California Department of Public Health
Weekly Facility COVID-19 Update Call
April 13, 2021
8:00 am – 9:00 am

AT&T Meeting Recording: 1 (866) 207-1041
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I. **Welcome / Introduction** — **Cassie Dunham**

- None Provided

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

- None Provided

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

Variants of high consequence

Currently, there are NO SARS-CoV-2 variants that rise to this level.

Variants of concern (VOC)

B.117 (first identified in UK), B.351 (first identified in South Africa), P.1 (first identified in Brazil) and B.1.427 and B.1.429 (first identified in CA, sometimes referred to as West Coast or California variants) are currently on CDC's classification as variants of concern.

Nationally: B.117 is the most common VOC in the US and represents > 25% of variants sequenced (while B127/129 makes up ~ 13%). In some areas of country B117 is quite widespread and makes up > 50% of what is sequenced (e.g., Minnesota > 50%).

In California: B.1.427/B.1.429 is the most common VOC making up 60-70% of samples sequenced while B117 is approximately 10% of what is sequenced.

Variant of Interest (VOI)

B.1.526, B.1.525 (originally found in New York) and P2 (originally identified in Brazil) - 22 in CA. These variants both have potential for immune evasion (reduction in neutralization by antibody as well as potential decrease neutralization monoclonal antibody). California has seen handful of these variants but in very low numbers.

Other

As we know neutralization assays/studies have shown some reduction in neutralization of B117 and B351. For B.117 studies have shown a similar or slightly decreased compared to wild type strains while

a significant reduction was seen in some but not all studies of B.1.351. The relevance of neutralization assays is unclear since these are in vitro studies and only consider one part of the immune system.

A preprint became available 2 day ago entitled "*Evidence for increased breakthrough rates of SARS-CoV-2 variants of concern in BNT162b2 mRNA vaccinated individuals" (link: https://www.medrxiv.org/content/10.1101/2021.04.06.21254882v1)*
This study was done in Israel where Pfizer vaccine is used almost exclusively. Vaccination started in late Dec 2020 with > 80% of the eligible population vaccinated with at least one dose. During the time of study, B.117 was the predominant strain (ranging from 70% late January to close to 100% in early March); B1.351 was < 1% of their sample. Investigators conducted a case-control study that examined both partially vaccinated (247 pairs) and fully vaccinated people (149 pairs).
An increased incidence of B117 case in fully vaccinated people was not seen, but there was an increase in partially vaccinated people. The authors also saw increased incidence B.1.351 in previously vaccinated individuals. These observations are consistent with some studies that show a large decrease neutralization with B.1.351, but little to no reduction in neutralization of B117.

State news: Update on the "Indian double mutant" was recently assigned Pangolin lineage (B.1.617). Stanford announced the news about this variant last week. A few of these have been confirmed by the Stanford laboratory. CDPH has investigated a handful of these cases. This particular variant is thought to have originated in India where it makes up 15-20% of cases in one region of the country
For background only: this variant has 2 spike substitutions (L452R in CA/West Coast variant and E48Q). Both 452 and 484 are in the receptor binding domain and mutations at that location have been implicated in immune evasion.

Sequencing efforts
The identification of variants underscores the importance of WGS. Through COVIDNet, California has expanded efforts and is currently sequencing ~7% of positive samples

We encourage specimens to be submitted for WGS particularly from critically ill and hospitalized patients. Contact your local health department.

Key websites
Science Brief: Background Rationale and Evidence for Public Health Recommendations for Fully Vaccinated People (cdc.gov)

https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/COVID-Variants.aspx

- Variants of concern (VOCs) maps and resources
    - https://pbs.twimg.com/media/EvMTRfDU4AEYbSR?format=jpg&name=large
    - https://cov-lineages.org/index.html - GRINCH report
    - https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/variant-surveillance/genomic-surveillance-dashboard.html
    - GSD PCR kit for B117 and B1351 free to PHLs: https://www.gsdx.us/rt-pcr-id
    - NS3 data https://nextstrain.org/groups/spheres

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

CDC recently updated their **Strategies for Optimizing the Supply of N95 Respirators, available at** Strategies for Optimizing the Supply of N95 Respirators: COVID-19 — This guidance has been updated to include the following:

- Acknowledged that the supply and availability of NIOSH-approved respirators have increased significantly over the last several months.
- For conventional capacity strategies:
    - Added language on extended use of N95 respirators as source control, and for this purpose they can be used until soiled, damaged or hard to breathe through, and be discarded immediately after removal; extended use of N95 respirators as PPE is a contingency capacity strategy.
    - Added language on use of respirators with exhalation valves, including findings from NIOSH research suggesting that even without covering the valve, N95 respirators with exhalation valves perform the same or better than surgical masks, procedure masks, cloth masks or fabric coverings.
- For contingency capacity strategies, i.e., during expected shortages or when there is uncertainty if future supply will be adequate:
    - Added a strategy to prioritize respirators for HCP who are using them as PPE over those HCP who are only using them for source control.
    - For extended use of N95 respirators as PPE, clarified that N95 respirators should be discarded immediately after being removed, such as for meal breaks.
- For crisis capacity strategies:
    - Removed the strategy of using non-NIOSH approved respirators developed by manufacturers who are not NIOSH-approval holders.
    - Highlighted that the number of reuses should be limited to no more than five uses (five donnings) per device by the same HCP to ensure an adequate respirator performance.
    - Removed decontamination of respirators as a strategy with limited re-use.
    - Emphasized that facemasks for caring for a patient with suspected or confirmed SARS-CoV-2 infection should only be used for certain scenarios as a last resort if respirators are severely limited.

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

To summarize, two investigational monoclonal antibody products are currently recommended for use in California:

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

These products have received an emergency use authorization (EUA) for the treatment of mild-to-moderate COVID-19 in adult and pediatric patients who are at high risk for progression to severe disease. Clinical trial data in outpatients have shown that these products may reduce COVID-19-related hospitalization or emergency room visits in symptomatic patients who are treated early.

All treatment sites can now order these products directly from AmerisourceBergen Corporation (ABC). 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.

Please note that the FDA recently released revised fact sheets for health care providers, which now include additional information on susceptibility of SARS-CoV2 variants to each of the monoclonal antibody therapies. The revised FDA fact sheets, which include this data, can be found in the meeting notes.

Given the sustained increase in variants resistant to bamlanivimab alone, and availability of alternative authorized monoclonal antibodies, the U.S. government has stopped the distribution of bamlanivimab alone. CDPH does not recommend bamlanivimab monotherapy for treatment due to these concerns.

In addition to these combination therapies, etesevimab alone is also available for direct ordering. **Note that etesevimab is only authorized for use in combination with bamlanivimab but can be ordered by itself to be combined with any bamlanivimab stock a facility already has on-hand.**

In addition to the above direct ordering process, both bamlanivimab 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.

- **Note again that bamlanivimab monotherapy is not recommended by CDPH for treatment of COVID-19 (see above).** However, under its EUA, bamlanivimab can be combined with etesevimab. See the Bamlanivimab plus Etesevimab EUA Fact Sheet for Providers for more information.

New NIH COVID-19 Treatment Guidelines re: Monoclonal Antibodies

On April 8th, the NIH COVID-19 Treatment Guidelines Panel updated its recommendation regarding the use of monoclonal antibodies for the treatment of COVID-19. Based on emerging data on the use of these products and on the in vitro susceptibility of SARS-CoV-2 variants, the Panel's recommendations now state:

- The Panel recommends using either **bamlanivimab 700 mg plus etesevimab 1,400 mg** or **casirivimab 1,200 mg plus imdevimab 1,200 mg** to treat outpatients with mild to moderate COVID-19 who are at high risk of clinical progression, as defined by the EUA criteria. (AIIa)
- Because clinical outcome data are limited and there are concerns regarding decreased susceptibility of variants, the Panel **recommends against** the use of **bamlanivimab monotherapy**. If combination products are not available, the use of bamlanivimab monotherapy can be considered for people who meet the EUA criteria on a case-by-case basis.
- The Panel **recommends against** the use of **anti-SARS-CoV-2 monoclonal antibodies** for patients who are hospitalized because of COVID-19, except in a clinical trial. However, their use should be considered for persons with mild to moderate COVID-19 who are hospitalized for a reason other than COVID-19 but who otherwise meet the EUA criteria.

For more information, please see the Panel's full statement, which includes a detailed discussion of the rationale behind these recommendations.

Additional Resources

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.

Bamlanivimab – *Bamlanivimab alone without etesevimab is not recommended for use in California:*
HHS/ASPR Bamlanivimab Update re: SARS-CoV2 Variants of Concern
Fact Sheet For Health Care Providers Emergency Use Authorization (EUA) Of Bamlanivimab (fda.gov)

Bamlanivimab/Etesevimab
Fact Sheet For Health Care Providers Emergency Use Authorization (EUA) Of Bamlanivimab And Etesevimab (fda.gov)
Bamlanivimab and Etesevimab EUA Letter of Authorization February 9 2021
Bamlanivimab plus Etesevimab FDA press release
Bamlanivimab plus Etesevimab FDA FAQs

Casirivimab / Imdevimab:
Casirivimab and Imdevimab Distribution Fact Sheet
Fact Sheet For Health Care Providers Emergency Use Authorization (EUA) Of Regen Covtm (Casirivimab With Imdevimab) (fda.gov)
Casirivimab and Imdevimab EUA Fact Sheet for Patients, Parents, and Caregivers (fda.gov)
Casirivimab and Imdevimab EUA Frequently Asked Questions updated 02102021 (fda.gov)

HHS/ASPR Call Center for Questions and Information Related to Monoclonal Antibodies:
Please share broadly with your networks of patients and providers.
English: 1-877-332-6585
Spanish:1-877-366-0310

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**

As a reminder, **Three** COVID-19 vaccines have received FDA emergency use authorization: Pfizer, Moderna, and Janssen.

This morning, 4/13/21, out of an abundance of caution, the CDC and FDA issued a recommendation to **pause the use of the Janssen vaccine** following reports of 6 cases of a rare and severe type of blood clot in individuals after receiving this vaccine. In these cases, a type of blood clot called cerebral venous sinus thrombosis (CVST) was seen in combination with low levels of blood platelets (thrombocytopenia). All six cases occurred among women between the ages of 18 and 48, and symptoms occurred 6 to 13 days after vaccination. The CDC and FDA's investigation is in process, and ACIP will meet tomorrow (Wednesday) to review the cases.

- Right now, these adverse events appear to be extremely rare. COVID-19 vaccine safety is a top priority for the federal government. People who have received the J&J vaccine who develop severe headache, abdominal pain, leg pain, or shortness of breath within three weeks after vaccination should contact their health care provider. Health care providers are asked to report adverse events to the Vaccine Adverse Event Reporting System at https://vaers.hhs.gov/reportevent.html.
    - Press release: https://www.cdc.gov/media/releases/2021/s0413-JJ-vaccine.html.
    - FDA/CDC press conference: https://www.youtube.com/watch?v=_ELXnGYgsJY.

Blue Shield is California's Third Party Administrator to build an enhanced vaccine network. This week, many local health jurisdictions have been added to the Blue Shield Network. Providers who have not signed agreements with the TPA will likely not be able to receive any more first dose allocations after mid-April. Second dose requests will be honored until all previously-started series are complete. Providers interested in becoming part of the vaccine network should contact Blue Shield at CovidVaccineNetwork@blueshieldca.com.

Doses/allocation:

- As of 4/12/21, 28,121,700 doses of COVID-19 vaccine have been delivered to LHJs and other provider sites. To date, 22,974,654 have been administered. 8,871,326 people have been fully vaccinated. 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 4/5/21, 835,651 vaccine doses have been administered to long term care facility patients and HCWs in California via the CDC-LTC Pharmacy program with CVS and Walgreens. 495,701 individuals have had at least one dose of Pfizer vaccine, and 332,820 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. This program officially concluded on March 31st, although both CVS and Walgreens have a small number of clinics remaining through mid-April.

The CDC Federal Retail Pharmacy Program continues to expand. The following pharmacy partners are receiving doses:

- Long-term care pharmacies: Innovatix, GeriMed, MHA, and select Cardinal member pharmacies. A link to the pharmacies included under each of these pharmacy groups can be found on the CDC website: https://www.cdc.gov/vaccines/covid-19/downloads/participating-ltc-pharmacy-list.pdf.
- Retail pharmacies: CVS, Rite Aid, Walgreens, Albertson's, Cardinal, Walmart, Topco, Kroger, CPESN, HealthMart, and GoodNeighbor. The pharmacies are receiving federal allocations of Moderna, Pfizer, and Janssen vaccine. Eligible persons can make appointments at the pharmacies' individual websites. Link with pharmacy scheduling links.

Clinical considerations for vaccines The CDC clinical considerations website is updated with the most recent information about all three vaccines, and the most recent update was from 3/5/21. 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

- On 4/9/21, Pfizer requested an amendment to the FDA EUA to expand the use of their COVID-19 vaccine to adolescents 12-15. Press release link.

Prioritization

- CDPH's guidance on vaccine prioritization was updated on March 25.
- Beginning April 15, 2021, every Californian age 16 and older will become eligible for COVID-19 vaccines.
- The full guidance is linked in the meeting notes: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/COVID-19/VaccineAllocationGuidelines.aspx.

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/**
- **Authorized Vaccinators: https://www.cdph.ca.gov/Programs/CID/DCDC/Pages/Immunization/Authorized-Licensees.aspx**
- **How to report inventory in Vaccine Finder.**

VII. **Questions and Answers**

Q: Should we be on hold for administering the Johnson & Johnson regarding the blood clots?
A: The CDC and FDA has issued a pause on the use of the J&J vaccine. Further information will be forthcoming.

Q: Regarding sending the specimen for whole genome sequencing and working with our local health department. I'm located in San Bernardino County and when I called my local health department, I got a general COVID number. I was wondering if there was a contact that you have for me so that we can participate.
A: I don't know the number offhand but if you give me your contact, I can try to follow up with you on that.

Q: We have a fairly active choral group in our independence residence of about 60 members. They are anxious to get together and start singing again, indoor without masks. Can you give me guidance as to if this is okay at this point and if not, is there any idea of when that might be okay?
A: I would first point to the recently updated AFL 20-22 on visitation. This address group activities and indicates that group activities can be facilitated for residents in your green zone. Physical distancing needs to be implemented along with appropriate hand hygiene and face coverings and this is even for fully vaccinated residents. So I would say that all of those measures apply and I'm not sure how well singing would go with the use of a face covering and distancing. So I suppose to address the root of your question, the answer is still no. Indoor singing without masks is not recommended at this time.
Q: Do you have any idea when that might be coming?

A: We are following the state and community guidance as we open up further, we've heard that indications of all that going well. Whether that would apply to some of our higher risk congregate/residential settings, I would anticipate that those would likely not open up fully to those types of activities until later. This is all contingent on the trends continuing to look favorable as far as ongoing transmission and vaccination coverage.
A: I would just add that we continue to anticipate what we believe that the behavior will be as far as transmission and efficacy of vaccines but again as we progress week to week and month to month, we continue to learn. So trying to anticipate a fixed date that we can commit to at this point, I think would be premature. We encourage people to be flexible, stay the course and follow the guidelines. We're certainly sensitive to people's desires to get back to some of the activities that they enjoy doing. We just need to, as a community and as a state population, to stay the course and follow the guidelines that we need to be following so we can get there sooner than later as we move through additional vaccinations and are able to track the course of things over the next few months.

Q: Will CDPH be incorporating vaccine status into any recommendations for hospital based and elective pre-procedure recommendations?
A: This is something that we are actively looking at and discussing. We are looking to CDC for updates to their guidances but I don't have anything concrete to share at this point.
Q: Any thoughts on in-person staff meetings in healthcare settings?
A: The guidance around what fully vaccinated individuals can do really pertains to closer indoor interactions without masks etcetera for individuals meeting with a small group, perhaps a private home for example. The recommendations still, in a public setting, is to avoid medium or larger gatherings even for fully vaccinated. I would think that would somewhat apply. We know that in many institutions, it's hard to avoid the need to do some in person interactions as groups but I think that you still need to be mindful of the need to maintain distancing and face coverings are still important. It's hard to say when that might no longer be recommended but at this point it still applies.

Q: We have a resident who is fully vaccinated and a daughter who is not vaccinated wants to come into the facility to do her mom's hair. We told her that she can't do it in our facility because she isn't fully vaccinated, but her mom could visit her house and then her mom won't have to quarantine when she gets back because she's fully vaccinated. Do you have any recommendations that I can give her in that situation?
A: The concern is around the daughter coming into the facility. She doesn't need to be fully vaccinated to visit but for those types of close interactions, we have indicated that the recommendation is that those be between the resident and the visitor who is fully vaccinated. You are correct that mom can leave the facility and she would not be expected to quarantine upon return. We acknowledge that we don't have the ability to monitor what everyone does once they leave the facility but we certainly recommend that people be mindful of safe practices. What is practiced at the facility is what needs to be is consistent with your facility's policies and procedures.
Q: I just saved my 2567 form my audit that was done on January 2020 and the letter is from April 2021. Do I file that in my 2020 surveys or in my 2021 surveys?
A: If the audit occurred in 2020 then I believe that you would be filing it in your 2020.
Q: For some reason the mail has been delayed in coming to us. It was mailed on April 7th but we just received it yesterday. Regarding the 10-day turnaround time, is there any consideration for the delay in the mail system or how 2567s are delivered to us?

A: Our long-term objective is to try to move towards an electronic delivery of 2567s but that will probably be a couple of years out. In the interim, if you are experiencing delays in the mail, I would encourage you to reach out to your point of contact for that survey and let them know that your mail was delayed. I'm sure they can work with you on some reasonable accommodation there.

Q: Regarding the high frequency testing by CDPH, we are participating in the pilot program where we do antigen testing on each individual staff member/contract vendor/visitor at the time of their visit each day. If we are doing the POC testing daily do we continue to have to confirm with a PCR weekly. I've heard conflicting information on the calls. These are asymptomatic negative individuals. Do I still have to have them do the confirmatory PCR testing weekly?
A: I would say no for the frequency of the routine screening testing of a point of care antigen testing mechanism or type of test is use twice a week. I think that for some facilities that were not testing individuals more frequently using the antigen testing, we've indicated that if the recommended frequency of testing wasn't met, that they minimum weekly PCR would be necessary. I don't believe that would be required if you are testing with the point of care testing daily or effectively daily at the time somebody presents for their shift. Although as a caveat, your local health department might have more stringent requirements in terms of testing that you would need to check with them about.
A: The other thing that I would like to add, for confirmatory testing, we are recommending confirmatory PCR if somebody tests positive with an antigen test or if they are symptomatic and test negative with the antigen test if they're involved with the state antigen testing program. For others who are using antigen tests and have their own CLIA license and their own ordering provider, you could considered treating a positive antigen test within the window period of the test as positive without needing confirmatory PCR.
Q: For the weekly testing reporting with CDPH and NHSN, would I then enter twice weekly testing or would I be able to still enter the once weekly but with a POC?
A: I think it would be best to take this question offline. We can try to have that clarified in the notes for you.

Q: Many of our staff were vaccinated back in December and January. Are there any boosters or are we kind of like the experimental pool for the efficacy of the vaccines? What should I pass back to the staff?
A: Those are still under development so there's no updated guidance in terms of any additional vaccinations that are needed at this time but we will keep an eye out for whatever the CDC does release.

Q: I've been working with my partners at Contra Costa Healthcare Services and we have been going out and dealing with farmworkers and under insured and homeless populations which traditionally have low access and low trust with the healthcare system. I'm wondering if there are plans, from an equity lens, of the Johnson & Johnson vaccine that we have been using, to have a FAQ in multiple languages and incorporating a sensitivity to the fact that the Johnson & Johnson vaccine is the one that we've been using on mobile sites, especially with populations that already did not have high trusts with the healthcare system. If those can be incorporated, that would be very much appreciated as we start to respond to those patients who are going to be calling regarding the venous thrombosis news.
A: I can take that back to our communications team.

Q: I was in touch with somebody from CDPH regarding pediatric patients because they're not eligible for the vaccine and visitation, if a family member who is fully vaccinated that would like to touch their baby. Right now we're doing the six feet social distancing so they stay in a box in the room and they're watching their baby from across the room. I know you guys are working on a guidance, do you have any idea when that's going to be released?
A: That's in the approval process right now. We would love to have that out by the end of the week but it may be next week. It is forthcoming in the near future.

Q: Regarding how to submit samples for variants, I'm from an assisted living facility and recently we had one resident who was fully vaccinated and tested negative after 90 days and then the test come out positive without any symptoms so we submitted a sample. So my question is, under what circumstances do we need to submit samples for the variant verification and what are the procedures?
A: We are most interested in individuals who are severely ill or hospitalized. Generally the procedure is that if you think it may need whole genome sequencing, ask the lab to hold onto the specimen. That's the biggest problem that we've run into. By the time we figure out that we need to do the sequencing, the specimen has been thrown away. So just have the lab hold onto it and you can contact your local health department and discuss the case with them. If you don't get anywhere, you can contact the state virus lab, they are always there to help you. I can give you that number again, (510) 307-8585.

Q: My question is in regard to the CDC guidelines for fully vaccinated patients admitted into a nursing home, they do not need to be quarantined or tested for COVID if there is a normal exposer. If the facility decides to quarantine the patients for five days and test on the sixth day before being moved to the green zone, is this acceptable for the facility for a deficiency? The facility is trying to use precautionary measures because we don't know if they were exposed or not so the facility will quarantine the fully vaccinated patient from the hospital for five days and on the sixth day, test the patient and they are negative, move to the green zone.
A: I can confirm that the new CDC guidance is that fully vaccinated individual no longer needs to quarantine unless there was a known exposure. As you alluded to, it can be hard to know whether there was an exposure in the hospital or anywhere else as somebody was during the 14 days before they're admitted to your facility. I'm not aware of guidance that specifically mentions what you are describing but I will acknowledge that you're essentially describing one of the options for shortened quarantine which is seven days or equivalent with a negative test obtained on day six. I think that is perhaps a reasonable middle ground to take if you are having concerns about transmission or exposures occurring in the hospitals in your referral network. It's more of a conservative approach.
A: I think the key is that there is adequate documentation for justification and cause for the quarantine where your surveyors will be looking for that information to determine if the quarantine is appropriate. If you feel like it's warranted because of the exposure coming from the hospital, I would recommend that you document that clearly. If there is some confusion or disagreement then you can always reach out to the leadership in the local district office to have a conversation about it.

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