lot more of those typical visitors, contactors and in your case, volunteers in hospitals. We will be adding guidance for that back in. Great point.

**Q:** I have a question regarding the six-foot distancing. I have contradictory recommendations from LA County ACDC with regards to what our current state guidelines are. Is there really a guidance that says that we need to decrease our number of beds to make sure that each bed is six feet apart? Second, What do we when we have already spoken to licensing and discussed with them the issues we have with the contradictory recommendations we have with ACDC and what the AFL have said as to how we are to proceed with those recommendations at this point in time? Third, was there any AFL that actually says that we have to have signs to use universal masking placed all over the building? Do we have to have signs that says we have to social distance? We know It's a practice but can you direct me to the regulation? Lastly, when we reach out to licensing, they sent us a LA County flyer that says six-foot distancing for beds but they sent us the one for residential and congregate settings and not for the SNF side.
**A:** Why don't you send me an email with a list of your issues and we can have our branch chief over in LA County go through this and reach out to you directly so that we can go through each one of the issues.

**Wednesday Webinar: 3–4 p.m., Attendee Information:**
**Register at:** https://www.hsag.com/cdph-ip-webinars
**Call-In Number: 415.655.0003 Access Code:** 133 788 3426