



## **Preparing for and Responding to COVID-19 in Nursing Homes and Assisted Living Facilities**

Given their congregate nature and residents served (e.g., older adults often with underlying chronic medical conditions), nursing home and assisted living facility populations are at high risk of being affected by coronavirus disease 2019 (COVID-19). If infected with SARS-CoV-2, the virus that causes COVID-19, residents are at increased risk of serious illness. The following recommendations from Maryland Department of Health (MDH) supplement [MDH Secretary's Orders](#), current Center for Medicare & Medicaid Services (CMS) regulations, the Centers for Disease Control and Prevention's (CDC's) general [infection prevention and control recommendations for COVID-19](#), and CDC's [Preparing for COVID-19: Long-term Care Facilities, Nursing Homes](#). The following recommendations should continue until otherwise determined by public health.

### **Infection Prevention Support:**

MDH recommends that facilities should assign at least one individual with training in infection prevention and control (IPC) to provide on-site management of their COVID-19 prevention and response activities per [CDC guidance](#).

### **Testing/Laboratory Diagnosis:**

COVID-19 Testing:

- Nursing homes and assisted living facilities must conduct COVID-19 testing in accordance with current [CMS](#) and [MDH](#) requirements, utilizing Point of Care and PCR testing as appropriate.

Testing for Other Respiratory Pathogens:

- Ensure access to tests for other respiratory viruses that can cause symptoms similar to COVID-19, as appropriate (e.g., rapid flu and influenza PCR and multiplex respiratory viral panels).
- For residents diagnosed with pneumonia, in addition to testing for COVID-19, run the following tests simultaneously, as appropriate:
  - Rapid influenza test, influenza PCR, and/or respiratory panel that includes influenza
  - Sputum culture, including for *Legionella*
  - *Legionella* and *Streptococcus pneumoniae* urinary antigen tests

## Case Definitions for the Purposes of this Guidance:

Suspect COVID-19 case:

- An individual with [compatible clinical illness](#)
- An asymptomatic individual with a [positive antigen point of care test\\*](#)

Confirmed COVID-19 case:

- An individual with a [positive SARS-CoV-2 PCR](#) regardless of symptoms
- An individual with [compatible clinical illness](#) with a positive SARS-CoV-2 antigen test

\*Asymptomatic individuals who test positive by antigen test should be tested by PCR as soon as possible to confirm the diagnosis. If the confirmatory PCR test is negative and the individual remains asymptomatic, they no longer need to be managed as a suspect case. If a case is ruled-out, close contacts can be released from quarantine unless they had close contact with other cases. See [CDC guidance regarding the interpretation of antigen tests](#) for more information.

## Outbreak Definitions:

COVID-19 outbreak: One or more confirmed cases of COVID-19 in a resident or staff member

A single COVID-19 case in a resident admitted <3 days will NOT be considered an outbreak, unless otherwise determined by the local or state health department.

An outbreak is over when at least 14 days have passed since the onset of the last case (or date of collection for asymptomatic individuals) and at least two rounds of weekly testing with all negative results have been completed after the last case.

Other respiratory outbreak definitions (see [respiratory illness guidelines](#) for managing these outbreaks):

- Influenza-like illness (ILI) outbreak: 3 or more ILI cases in 7 days
- Influenza outbreak: 2 residents and/or staff with ILI or pneumonia within 3 days and at least one has a positive influenza test
- Pneumonia outbreak: 2 or more cases of pneumonia in a unit within 7 days
- A respiratory outbreak can be combination of ILI, influenza, and pneumonia cases.

The following scenarios must be reported to the LHD within 24 hours:

- One or more confirmed COVID-19 cases among residents and/or staff
- Two or more cases of suspect COVID-19 cases within 14 days
- Three or more residents or staff with new-onset respiratory symptoms that occur within 72 hours
- Respiratory outbreaks as defined in the respiratory outbreak guidelines

## **Preventive Measures Against COVID-19**

### **General:**

- Share the [latest general information about COVID-19](#) with staff, residents, and families.
- Skilled Nursing Facilities must adhere to the [CMS Core Principles of COVID-19 Infection Prevention](#), [CDC guidance for long term care facilities](#), and [CDC infection prevention and control recommendations in response to COVID-19 vaccination](#). MDH strongly recommends that assisted living facilities also adhere to the same core principles [and CDC guidance](#).
- Vaccination against COVID-19 is strongly recommended for residents and staff. Information about COVID-19 vaccination can be found on the [CDC website](#).

### **Personal Protective Equipment (PPE) Use and Infection Control:**

- **PPE:**
  - For source control and respiratory protection, healthcare personnel (HCP) and volunteers should wear a [well-fitting](#), medical grade face mask or respirator at all times while they are in the facility. Visitors are allowed to wear cloth face coverings but healthcare personnel and volunteers should not.
  - Eye protection such as goggles or face shields protect against exposure to splashes and sprays of infectious material from others. Consider use of eye protection by all staff members at all times to reduce risk of exposure.
  - As tolerated, residents should wear masks or cloth face coverings at all times when outside of their rooms, when they have visitors or staff in their rooms, and when they are within 6 feet of anyone else, including staff members, unless otherwise permitted [in CDC guidance](#). If residents are participating in communal dining or group activities where face coverings are not required (i.e., all other individuals are vaccinated), face coverings should still be worn in the hallways on the way to/from the activity.
  - All staff should wear appropriate PPE as follows, and use [CDC guidance on optimization of PPE](#) when supply challenges are expected or occurring.
    - For the care of residents with suspected or confirmed COVID-19, HCP should wear: gloves, gown, N95 (or facemask if N95 is not available), eye protection. In nursing homes and assisted-living facilities, fit tested N95 respirators should be prioritized for the care of residents with suspected and confirmed COVID-19.
    - For the care of residents on observation/quarantine, HCP should wear: gloves, gown, N95 (or facemask if N95 is not available), eye protection.
    - For the care of residents in the general population, HCP should wear: facemask, eye protection, and use additional PPE per standard precautions (SP). For residents with known or suspected colonization or infection with other infectious diseases or multidrug-resistant organisms (MDROs), use

appropriate transmission-based precautions such as contact or droplet precautions in addition to SP.

- Non-fit-tested N95 respirators can be substituted for facemasks if the supply of facemasks is limited, but staff should understand that they are not being used as N95 respirators in such circumstances. Facilities requiring the use of respirators (i.e. N95) must have a written [respiratory protection program](#) per federal regulations.
- Gowns and gloves should be discarded (or washed, if cloth gowns are used) after each resident encounter, and not worn outside of resident rooms. Remove and dispose of gowns and gloves just inside of each resident's room and perform hand hygiene before entering the hallway.
- Shoe covers should not be worn as part of PPE for the care of residents or on a COVID unit.
- Frequently reinforce adherence to infection prevention and control measures, including hand hygiene and selection and use of the appropriate PPE for Standard and Transmission-based Precautions (TBP). Identify staff champions if possible, and explore creative educational methods to reinforce key messaging and engagement.
  - [Educate staff on the appropriate and safe use of PPE](#). Ensure education is completed at minimum upon hire, at routine intervals, and each time equipment or procedures are changed. Agency or supplemental staff should be educated on the facility's infection prevention and control policies and procedures including the use of PPE prior to the start of their first work shift.
  - Ensure HCP demonstrate competency with safely putting on and removing PPE. Ensure that HCP know that masks and eye protection should only be touched by the sides, elastics, ties etc. as these are less likely to be contaminated.
  - Instruct staff to perform hand hygiene before and after touching their masks and eye protection, after removing gloves, and after any interactions with the residents or their environment.
- Dispose of soiled PPE according to routine waste disposal practices.
- **Infection Control:**
  - Dedicate equipment (e.g., blood pressure cuffs, pulse oximetry sensors, etc.) to each resident and/or care area, particularly those on transmission-based precautions, as much as possible. Clean and disinfect shared equipment with a product on the [EPA List N](#), according to manufacturer's instructions between residents.
  - [Aerosol-generating procedures](#) should be avoided. If unavoidable, they should be performed in a private, closed room with a closed door while wearing appropriate PPE (i.e., gown, gloves, fit-tested N95 or higher-level respirator, and eye protection). Consider methods for increasing [ventilation](#) in the room, including opening windows or installing portable HEPA filters.

- Implement or continue a program for observing and monitoring adherence to hand hygiene, PPE use, and equipment disinfection, and ensure observations occur on all shifts.
- **Ensure Adequate Supplies:**
  - Use a PPE [burn rate calculator](#) to determine the PPE utilization rate and guide supply ordering. This is especially important during an outbreak or during times of high community disease incidence because daily utilization of PPE may increase significantly.
  - Ensure the facility has an adequate supply stockpile as per [state guidance](#).
  - If PPE supply shortages are expected, the facility should notify the local health department.
  - If PPE shortages are identified or anticipated, [initiate measures to optimize current supply](#). Contingency and then crisis capacity measures are meant to be considered and implemented sequentially. As PPE availability improves, healthcare facilities should promptly resume conventional or standard practices.
  - PPE should be readily available and kept well-stocked in areas where resident care is provided.
  - Alcohol-based hand sanitizer and EPA-registered disinfectants should be readily available for use in resident care and common areas. Alcohol-based hand sanitizer should be available inside of every residents' room if possible.
  - Sinks should be kept well-stocked with soap and paper towels for handwashing.
- **Environmental Cleaning:**
  - Frequently touched surfaces (e.g. tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks & cell phones) should be disinfected frequently and as needed with an [EPA registered disinfectant on List N](#) or a 1:10 bleach solution.
  - Between uses, clean and disinfect any equipment that is shared between residents (e.g. blood pressure cuffs, pulse oximetry sensors, therapy equipment, etc.) Follow manufacturer instructions, use an [EPA registered disinfectant on List N](#) or a 1:10 bleach solution, and make sure the surfaces stay wet for the required contact time.
  - Environmental services staff should use Standard Precautions and any appropriate Transmission-based Precautions while performing daily and terminal cleaning of resident rooms and common areas.

### **Quarantine Residents with Suspected or Known Exposures to COVID-19:**

Per [CDC guidance](#), observation/quarantine is no longer recommended for newly admitted or readmitted residents who are fully vaccinated, do not have symptoms, and have not had prolonged close contact with someone with COVID-19 in the prior 14 days. Individuals are considered fully vaccinated two weeks after their final vaccine dose (i.e., the first dose of a single dose vaccine or the second dose of a two-dose series). Other people should be considered unvaccinated or not fully vaccinated. Guidance for quarantine or observation of

unvaccinated individuals remains the same. Recommendations for unvaccinated people should be followed for individuals with immunocompromising conditions, even if they are fully vaccinated.

- **Who Should Be Quarantined:**

- Create a dedicated observation/quarantine area (this could be a separate unit/wing, if possible, or dedicated private rooms in one area) for newly admitted, readmitted, or other residents requiring quarantine, including:
  - New admissions.
  - Current residents being readmitted from an outside facility.
  - Current residents returning from an excursion in the community where they spent 24 hours or longer.
  - Current residents after suspected exposure to COVID-19 regardless of vaccination status. Those with [close contact](#) should be placed on observation, but other residents with suspected contact that does not meet the definition of close contact may also be placed on observation per facility's judgment.

- **Management of Individuals in Quarantine:**

- Residents in the observation/quarantine unit should be placed on transmission-based precautions using contact and droplet precautions.
- Residents on observation must have private rooms and should have private bathrooms.
- Residents who have been hospitalized for suspect or confirmed COVID-19 can be discharged from the hospital whenever it is clinically indicated. They do NOT require retesting to be discharged. Residents with suspect COVID-19 should be admitted to an area dedicated to the care of suspect COVID-19 patients or isolated in a private room and promptly tested for COVID-19. Residents with confirmed COVID-19 should be admitted directly to the COVID-19 unit until they have completed the requirements for the discontinuation of TBP. Recovered residents who have completed the requirements for the discontinuation of TBP in the time frame [established by CDC](#) within the past 90 days may be admitted directly to the general population.
- All residents, regardless of vaccination status, should be screened for COVID-19 symptoms prior to admission or readmission using at least the following methods:
  - Verbal report received from the transferring facility
  - Temperature taken (cutoff for fever is  $\geq 100.0^{\circ}\text{F}$ )
  - Questions asked about symptoms, e.g. fever, cough, shortness of breath, fatigue, muscle or body aches, headache, loss of sensation of smell and/or taste, sore throat, congestion or runny nose, nausea or vomiting, or diarrhea
- If a new or re-admitted resident who is not fully vaccinated screens negative for COVID-19 symptoms, they should be admitted to the observation unit/area for 14 days. COVID-19 testing may be considered for asymptomatic residents being admitted to this area, but it is not required.

- If a new or re-admitted resident screens positive for COVID-19 symptoms, they should be moved to an area dedicated to the care of suspect COVID-19 patients or remain isolated in their current private room in the observation unit and promptly tested for COVID-19. If the test result is positive, the patient should be transferred to the COVID-19 unit. If the test result is negative, the resident should be transferred back to and/or remain in the observation unit/area for 14 days; a negative test result does not mean that the resident was not exposed, and it is still possible that they could develop symptoms.
- After 14 days on the observation/quarantine unit, if the resident does not ever screen or test positive for COVID-19, they can be relocated to the general population.
- Additional resources: [Frequently Asked Questions \(FAQs\) on Managing New Admissions and Readmissions for Maryland Nursing Homes](#).

### **Management of Staff:**

- Facilities should prepare for staff shortages. All nursing homes are required to register with the Chesapeake Registry Program <http://www.chesapeakeregistry.com/>. Facilities should also make additional plans to address shortages, such as requesting assistance from local hospitals, staffing agencies, and other facilities (e.g., via mutual aid agreements).
- Use [CDC guidance on Strategies to Mitigate HCP Staffing Shortages](#) if needed. Contingency or crisis capacity staffing strategies must be implemented sequentially, and facilities should return to conventional staffing strategies as soon as possible.
- Observe and enforce social distancing among staff, including in hallways, medication rooms, break or huddle rooms, and outdoors.
- Set up staff common areas such as break rooms and nurses' stations to promote physical distancing and set room capacity limits accordingly. Consider removing extra chairs and tables, marking 6 feet of space on the floor, or using repurposed common areas such as unused resident activity or dining spaces for additional staff break space to encourage distancing.
- [CDC guidance](#) allows fully vaccinated staff to congregate without masking or social distancing, but only when all people present are fully vaccinated staff. Unless all staff are vaccinated, allowing staff to congregate without masks could lead to unvaccinated staff also removing their masks without social distancing, increasing the chances of transmission and prolonged outbreaks in the facility.
- Ensure high-touch surfaces in common staff spaces like medication carts, dining tables, computer keyboards, etc., are cleaned and disinfected frequently.

### **Visitation:**

- Visitation should be facilitated according to [CMS requirements](#) and while adhering to [CDC recommendations](#).

- Outdoor visitation is preferred over indoor visitation when feasible.
- Facilities should consider how the number of visitors per resident at one time and the total number of visitors in the facility at one time (based on the size of the building and physical space) may affect the ability to maintain the core principles of infection prevention.
- MDH encourages nursing homes to promote vaccination for visitors, and to either test for or ask visitors to be tested for COVID-19 prior to the visit if they are not fully vaccinated. However, facilities may not require testing or vaccination as a condition of visitation.
- During indoor visitation, facilities should limit visitor movement in the facility. For example, visitors should not walk around different halls of the facility.
- Facilities should not have in person tours until further notice.

### **Communal Activities and Dining:**

- **General:**
  - While adhering to the [CMS core principles of COVID-19 infection prevention](#) and [CDC infection prevention and control recommendations](#), communal activities and dining may occur in facilities where there is no ongoing outbreak of COVID-19.
  - Physical distancing and source control recommendations can be relaxed only when all participants and staff present are known to be fully vaccinated. Maintaining source control and physical distancing is still the safest option. Face coverings should still be used when participants are in common areas on their way to/from the activity or dining room.
  - Facilities should consider limiting groups to residents that live on a single unit.
  - Facilities may be able to offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.
- **Rehab Therapy Gyms:**
  - Rehab gyms may be opened for physical therapy if the facility is not having an active outbreak.
  - Physical distancing of at least 6 feet should be maintained among residents and staff as much as possible.
  - Staff must wear appropriate PPE, including respiratory protection and eye protection.
  - Residents must perform hand hygiene before leaving the room and after returning.
  - The rehab therapy room and equipment must be thoroughly cleaned and disinfected between each use.
  - Residents who are on transmission-based precautions (TBP) should receive in-room therapy services only.

- **Memory Care:**
  - [Caring for residents with dementia](#) presents a formidable challenge to maintaining social distancing, movement restrictions, and other infection prevention measures. Changes in routines, environments, and caregivers can result in anxiety and behavioral changes.
  - Try to maintain routines while reminding and assisting residents to perform frequent hand hygiene and to wear face masks as tolerated.
  - Redirect and remind residents not to congregate if they must walk around the unit.
  - Consider separating furniture in common areas to encourage physical distancing.
  - Clean and disinfect frequently touched surfaces regularly.

### **Identify Cases of COVID-19:**

- **Identifying COVID-19 in Staff:**
  - Staff with any symptoms that could be compatible with COVID-19, even mild illness, should not report to work regardless of vaccination status.
  - Sick leave policies should be non-punitive and allow staff to stay home while symptomatic, on quarantine following an exposure, or on isolation for confirmed COVID-19.
  - Staff who have known or suspected COVID-19 exposures should be managed and possibly excluded from work as per [CDC guidance for Risk Assessment and Work Restrictions for HCP](#). Staff who are fully vaccinated (2 weeks have passed after the second dose of a two-dose series or a single dose of a one-dose vaccine) do not need to be excluded from work after an exposure unless they become symptomatic. However, staff who have had close contact with a case or a higher-risk exposure should be tested immediately and 5 to 7 days after exposure, regardless of vaccination status. Only staff who tested positive during the past 90 days do not need to test after close contact with a case or after a higher-risk exposure.
  - Facilities must screen all staff at the beginning of each shift for signs or symptoms of COVID-19, including performing temperature checks. Staff who exhibit symptoms should be excluded from work and tested or counseled to seek testing, regardless of vaccination status.
  - Any staff developing signs or symptoms consistent with COVID-19 while at work should keep their facemask on, maintain 6 feet of distancing from others, inform their supervisor, and leave the workplace to isolate at home as soon as possible. Symptomatic staff members should be tested for COVID-19, regardless of vaccination status.
  - Staff with negative COVID-19 molecular amplification tests (e.g., PCR) collected after the onset of symptoms can generally return [24 hours](#) after the resolution of symptoms without the use of antipyretics as long as there is no known exposure or clinical suspicion for COVID-19. If there is an alternate diagnosis (e.g., tested positive for influenza), criteria for return to work should be based on that diagnosis.

- Facilities should use the [CDC return-to-work guidance](#) when deciding when staff with suspected or confirmed COVID-19 should be allowed to return to work.
- **Identifying COVID-19 in Residents:**
  - Older adults with COVID-19 may not show common symptoms such as fever or respiratory symptoms. Less common symptoms can include new or worsening malaise, headache, or new dizziness, nausea, vomiting, diarrhea, loss of taste or smell. Additionally, temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation, testing, and further evaluation for COVID-19.
  - Nursing homes and assisted living must screen all residents at least daily, preferably three times per day, including temperature checks, pulse oximetry checks, and monitoring for signs and symptoms of COVID-19.

### **Prepare for an Outbreak:**

- Prepare facility internal and external communications in the event of a COVID-19 case being identified in your facility.
- Maintain an updated list of public health communicable disease and leadership contacts and ensure it is readily accessible.
- Create plans for a COVID unit. See “Cohorting Residents with COVID-19” below.

## **Responding to an Outbreak**

### **Communication, Surveillance, and Reporting:**

- Notify the local health department (LHD) of the outbreak immediately.
- Report new onsets of illness and new positive lab results to the LHD on a daily basis and conduct daily active surveillance (residents and staff) until the outbreak is over.
- Maintain a line list of all residents and staff with possible symptoms of COVID-19. Use the template provided by the local health department or posted on the MDH website.
- Update the line list and share it with the LHD daily.
- Increase monitoring of residents' symptoms and vitals with pulse oximetry to at least 3 times daily.
- Continue screening of staff for symptoms and fever every shift.
- Provide frequent education about COVID-19 to facility-based and consultant personnel (e.g., wound care, podiatry, hospice), vendors (e.g., barber), visitors, and volunteers who provide care or services in the facility. Inclusion of consultants is important, since they commonly provide care in multiple facilities and can be exposed to or serve as a source of pathogen transmission.
- Brief the leadership team on priority activities in the event of a suspected or confirmed case.
- Ensure frequent and ongoing communication with all staff, families, and residents.
- By 5:00 pm the next calendar day, inform residents, residents' representatives, and staff of the first COVID-19 case or when 3 or more residents or staff have new respiratory symptoms that occur within 72 hours.
- Provide updates weekly or each time a new COVID-19 case identified or when 3 additional residents or staff develop symptoms within 72 hours of each other. Follow all current directives and orders concerning notification.
- Post signs to make residents, staff, and visitors aware of the outbreak.
- Coordinate public communications with the health department.

### **Testing:**

- All residents and staff, including those who are fully vaccinated, should be tested immediately upon the identification of an outbreak, and all staff and residents that tested negative should be retested every 3-7 days until the outbreak closes.
  - It is recommended that COVID-19 testing during outbreaks be done by PCR, as antigen tests become less reliable as community prevalence drops and specimens submitted for PCR testing can be submitted for viral sequencing.
  - Only individuals who have tested positive for COVID by PCR within the past 90 days are exempted from testing.
  - Facilities must follow local health department recommendations and [CMS](#) and [MDH](#) testing requirements.

- Facilities should consider adding additional targeted resident testing during outbreak situations (e.g., twice weekly, especially on affected units, residents or staff with known exposures).
- Each symptomatic person should be tested for COVID-19 and influenza as soon as possible after the onset of symptoms. Consider other tests including a respiratory PCR panel test. For residents with pneumonia, obtain urinary antigen testing for *Legionella* and *S. pneumoniae*, and obtain sputum for bacterial culture and *Legionella* PCR.

### **Care of Residents with Suspected or Confirmed COVID:**

- Confirmed (positive by PCR or symptomatic and positive by POC or PCR) and suspect COVID-19 cases (symptomatic residents with testing pending and asymptomatic residents who have tested positive by rapid antigen test with pending PCR results) should be immediately placed on droplet and contact precautions in a private room.
- Suspect cases should be isolated in a private room, but not placed on the COVID unit until their COVID-19 status is confirmed; this may be on designated unit for suspect case or on the observation unit. If this is not possible, the resident's current private room can be utilized.
- Confirmed cases should be placed on the COVID-19 unit, if possible.
- Residents who are suspected to have COVID-19 or who are COVID-19 positive should stay in their rooms and out of common areas. If they need to come out of their rooms, they should wear face masks, if tolerated, distance from others, and use respiratory etiquette.
- Your local health department can assist with resident placement decisions.
- Ensure signage is posted to clearly designate that the resident is on transmission-based precautions (TBP). Use standard, contact, and droplet precautions with eye protection (i.e., gown, gloves, face mask or N95, and face shield or goggles). Signage should not indicate diagnosis (e.g., COVID Positive Room).
- Roommates should be separated from the suspect or confirmed case and placed on observation/quarantine because of known exposure. They should be in separate private rooms (refer to first three bullets in this section) and cared for using TBP.
- Roommates and other potentially exposed individuals should be tested along with the suspect case, even if recent surveillance testing was performed.
- To the extent possible, use dedicated medical equipment for suspected and confirmed cases. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to the manufacturer's instructions and using a product [EPA List N](#) or a 1:10 bleach solution for the necessary contact time.
- **PPE for Residents with Suspected or Confirmed COVID-19:**
  - As described in the PPE section above, use standard, contact, and droplet precautions with eye protection (i.e., gown, gloves, N95 (face mask if N95s are not available), and face shield or goggles) for residents who:
    - Have an undiagnosed illness compatible with COVID-19 (PUIs)
    - Tested positive for COVID-19 by PCR or antigen test

- Had close contact with a confirmed or suspect case, including roommates of cases and residents who were cared for by a positive staff member.
- On observation due to recent admission, readmission, or exposure.
- The use of all PPE may be recommended for all residents on affected units or for all residents in the facility if the outbreak is ongoing or widespread. Consult with the local health department for guidance.
- For positive residents, follow [current CDC guidance](#) for discontinuation of contact and droplet precautions. For those who are negative or not tested, follow guidance in [Table 4. of Guidelines for Prevention and Control of Upper and Lower Acute Respiratory Illnesses \(including Influenza and Pneumonia\) in Healthcare Settings](#)
- Standard precautions plus mask and optional eye protection may generally be used with other residents during an outbreak, unless they are on transmission-based precautions for another reason.
- [Aerosol-generating procedures](#) should be avoided, when possible. If these procedures are medically necessary, [proper PPE should be worn including a fit tested N95 or higher-level respirator](#).
- Discontinuation of Transmission-based Precautions for Residents Following Confirmed COVID-19:
  - [Time-based or symptom-based strategies](#) are preferred to discontinue isolation, work exclusion, and transmission based precautions. The test-based strategy may be used in cases of prolonged symptoms, or for severely immunocompromised individuals.
- **Cohorting Residents with Confirmed COVID-19:**
  - **Nursing homes should:**
    - Create dedicated space for the care of COVID-positive residents. Determine the location(s) of the COVID-19 care unit(s) and create a staffing plan to ensure staff are dedicated to the care of COVID-19 positive residents (only) each shift. Include a plan for overflow of COVID-positive residents.
    - Create physical separation of the COVID-19 unit from other rooms or units housing residents without confirmed COVID-19. This can be a separate floor, wing, or cluster of rooms.
    - Dedicate a separate entrance and a door that can be closed, if possible.
    - Display appropriate signage to indicate isolation status.
    - Ensure clean PPE is available outside each resident's room. Use standard, contact, and droplet precautions with eye protection (i.e., gown, gloves, face mask or N95, and face shield or goggles).
    - Place a trash bin just inside each resident's door for used PPE.
    - Dedicate and separate a staff restroom, break room, and work area for staff working on the dedicated COVID-19 unit, as available.
    - Dedicate equipment such as vital signs machines signs machines, glucometers, and medication carts for the unit. Equipment should be cleaned and disinfected between residents to prevent the spread of other infectious diseases or MDROs.
  - **Assisted Living facilities without COVID units should:**
    - Isolate positive residents in a private room and keep the door closed.

- Display appropriate signage on each resident's door to indicate isolation status.
- Ensure clean PPE is available outside each resident's room.
- Place a trash bin just inside each resident's door for used PPE.
- Dedicate and separate a staff restroom, break room, and work area for staff working with residents confirmed to have COVID-19, as available.
- Dedicate equipment such as vital signs machines, glucometers, and medication carts for residents confirmed positive for COVID-19. Equipment should be cleaned and disinfected between residents to prevent the spread of other infectious diseases or MDROs.
- **Dedicated Staffing:**
  - Dedicate staff to work only on the COVID-19 care unit (or with only COVID-19 positive residents) over a single shift. This is especially important for direct caregivers, but applies to environmental services, therapy, and any other staff deemed essential.
  - Train these staff members on infection control, donning and doffing of PPE, extended use and limited re-use of PPE (when allowed), cleaning and disinfection of surfaces in resident rooms, hallways, and staff areas, and cleaning and disinfection of equipment between uses, and safe linen and waste handling.
  - In general, only essential personnel should enter the room of patients with COVID-19. Healthcare facilities should consider assigning daily cleaning and disinfection of high touch surfaces to nursing personnel who will already be in the room providing care to the patient.
- **Contact Tracing:**
  - When a staff member or resident tests positive for COVID-19, initiate an investigation to identify other potentially exposed individuals:
    - For staff cases, conduct an interview to determine if there was close contact with other staff members during the infectious period. To identify residents who may have been exposed to the infected staff member, use assignment sheets and conduct interviews to identify other residents who may not appear on the assignment sheet. Residents who meet the time and distance criteria for close contact should be considered exposed regardless of PPE used by the staff member and resident and regardless of the [resident's vaccination status](#).
    - For resident cases, roommates should be considered close contacts. Other close resident contacts should be identified through interviews with the resident if possible and/or through interviews with caregivers who observe the resident's activities. Staff who were in proximity to the resident should be evaluated for potential high-risk exposures through PPE breaches.
  - If staff is determined to have an exposure, follow [CDC's Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to COVID-19. Fully vaccinated staff](#), unless they are immunocompromised, generally do not need to be excluded from work after an exposure unless they develop symptoms or test positive. Exposed staff should be tested immediately and 5 to 7 days after exposure unless they have been infected

- during the last 90 days and remain asymptomatic. If you have a question about an exposure or exclusion, consult your local health department.
- Residents who had close contact with a confirmed case within 48 hours of the case's symptom onset or positive test date should be moved to the observation/quarantine unit (if asymptomatic), or if available, a unit for persons under investigation for COVID-19 (if symptomatic). If such a unit is not available, isolate the resident in a private room. Exposed residents should be tested immediately and 5 to 7 days after exposure unless they have been infected during the last 90 days and remain asymptomatic.
    - If multiple residents are cared for by a positive staff member and it is not possible to place each in a private room, leave the exposed residents in place, but care for them using contact and droplet precautions (N95 (or facemask if N95 not available), gowns, gloves, and eye protection).
    - It may be recommended to place all residents on affected units on contact and droplet precautions (N95 or facemask if N95 not available), gowns, gloves, and eye protection).
    - Facilities should consult with their local health department to discuss any additional recommendations.

### **Admissions and Transfers:**

- Facilities should remain open to new admissions unless specifically instructed otherwise by public health officials.
- Transport personnel and any facility receiving residents with potential exposure to COVID-19 or with suspected or confirmed COVID-19 must be verbally notified about the diagnosis prior to transfer.
- While awaiting transfer, residents should wear a facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed). Appropriate PPE should be used by HCP and transport personnel when coming in contact with the resident.

### **Visitation:**

- Following the identification of a case of COVID-19, all visitation except for compassionate care visits should be halted while universal testing of all residents and staff (regardless of vaccination status) is being conducted
- After the results of the first round of universal testing is complete:
  - Outdoor visitation may resume for any individuals who are not on TBP due to being confirmed or suspect case, or identified as a close contact of a case.
  - Indoor visitation must remain suspended on the unit with the first case(s) until the outbreak closes. If additional cases are identified on other units at any time, all indoor visitation should be suspended for the entire facility until the outbreak closes.

- If no additional cases are identified after the first round of testing, or the other cases are limited to the same unit as the index case, indoor visitation may resume for individuals on the unaffected units who are not on TBP.

### **Movement Restrictions, Communal Activities, and Group Dining:**

- [CMS core principles](#) of infection prevention must be followed at all times.
- Residents with suspected or confirmed COVID-19 (including those without symptoms), those on observation for COVID-19, and those on transmission-based precautions for another infectious condition, must remain in their room with the door closed, if safely able to do so, until they have been cleared from observation or Transmission-Based Precautions.
- During an outbreak, discuss with the local health department allowing residents who are not on transmission-based precautions to walk around their own units or to go directly outside. Residents should not move between units. Facilities should consider scheduling residents to be out of their room with staff supervision to ensure social distancing. During an outbreak, residents should not congregate, regardless of vaccination status.
- When a case/outbreak is identified, all group activities and group dining should stop immediately, and therapy should be done in-room only. Depending on the progression of the outbreak, local health departments may consider allowing limited group activities and dining and limited use of the therapy gym on unaffected units. This should not be done without the permission of the LHD.
- Avoid transferring residents between units.
- Cohort staff. Staff should not float between units. Personnel should not go back and forth between different areas of the facility. Assign employees to care for the same group of patients each shift, if possible.

### **Other Actions During an Outbreak:**

- Reinforce education for staff on PPE, hand hygiene, cleaning and disinfection, and social distancing.
- Facilities should consider assigning infection prevention monitors on each shift and unit who ensure social distancing, hand hygiene, correct PPE use, and masking.
- Emphasize mask use and hand hygiene for residents.
- Make sure that hand sanitizer, soap, paper towels, PPE, and disinfectant wipes are readily available in multiple locations near the points of use.
- If possible, offer vaccine to staff and residents who had previously declined.
- If one or more residents or staff members is found to have a SARS-CoV-2 variant of concern or interest, additional or enhanced control measures might be recommended, as these variants are often more transmissible and associated with more severe disease.