# Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes

Nursing Homes & Long-Term Care Facilities

Updated Mar. 29, 2021

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

This guidance summarizes the core infection prevention and control practices for nursing homes during the SARS-CoV-2 pandemic.  Some of these recommendations can be modified in response to COVID-19 vaccination.  Those modifications, which will be regularly updated, are posted in CDC’s Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

## Summary of Recent Changes

## Updates as of March 29, 2021

* Two prior guidance documents, “Responding to COVID-19 in Nursing Homes” and “Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes” were merged with this guidance.
* The criteria for health department notification was updated to be consistent with Council of State and Territorial Epidemiologist (CSTE) guidance for reporting.
* Information on the importance of vaccinating residents and healthcare personnel (HCP) was added along with links to vaccination resources.
* Visitation and physical distancing measures were updated.
* Added  proper use and handling of personal protective equipment (PPE).
* Added  universal PPE use to align with the interim infection prevention and control guidance for HCP.
* Added considerations for situations when it might be appropriate to keep the room door open for a resident with suspected or confirmed SARS-CoV-2 infection.
* A description was included about when it may be appropriate for a resident with a suspected SARS-CoV-2 infection to “shelter-in-place.”
* Added management of residents who had close contact with someone with SARS-CoV-2 infection which includes a description of quarantine recommendations including resident placement, recommended PPE, and duration of quarantine.
* Added addressing circumstances when quarantine is recommended for residents who leave the facility.
* Added responding to a newly identified SARS-CoV-2-infected HCP or resident.
* Added addressing quarantine and work exclusion considerations for asymptomatic residents and HCP who are within 90 days of resolved infection.

## Key Points

* Older adults living in congregate settings are at high risk of being affected by respiratory and other pathogens, such as SARS-CoV-2.
* A strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP).
* Even as nursing homes resume normal practices and begin relaxing restrictions, nursing homes must sustain core IPC practices and**remain vigilant for SARS-CoV-2 infection among residents and HCP in order to prevent spread and protect residents and HCP** from severe infections, hospitalizations, and death.
* These recommendations supplement CDC’s Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic and are specific for nursing homes, including skilled nursing facilities, but may also apply to other long-term care and residential settings.

This guidance summarizes the core infection prevention and control practices for nursing homes during the SARS-CoV-2 pandemic.  Some of these recommendations can be modified in response to COVID-19 vaccination.  Those modifications, which will be regularly updated, are posted in CDC’s Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

## Introduction

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at high risk of being affected by respiratory pathogens like SARS-CoV-2 and other pathogens, including multidrug-resistant organisms (e.g., carbapenemase-producing organisms, *Candida auris*). As demonstrated by the COVID-19 pandemic, a strong infection prevention and control (IPC) program is critical to protect both residents and healthcare personnel (HCP). Even as nursing homes resume more normal practices and begin relaxing restrictions, **nursing homes must sustain core IPC practices and remain vigilant for SARS-CoV-2 infection among residents and HCP in order to prevent spread and protect residents and HCP** **from severe infections, hospitalizations, and death**.

This guidance has been updated and organized according to IPC practices that should remain in place whether or not nursing homes are experiencing outbreaks of SARS-CoV-2. Additional guidance is included to assist nursing homes and public health authorities with resident placement and cohorting decisions when responding to SARS-CoV-2 infections and exposures.

These recommendations supplement CDC’s Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic and are specific for nursing homes, including skilled nursing facilities, but may also be applicable to other long-term care and residential settings.

Unless noted in the Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination, this guidance applies regardless of vaccination status and level of vaccination coverage in the facility.

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Infection Prevention and Control Program

### Assign One or More Individuals with Training in Infection Control to Provide On-Site Management of the IPC Program

* This should be a full-time role for at least one person in facilities that have more than 100 residents or that provide on-site ventilator or hemodialysis services. Smaller facilities should consider staffing the IPC program based on the resident population and facility service needs identified in the IPC risk assessment.
* CDC has created an online training course at https://www.train.org/cdctrain/training\_plan/3814  that can orient individuals to this role in nursing homes.

### Provide Supplies Necessary to Adhere to Recommended Infection Prevention and Control Practices

* Hand Hygiene Supplies:
	+ Put FDA-approved alcohol-based hand sanitizer with 60-95% alcohol in every resident room (ideally both inside and outside of the room) and other resident care and common areas (e.g., outside dining hall, in therapy gym).
	+ Unless hands are visibly soiled, performing hand hygiene using an alcohol-based hand sanitizer is preferred over soap and water in most clinical situations (e.g., before and after touching a resident) due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and, in the absence of a sink, are an effective method of cleaning hands.
	+ Make sure that sinks are well-stocked with soap and paper towels for handwashing.
* Personal Protective Equipment (PPE):
	+ Employers should select appropriate PPE and provide it to HCP in accordance with Occupational Safety and Health Administration (OSHA) PPE standards (29 CFR 1910 Subpart I)
	+ Facilities should have supplies of facemasks, N95 or higher-level respirators, gowns, gloves, and eye protection (i.e., face shield or goggles).
	+ Implement a respiratory protection program that is compliant with the OSHA respiratory protection standard (29 CFR 1910.134external icon) for employees if not already in place. The program should include medical evaluations, training, and fit testing.
	+ Perform and maintain an inventory of PPE in the facility.
		- Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools.
		- Identify health department or healthcare coalition contacts for getting assistance during PPE shortages.
		- Use the Supplies and PPE pathway in the National Healthcare Safety Network (NHSN) Long-term Care Facility (LTCF) COVID-19 Module to indicate critical PPE shortages (i.e., less than one week supply remaining despite use of CDC PPE optimization strategies).
	+ Make necessary PPE available in areas where resident care is provided.
		- Consider designating staff responsible for stewarding those supplies and monitoring and providing just-in-time feedback, promoting appropriate use by staff.
	+ Position a trash can near the exit inside the resident room to make it easy for staff to discard PPE prior to exiting the room or before providing care for another resident in the same room.
	+ Follow CDC PPE optimization strategies, which offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted.
* Environmental Cleaning and Disinfection:
	+ Develop a schedule for regular cleaning and disinfection of shared equipment, frequently touched surfaces in resident rooms and common areas.
	+ Ensure EPA-registered, hospital-grade disinfectants are available to allow for frequent cleaning of high-touch surfaces and shared resident care equipment.
	+ Use an EPA-registered disinfectant from List N:disinfectants for coronavirus (COVID-19) on the EPA website to disinfect surfaces that might be contaminated with SARS-CoV-2. Ensure HCP are appropriately trained on its use and follow the manufacturer’s instructions for all cleaning and disinfection products (e.g., concentration, application method, and contact time).

### Educate Residents, Healthcare Personnel, and Visitors about SARS-CoV-2, Current Precautions Being Taken in the Facility, and Actions They Should Take to Protect Themselves

* Provide culturally and linguistically tailored information about SARS-CoV-2 infection, including the signs and symptoms that could signal infection.
* Provide information about strategies for managing stress and anxiety.
* Regularly review CDC’s Interim Infection Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic for current information and ensure staff and residents are updated when this guidance changes.
* Educate and train HCP, including facility-based and consultant personnel (e.g., rehabilitation therapy, wound care, podiatry, barber), ombudsman, and volunteers who provide care or services in the facility. Including consultants is important since they commonly provide care in multiple facilities where they can be exposed to and serve as a source of SARS-CoV-2.
	+ Educate HCP about any new policies or procedures.
	+ Reinforce sick leave policies and **remind HCP not to report to work when ill.**
	+ Reinforce adherence to standard IPC measures including hand hygiene and selection and correct use of PPE. Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing their resident care activities.
		- CDC has created training resources at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-home-long-term-care.html for front-line staff that can be used to reinforce recommended practices for preventing transmission of SARS-CoV-2 and other pathogens.
* Educate residents and families through educational sessions and written materials on topics including information about SARS-CoV-2, actions the facility is taking to protect them and their loved ones, any visitor restrictions that are in place, and actions they should take to protect themselves in the facility, emphasizing the importance of source control, physical distancing and hand hygiene.
* Have a plan and mechanism to regularly communicate with residents, families and HCP, including if cases of SARS-CoV-2 infection are identified among residents or HCP.

Find the contact information for the healthcare-associated infections program in your state health department as well as your local health department at https://www.cdc.gov/hai/state-based/index.html

### Notify HCP, residents, and families about outbreaks, and report SARS-CoV-2 infection, facility staffing, testing, and supply information to public health

* Notify the health department promptly   about any of the following:
	+ ≥ 1 residents or HCP with suspected or confirmed SARS-CoV-2 infection,
	+ Resident with severe respiratory infection resulting in hospitalization or death, or≥ 3 residents or HCP with acute illness compatible with COVID-19 with onset within a 72 hour period
* Notify HCP, residents, and families promptly about identification of SARS-CoV-2 in the facility  and maintain ongoing, frequent communication with residents, families, and HCP with updates on the situation and facility actions.
* Report SARS-CoV-2 infections, facility staffing and supply information, and point of care testing data to the National Healthcare Safety Network (NHSN) Long-term Care Facility  (LTCF) COVID-19 Module weekly at https://www.cdc.gov/nhsn/ltc/covid19/index.html. CDC’s NHSN provides long-term care facilities with a secure reporting platform to track infections and prevention process measures in a systematic way.
	+ Weekly data submission to NHSN will meet the Centers for Medicare and Medicaid Services (CMS) COVID-19 reporting requirements at https://www.cms.gov/files/document/qso-20-29-nh.pdf

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## Vaccinations

### Vaccinate Residents and HCP against SARS-CoV-2

* Receiving a COVID-19 vaccination is an important step to prevent getting sick with COVID-19 disease. CDC continues to stress the importance of getting vaccinated when it is offered to you.
* The Long-Term Care Facility Toolkit: Preparing for COVID-19 Vaccination at Your Facility provides resources including information on preparing for vaccination, vaccination safety monitoring and reporting, frequently asked questions, and printable tools.
* Weekly vaccination numbers of nursing home residents and HCP can be reported into the NHSN LTCF Weekly HCP & Resident COVID-19 Vaccination Reporting module at https://www.cdc.gov/nhsn/ltc/index.html
* Guidance on adjustment to IPC recommendations following vaccination is available in CDC’s Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

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## Source Control and Distancing Measures

### Implement Source Control Measures

* Source control refers to use of well-fitting cloth masks, facemasks, or respirators to cover a person’s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. In addition to providing source control, these devices also offer varying levels of protection against exposure to infectious droplets and particles produced by infected people. Fit-tested respirators are most protective for the wearer. Ensuring a proper fit is important to optimize both the source control and protection offered. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19.
* Residents, if tolerated, should wear a well-fitting form of source control upon arrival and throughout their stay in the facility. Residents may remove their source control when in their rooms but should put it back on when around others (e.g., HCP or visitors enter the room) and whenever they leave their room, including when in common areas or when outside of the facility. More information on options to improve fit is available from CDC at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/mask-fit-and-filtration.html
	+ Source control should not be placed on anyone who cannot wear a mask safely, such as someone who has a disability or an underlying medical condition that precludes wearing a mask or who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
* For additional guidance on recommended source control for HCP, refer to section: Implement Universal Use of Personal Protective Equipment below.
	+ HCP should wear well-fitting source control at all times while they are in the healthcare facility, **including in breakrooms or other spaces where they might encounter co-workers**.
	+ To reduce the number of times HCP must touch their face and potential risk for self-contamination, HCP should consider continuing to wear the same respirator or well-fitting facemask throughout their entire work shift when the respirator or facemask is used for source control.
	+ HCP should remove their respirator or facemask, perform hand hygiene, and put on their community source control (i.e., mask), when leaving the facility at the end of their shift.
* Visitors and others who enter the facility (e.g., contractors, people making deliveries), if permitted into the facility, should wear a well-fitting form of source control while in the facility.

### Implement Physical Distancing Measures

* Although most care activities require close physical contact between residents and HCP, when possible, maintaining physical distance between people (at least 6 feet) is an important strategy to prevent SARS-CoV-2 transmission.
* Remind HCP to practice physical distancing and wear source control when in break rooms or common areas.
* The following activities can be considered for residents who do not have current suspected or confirmed SARS-CoV-2 infection, including those who have fully recovered, and residents who have not had close contact with a person with SARS-CoV-2 infection:
	+ Communal dining and group activities at the facility
		- As activities are occurring in communal spaces and could involve individuals who have not been fully vaccinated, residents should practice physical distancing, wear source control (if tolerated), and perform frequent hand hygiene.
	+ Social excursions outside the facility
		- Residents and their families should be educated about potential risks of public settings, particularly if they have not been fully vaccinated, and reminded to avoid crowds and poorly ventilated spaces.
		- They should practice physical distancing, wear source control (if tolerated), and perform frequent hand hygiene.
		- Considerations for fully vaccinated residents who are visiting friends or family in a private setting outside the facility are described in the Interim Public Health Recommendations for Fully Vaccinated People at https://www.cdc.gov/coronavirus/2019-ncov/vaccines/fully-vaccinated-guidance.html
	+ They should inform the facility if they have close contact with a person with SARS-CoV-2 infection while outside the facility
	+ Quarantine considerations for residents who leave the facility are described in Create a Plan for Residents who leave the Facility at https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html#new-admissions

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## Visitation

### Have a Plan for Visitation

* Have a facility plan for managing visitation, including use of restrictions when necessary.
* While facilities are encouraged to facilitate in-person visits whenever possible, the CMS visitation memo describes  situations requiring temporary restriction of indoor visitors, except for compassionate care reasons. Please refer to CMS visitation memo at https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf,  CDC Updated Healthcare IPC Recommendations in Response to COVID-19 Vaccination**,**as well as your state and local health department for additional guidance.
* Send letters or emails to families reminding them not to visit when ill or if they have had close contact with someone with SARS-CoV-2 infection in the prior 14 days.
* Post signs at the entrances to the facility advising visitors to check-in with the front desk to be assessed for symptoms prior to entry.
* Symptoms of COVID-19
* Fever of 100.0 °F or higher or report feeling feverish
* Close contact to someone with COVID-19 during the prior 14 days
* Undergoing evaluation for COVID-19 (such as pending viral test) due to exposure or close contact to a person with COVID-19
* Diagnosis of COVID-19 in the prior 10 days
* Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.
* When visitation is restricted:
	+ Send letters or emails  to families advising them of the restrictions
	+ Facilitate and encourage alternative methods for visitation  (e.g., video conferencing) and communication with the resident

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## Personal Protective Equipment

### Ensure Proper Use and Handling of Personal Protective Equipment

* Facilities should have policies and procedures addressing:
	+ Which PPE is required in which situations (e.g., residents with suspected or confirmed SARS-CoV-2 infection, residents placed in quarantine)
	+ Recommended sequence for safely donning and doffing PPE
* Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses.
* Bundle care activities to minimize the number of HCP entries into a room.
* If PPE shortages are anticipated or exist, implement CDC PPE optimization strategies  CDC Strategies for Optimizing the Supply of PPE during Shortages offer a continuum of options for use when PPE supplies are stressed, running low, or exhausted, and are intended to be implemented sequentially (i.e., implementing contingency strategies prior to implementing crisis strategies).
* Additional information is available:
	+ Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
	+ Personal Protective Equipment: Questions and Answers.
	+ Summary for Healthcare Facilities: Strategies for Optimizing the Supply of PPE during Shortages | CDC

### Implement Universal Use of Personal Protective Equipment

* Transmission from asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection can occur in healthcare settings, particularly in geographic areas with moderate to substantial community transmission.
* The fit of the medical device used to cover the wearer’s mouth and nose is a critical factor in the level of source control (preventing exposure of others) and level of the wearer’s exposure to infectious particles. Respirators offer the highest level of both source control and protection against inhalation of infectious particles in the air.  Facemasks that conform to the wearer’s face so that more air moves through the material of the facemask rather than through gaps at the edges are more effective for source control than facemasks with gaps and can also reduce the wearer’s exposure to particles in the air. Improving how a facemask fits can increase the facemask’s effectiveness for decreasing particles emitted from the wearer and to which the wearer is exposed.
* **HCP working in facilities located in areas with moderate to substantial community transmission** are more likely to encounter asymptomatic or pre-symptomatic residents with SARS-CoV-2 infection. If SARS-CoV-2 infection is **not** suspected in a resident (based on symptom and exposure history):
	+ HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis; for example, use an N95 respirator or equivalent or higher level respirator if the patient is suspected to have tuberculosis).
	+ Additionally, HCP should use PPE as described below:
		- N95 respirators or equivalent or higher-level respirators should be used for
			* All aerosol generating procedures (refer to Which procedures are considered aerosol generating procedures in healthcare settings FAQ)
		- One of the following should be worn by HCP while in the facility and for protection during resident care encounters:
			* A NIOSH-approved N95 respirator OR
			* A respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators OR
			* A well-fitting facemask (e.g., selection of a facemask with a nose wire to help the facemask conform to the face; selection of a facemask with ties rather than ear loops; use of a mask fitter; tying the facemask’s ear loops and tucking in the side pleats; fastening the facemask’s ear loops behind the wear’s head; use of a cloth mask over the facemask to help it conform to the wearer’s face)
				+ Additional information about strategies to improve fit and filtration are available in Improve the Fit and Increase the Filtration of Your Mask to Reduce the Spread of COVID-19 at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/mask-fit-and-filtration.html
				+ If implementing new strategies or equipment to improve fit, HCP should receive training on how to safely don and doff their facemask and the facility protocol for cleaning and disinfecting any reusable equipment (e.g., fitter). They should also ensure that any new strategies do not impede their vision or ability to breathe.
			* Eye protection should be worn during patient care encounters to ensure the eyes are also protected from exposure to respiratory secretions.
	+ **HCP working in areas with minimal to no community transmission**should continue to adhere to Standard and Transmission-Based Precautions based on anticipated exposures and suspected or confirmed diagnoses. This might include use of eye protection, an N95 or equivalent or higher-level respirator, as well as other PPE. In addition, universal use of a well-fitting facemask for source control is recommended for HCP if not otherwise wearing a respirator.

Additional considerations for universal use of PPE in facilities where transmission of SARS-CoV-2 is suspected or identified is described in the section: Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident.

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## Testing

### Create a Plan for Testing Residents and Healthcare Personnel for SARS-CoV-2

* Guidance addressing when to test residents and HCP for SARS-CoV-2 and how to interpret results of antigen tests is available at the following links:
	+ Testing Guidelines for Nursing Homes at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html
	+ Interim Guidance on Testing Healthcare Personnel for SARS-CoV-2 at https://www.cdc.gov/coronavirus/2019-ncov/hcp/testing-healthcare-personnel.html
	+ SARS-CoV-2 Antigen Testing in Long Term Care Facilities at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-antigen-testing.html
* The plan should align with state and federal requirements for testing residents and HCP for SARS-CoV-2 and address:
	+ Triggers for performing testing (e.g., a resident or HCP with symptoms consistent with COVID-19, a resident or HCP with SARS-CoV-2 in the facility, routine testing)
	+ Access to tests capable of detecting the virus and an arrangement with laboratories to process tests or capacity to conduct and process point-of care tests onsite
	+ Process for and capacity to perform SARS-CoV-2 testing of all residents and HCP
	+ Training for HCP on how to collect and process specimens correctly, including correct use of PPE
	+ A procedure for addressing residents or HCP who decline or are unable to be tested (e.g., maintaining Transmission-Based Precautions until symptom-based criteria are met for a symptomatic resident who refuses testing)
	+ A plan to respond to results of the testing prior to initiating testing, for additional information see section: Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident
* Additional information about testing of residents and HCP is available:
	+ Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings, which includes considerations for health departments and nursing homes for facility-wide testing, at https://www.cdc.gov/coronavirus/2019-ncov/hcp/broad-based-testing.html
	+ Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID-19 Focused Survey Tool  at https://www.cms.gov/files/document/qso-20-38-nh.pdf

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## Evaluating and Managing Personnel and Residents

### Evaluate and Manage Healthcare Personnel

* Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
* Create an inventory of all volunteers and personnel who provide care in the facility. Use that inventory to determine which personnel are non-essential and whose services can be delayed if such restrictions are necessary to prevent or control transmission.
* Establish a process to ensure HCP (including consultant personnel and ancillary staff such as environmental and dietary services) entering the facility are assessed for symptoms of COVID-19  or close contact outside the facility to others with SARS-CoV-2 infection and that they are practicing source control.
	+ Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, HCP report absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not had close contact with others with SARS-CoV-2 infection during the prior 14 days.
		- Fever can be either measured temperature ≥100.0°F or subjective fever. People might not notice symptoms of fever at the lower temperature threshold that is used for those entering a healthcare setting, so they should be encouraged to actively take their temperature at home or have their temperature taken upon arrival.
* HCP who report symptoms should be excluded from work and should notify occupational health services to arrange for further evaluation. In addition, asymptomatic HCP who report close contact with others with SARS-CoV-2 infection might need to be excluded from work.
	+ If HCP develop fever (Temperature ≥100.0°F) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace.
* Have a plan for how to respond to HCP with SARS-COV-2 infection who worked while ill (e.g., identifying exposed residents and co-workers and initiating an outbreak investigation in the unit or area of the building where they worked).
* Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including providing resources to assist HCP with anxiety and stress. Strategies to mitigate staffing shortages are available.
* Information about when non-essential personnel should have limited entry into facilities can be found in the CMS Re-opening Memo at https://www.cms.gov/files/document/qso-20-30-nh.pdf
* Information about when HCP with suspected or confirmed SARS-CoV-2 infection may return to work is available in the Interim Guidance on Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 at https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html
* Information about risk assessment and work restrictions for HCP exposed to SARS-CoV-2 is available in the Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to Coronavirus Disease 2019 (COVID-19) at https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

### Identify Space in the Facility that Could be Dedicated to Monitor and Care for Residents with Confirmed SARS-CoV-2 Infection

* Determine the location of the COVID-19 care unit and create a staffing plan.
	+ Doing this before residents or HCP with SARS-CoV-2 infection are identified in the facility will allow time for residents to be relocated to create space for the unit and to identify HCP to work on this unit.
	+ Facilities that have already identified cases of SARS-CoV-2 infection among residents but have not developed a COVID-19 care unit should work to create one unless the proportion of residents with SARS-CoV-2 infection makes this impossible (e.g., the majority of residents in the facility are already infected).
* The location of the COVID-19 care unit should ideally be physically separated from other rooms or units housing residents without confirmed SARS-CoV-2 infection. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with SARS-CoV-2 infection.
* Identify HCP who will be assigned to work only on the COVID-19 care unit when it is in use. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. If possible, HCP should avoid working on both the COVID-19 care unit and other units during the same shift.
	+ To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
	+ Ideally, environmental services (EVS) staff should be dedicated to this unit, but to the extent possible, EVS staff should avoid working on both the COVID-19 care unit and other units during the same shift.
	+ To the extent possible, HCP dedicated to the COVID-19 care unit (e.g., NAs and nurses) will also be performing cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from List N at https://www.epa.gov/coronavirus/about-list-n-disinfectants-coronavirus-covid-19-0 into the room and wipe down high-touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.
* HCP working on the COVID-19 care unit should have access to a restroom, break room, and work area that are separate from HCP working in other areas of the facility.
	+ Ensure HCP practice source control measures and physical distancing in the break room and other common areas (i.e., other than while eating, HCP wear a respirator or source control and sit at least 6 feet apart while on break).
	+ Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).
* CDC PPE optimization strategies should be followed during shortages. Guidance addressing placement, duration, and recommended PPE when caring for residents with SARS-CoV-2 infection is described in Section: Manage Residents with Suspected or Confirmed SARS-CoV-2 infection.

Older adults with SARS-CoV-2 infection 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, more than two temperatures >99.0°F might also be a sign of fever in this population. Identification of these symptoms should prompt isolation and further evaluation for SARS-CoV-2 infection.

### Evaluate Residents at least Daily

* Ask residents to report if they feel feverish or have symptoms consistent with COVID-19.
* Actively monitor all residents upon admission and at least daily for fever (temperature ≥100.0°F) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. If residents have fever or symptoms consistent with COVID-19, implement precautions described in the section: Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection.
	+ Refer to CDC resources at https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf  for performing respiratory infection surveillance in long-term care facilities during an outbreak.
* Information about the clinical presentation and course of patients with SARS-CoV-2 infection is described in the Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 (COVID-19) at https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-guidance-management-patients.html
* CDC has also developed Testing Guidelines for Nursing Homes at https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-testing.html

### Manage Residents with Suspected or Confirmed SARS-CoV-2 Infection

* Residents with suspected SARS-CoV-2 infection should be prioritized for testing.
* Residents with suspected or confirmed SARS-CoV-2 infection do not need to be placed into an airborne infection isolation room (AIIR) but should be cared for HCP using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown.
	+ CDC PPE optimization strategies include a hierarchy of strategies to implement when PPE are in short supply or unavailable (e.g., use of a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators or a well-fitting facemask when NIOSH-approved N95 or equivalent or higher-level respirators are not available).
	+ Ideally a resident with suspected SARS-CoV-2 infection should be moved to a single-person room with a private bathroom while test results are pending.
		- In general, it is recommended that the door to the room remain closed to reduce transmission of SARS-CoV-2.  This is especially important for residents with suspected or confirmed SARS-CoV-2 infection being cared for outside of the COVID-19 care unit.  However, in some circumstances (e.g., memory care units), keeping the door closed may pose resident safety risks and the door might need to remain open.  If doors must remain open, work with facility engineers to implement strategies to minimize airflow into the hallway.
	+ If limited single rooms are available or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter-in-place at their current location pending return of test results.
	+ Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection.
	+ Roommates of residents with SARS-CoV-2 infection should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents while they are in quarantine (i.e., for the 14 days following the date their roommate was moved to the COVID-19 care unit).
* Increase monitoring of residents with suspected or confirmed SARS-CoV-2 infection, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least 3 times daily to identify and quickly manage serious infection.
* For decisions on removing residents who have had SARS-CoV-2 infection from Transmission-Based Precautions refer to the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19 at https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html

If a resident requires a higher level of care or the facility cannot fully implement all recommended infection control precautions, the resident should be transferred to another facility that is capable of implementation**. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer**.

This guidance summarizes the core infection prevention and control practices for nursing homes during the SARS-CoV-2 pandemic.  Some of these recommendations can be modified in response to COVID-19 vaccination.  Those modifications, which will be regularly updated, are posted in CDC’s Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

## Managing Residents with Close Contact

### Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection

* Residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure.
* Residents in quarantine should be placed in a single-person room. If limited single rooms are available or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should shelter-in-place at their current location while being monitored for evidence of SARS-CoV-2 infection.
	+ Residents should only be placed in a COVID-19 care unit if they have confirmed SARS-CoV-2 infection. Placing a resident without confirmed SARS-CoV-2 infection (i.e., with symptoms concerning for COVID-19 pending testing or with known exposure) in a dedicated COVID-19 care unit could put them at higher risk of exposure to SARS-CoV-2.
* HCP should wear an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown when caring for these residents.
	+ CDC PPE optimization strategies include a hierarchy of strategies to implement when PPE are in short supply or unavailable (e.g., use of a respirator approved under standards used in other countries that are similar to NIOSH-approved N95 filtering facepiece respirators or a well-fitting facemask when NIOSH-approved N95 or equivalent or higher-level respirators are not available).
* Residents can be transferred out of quarantine if they remain with no fever and without symptoms for 14 days.
	+ Alternatives to the 14-day quarantine period are described in the Options to Reduce Quarantine for Contacts of Persons with SARS-CoV-2 Infection Using Symptom Monitoring and Diagnostic Testing.  Healthcare facilities could consider these alternatives as a measure to mitigate staffing shortages, space limitations, or PPE supply shortages but, due to the special nature of healthcare settings (e.g., patients at risk for worsening outcomes, critical nature of HCP, challenges with physical distancing), they are not the preferred option. Healthcare facilities should understand that shortening the duration of quarantine might pose additional transmission risk.

Guidance addressing quarantine and testing during an outbreak is described in Section: Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident.

This guidance summarizes the core infection prevention and control practices for nursing homes during the SARS-CoV-2 pandemic.  Some of these recommendations can be modified in response to COVID-19 vaccination.  Those modifications, which will be regularly updated, are posted in CDC’s Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

## New Admissions and Residents who Leave the Facility

### Create a Plan for Managing New Admissions and Readmissions

* Residents with **confirmed SARS-CoV-2 infection**who have **not met** criteria for discontinuation of Transmission-Based Precautions should be placed in the designated COVID-19 care unit.
* In general, all other new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission.
	+ Exceptions include residents within 3 months of a SARS-CoV-2 infection and fully vaccinated residents as described in CDC’s Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination.
	+ Facilities located in areas with minimal to no community transmission might elect to use a risk-based approach for determining which residents require quarantine upon admission. Decisions should be based on whether the resident had close contact with someone with SARS-CoV-2 infection while outside the facility and if there was consistent adherence to IPC practices in healthcare settings, during transportation, or in the community prior to admission.

Guidance addressing placement, duration, and recommended PPE when caring for residents in quarantine is described in Section: Manage Residents who have had Close Contact with Someone with SARS-CoV-2 Infection.

### Create a Plan for Residents who leave the Facility

* Residents who leave the facility should be reminded to follow all recommended IPC practices including source control, physical distancing, and hand hygiene and to encourage those around them to do the same.
	+ Individuals accompanying residents (e.g., transport personnel, family members) should also be educated about these IPC practices and should assist the resident with adherence.
* For residents going to medical appointments, regular communication between the medical facility and the nursing home (in both directions) is essential to help identify residents with potential exposures or symptoms of COVID-19 before they enter the facility so that proper precautions can be implemented.
* In most circumstances, quarantine is not recommended for residents who leave the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and **do not** have close contact with someone with SARS-CoV-2 infection.
	+ Quarantining residents who regularly leave the facility for medical appointments (e.g., dialysis, chemotherapy) would result in indefinite isolation of the resident that likely outweighs any potential benefits of quarantine.
* Facilities might consider quarantining residents who leave the facility if, based on an assessment of risk, uncertainty exists about their adherence or the adherence of those around them to recommended IPC measures.
* Residents who leave the facility for 24 hours or longer should generally be managed as described in the New Admission and Readmission section.

Guidance addressing placement, duration, and recommended PPE when caring for residents in quarantine is described in Section: Manage Residents who have had Close Contact with Someone with SARS-CoV-2 Infection.

This guidance summarizes the core infection prevention and control practices for nursing homes during the SARS-CoV-2 pandemic.  Some of these recommendations can be modified in response to COVID-19 vaccination.  Those modifications, which will be regularly updated, are posted in CDC’s Updated Healthcare Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination at https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html

## New Infection in Healthcare Personnel or Resident

### Respond to a Newly Identified SARS-CoV-2-infected Healthcare Personnel or Resident

* Because of the high risk of unrecognized infection among residents, a single new case of SARS-CoV-2 infection in any HCP or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak.
	+ Consider increasing monitoring of all residents from daily to every shift to more rapidly detect those with new symptoms.
* Implement facility-wide testing along with the following recommended infection prevention precautions:
	+ HCP should care for residents using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown.
	+ Residents should generally be restricted to their rooms and serial SARS-CoV-2 testing performed.
	+ Consideration should be given to halting social activities and communal dining; if these activities must continue for uninfected residents, they should be conducted using source control and physical distancing for all participants.
	+ Guidance about visitation during facility outbreaks is available from CMS  at https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf

Residents could leave their rooms to permit visitation; visitors should be informed about the outbreak in order to make informed decisions about visitation.

* + For additional information about visitation, see section: Have a Plan for Visitation and CMS visitation memo pdf at https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf
	+ Restrict non-essential HCP for areas where CMS limits indoor visitation.
		- Consider implementing telehealth to offer remote access to healthcare.
* Continue repeat viral testing of all previously negative residents in addition to testing of HCP, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result.
* Recommended precautions should be continued for residents until no new cases of SARS-CoV-2 infection have been identified for at least 14 days.
* The incubation period for SARS-CoV-2 infection can be up to 14 days and the identification of a new case within that period after starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.

### Considerations for Residents and HCP who are within 3 months of prior infection

* CDC currently recommends that asymptomatic residents who have recovered and are within 3 months of a positive test for SARS-CoV-2 infection may not need to be quarantined or tested following re-exposure to someone with SARS-CoV-2 infection. However, there might be clinical scenarios in which the uncertainty about a prior infection or the durability of the immune response exist, for which providers could consider testing for SARS-CoV-2 and quarantine following exposure that occurs less than 3 months after their initial infection, Examples could include:
	+ Residents with underlying immunocompromising conditions (e.g., patient after organ transplantation) or who become immune compromised (e.g., receive chemotherapy) in the 3 months following SARS-CoV-2 infection and who might have an increased risk for reinfection. However, data on which specific conditions may lead to higher risk and the magnitude of risk are not available.
	+ Residents for whom there is concern that their initial diagnosis of SARS-CoV-2 infection might have been based on a false positive test result (e.g., resident was asymptomatic, antigen test positive, and a confirmatory nucleic acid amplification test (NAAT) was not performed).
	+ Residents for whom there is evidence that they were exposed to a novel SARS-CoV-2 variant (e.g., exposed to a person known to be infected with a novel variant) for which the risk of reinfection might be higher.

CDC continues to actively investigate the frequency of reinfection and the circumstances surrounding these episodes, including the role that new variants might play in reinfection, and will adjust guidance as necessary as more information becomes available.

## Definitions

**Healthcare Personnel (HCP):** HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances (e.g., blood, tissue, and specific body fluids); contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air. HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, home healthcare personnel, physicians, technicians, therapists, phlebotomists, pharmacists, students and trainees, contractual staff not employed by the healthcare facility, and persons not directly involved in patient care, but who could be exposed to infectious agents that can be transmitted in the healthcare setting (e.g., clerical, dietary, environmental services, laundry, security, engineering and facilities management, administrative, billing, and volunteer personnel).

**Healthcare settings:** Places where healthcare is delivered and includes, but is not limited to, acute care facilities, long term acute care facilities, inpatient rehabilitation facilities, nursing homes and assisted living facilities, home healthcare, vehicles where healthcare is delivered (e.g., mobile clinics), and outpatient facilities, such as dialysis centers, physician offices, and others.

Source Control**:**  Use of well-fitting cloth masks, facemasks, or respirators to cover a person’s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Cloth masks, facemasks, and respirators should not be placed on children under age 2, anyone who cannot wear one safely, such as someone who has a disability or an underlying medical condition that precludes wearing a cloth mask, facemask, or respirator safely, or anyone who is unconscious, incapacitated, or otherwise unable to remove their cloth mask, facemask, or respirator without assistance. Face shields alone are not recommended for source control.

**Cloth mask:** Textile (cloth) covers that are intended primarily for source control. **They are not personal protective equipment (PPE) appropriate for use by healthcare personnel as the degree to which cloth masks protect the wearer is unclear.**Guidance on design, use, and maintenance of cloth masks is available at https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/diy-cloth-face-coverings.html

**Facemask:** Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

**Respirator:** A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by CDC/NIOSH, including those intended for use in healthcare.

**Minimal to no community transmission of SARS-CoV-2:** Sustained transmission with high likelihood or confirmed exposure within communal settings and potential for rapid increase in cases

**Substantial community transmission of SARS-CoV-2**: Large scale community transmission, including communal settings (e.g., schools, workplaces)

**Close Contact:** Someone who was within 6 feet of an infected person for a cumulative total of 15 minutes or more over a 24-hour period\* starting from 2 days before illness onset (or, for asymptomatic patients, 2 days prior to test specimen collection) until the time the patient is isolated.

\*Individual exposures added together over a 24-hour period (e.g., three 5-minute exposures for a total of 15 minutes). Data are limited, making it difficult to precisely define “close contact;” however, 15 cumulative minutes of exposure at a distance of 6 feet or less can be used as an operational definition for contact investigation. Factors to consider when defining close contact include proximity (closer distance likely increases exposure risk), the duration of exposure (longer exposure time likely increases exposure risk), whether the infected individual has symptoms (the period around onset of symptoms is associated with the highest levels of viral shedding), if the infected person was likely to generate respiratory aerosols (e.g., was coughing, singing, shouting), and other environmental factors (crowding, adequacy of ventilation, whether exposure was indoors or outdoors). Because the general public has not received training on proper selection and use of respiratory PPE, such as an N95, the determination of close contact should generally be made irrespective of whether the contact was wearing respiratory PPE.  At this time, differential determination of close contact for those using fabric face coverings is not recommended.

* Information about risk assessment and work restrictions for HCP exposed to SARS-CoV-2 is available in the Interim U.S. Guidance for Risk Assessment and Work Restrictions for Healthcare Personnel with Potential Exposure to Coronavirus Disease 2019 (COVID-19) at https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html
* Risk assessment considerations for residents who are exposed in a healthcare setting is available in the FAQs for Infection Control at https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control