To maximize protection from the Delta variant and prevent possibly spreading it to others, get vaccinated as soon as you can and wear a mask indoors in public if you are in an area of substantial or high transmission.

# Interim Infection Prevention and Control

COVID-19

# Nursing Homes

Nursing Homes & Long-Term Care Facilities

Updated Sept. 10, 2021 Print

## Summary of Recent Changes

### Updates as of September 10, 2021

- Updated outbreak response guidance to promote use of contact tracing approach. Alternative broad-based approaches to outbreak response at a facility-wide or unit level are also described.
- Updated expanded screening testing recommendations for healthcare personnel (HCP).
- Updated recommendations for quarantine of fully vaccinated residents.
- Updated visitation guidance.

Previous Updates

## 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, they 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.

In general, healthcare facilities should continue to follow the IPC recommendations for unvaccinated individuals (e.g., use of Transmission-Based Precautions for those that have had close contact to someone with SARS-CoV-2 infection) when caring for fully vaccinated individuals with moderate to severe immunocompromise due to a medical condition or receipt of immunosuppressive medications or treatments.

Other factors, such as end-stage renal disease, likely pose a lower degree of immunocompromise and there might not be a need to follow the recommendations for those with moderate to severe immunocompromise. However, fully vaccinated people in this category should consider continuing to practice physical distancing and use of source control while in a healthcare facility.

Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventive actions are tailored to each individual and situation.

# Introduction

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 post-acute care settings.

Employers should be aware that other local, state, and federal requirements may apply, including those promulgated by OSHA.

**Defining Community Transmission of SARS-CoV-2**

Several of the IPC measures (e.g., use of source control, screening testing) are influenced by levels of SARS-CoV-2 transmission in the community. Two different indicators in CDC's COVID-19 Data Tracker are used to determine the level of SARS-CoV-2 transmission for the county where the healthcare facility is located. If the two indicators suggest different transmission levels, the higher level is selected.

# 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 that can orient individuals to this role in nursing homes.

### Provide Supplies Necessary to Adhere to Recommended IPC Practices

- Ensure HCP have access to all necessary supplies including alcohol-based hand sanitizer with 60-95% alcohol, personal protective equipment (PPE), and supplies for cleaning and disinfection.
  - 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).

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

- 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 about recommended practices to prevent spread of SARS-CoV-2, including reminding them not to report to work when ill.
  - Training should include facility-based and consultant personnel (e.g., rehabilitation therapy, wound care, podiatry, barber), ombudsmen, 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.
  - CDC has created training resources 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 from SARS-CoV-2, and actions they should take to protect themselves and others in the facility, emphasizing when they should wear source control, physical distance, and perform hand hygiene.

### Notify HCP, Residents, and Families about Outbreaks, and Report SARS-CoV-2 Infections, Facility Staffing, Testing, and Supply Information to Public Health Authorities

- 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
  - ≥ 3 residents or HCP with acute illness compatible with COVID-19 with onset within a 72-hour period
- Find the contact information for the healthcare-associated infections program in your state health department, as well as your local health department.
- Notify HCP, residents, and families promptly about identification of SARS-CoV-2 in the facility and maintain ongoing, frequent communication with HCP, residents, and families 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. 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 .

## Vaccinations

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

- Vaccination acceptance among nursing home personnel remains low, but is critical to protect both staff and residents against COVID-19. CDC continues to stress the importance of getting vaccinated when it is offered to you.
- Per CMS requirements , weekly vaccination numbers of nursing home residents and HCP must be reported into the NHSN LTCF Weekly HCP & Resident COVID-19 Vaccination Reporting module.

## Source Control and Physical Distancing Measures

Refer to Interim Infection Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic for details regarding source control and physical distancing measures recommended for vaccinated and unvaccinated HCP and residents.

## Visitation

### Have a Plan for Visitation

- Send letters or emails to families and post signs at entrances reminding them of the importance of getting vaccinated, recommendations for source control and physical distancing and any other facility instructions related to visitation, including not to visit if they have any of the following:
  - a positive viral test for SARS-CoV-2,
  - symptoms of COVID-19, or
  - if they currently meet criteria for quarantine
- Facilitate and encourage alternative methods for visitation (e.g., video conferencing) and communication with the resident.

Additional information about visitation for nursing homes and intermediate care facilities for individuals with intellectual disabilities and psychiatric residential treatment facilities is available from CMS.

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

# Personal Protective Equipment

**Ensure Proper Use, Handling, and Implementation of Personal Protective Equipment**

- Information is available:
  - Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC
  - Personal Protective Equipment: Questions and Answers | CDC
  - Optimizing Personal Protective Equipment (PPE) Supplies (cdc.gov)

# Testing

**Create a Plan for Testing Residents and HCP for SARS-CoV-2**

- Anyone with even mild symptoms of COVID-19, regardless of vaccination status, should receive a viral test as soon as possible.
- Asymptomatic HCP with a higher-risk exposure and residents with close contact with someone with SARS-CoV-2 infection, regardless of vaccination status, should have a series of two viral tests for SARS-CoV-2 infection. In these situations, testing is recommended immediately (but not earlier than 2 days after the exposure) and, if negative, again 5–7 days after the exposure. Criteria for use of post-exposure prophylaxis are described elsewhere .
- Testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic, including if they have had close contact or a higher-risk exposure; this is because some people may be non-infectious but have detectable virus from their prior infection during this period (additional information is available).
- Expanded screening testing of asymptomatic HCP should be as follows:
  - Fully vaccinated HCP may be exempt from expanded screening testing.
  - In nursing homes, unvaccinated HCP should continue expanded screening testing based on the level of community transmission as follows:
    - In nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have a viral test twice a week.
      - If unvaccinated HCP work infrequently at these facilities, they should ideally be tested within the 3 days before their shift (including the day of the shift).
    - In nursing homes located in counties with moderate community transmission, unvaccinated HCP should have a viral test once a week.
    - In nursing homes located in counties with low community transmission, expanded screening testing for asymptomatic HCP, regardless of vaccination status, is not recommended. Per recommendations above, these facilities should prioritize resources to test vaccinated and unvaccinated symptomatic people and all close contacts, as well as be prepared to initiate outbreak response immediately if a nursing home-onset infection is identified among residents or HCP.

Detailed information on outbreak testing is described in Section: New Infection In Healthcare Personnel or Resident.

# Evaluating and Managing Personnel and Residents

**Refer to CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic for more information.**

- HCP should not work while acutely ill, even if SARS-CoV-2 testing is negative, in order to minimize the risk of transmission of other infectious pathogens, including respiratory pathogens such as influenza.
  - Implement sick leave policies that are non-punitive, flexible, and consistent with public health policies that support HCP to stay home when ill.
- Guidance on when HCP with SARS-CoV-2 infection could return to work, and on work restrictions for HCP with higher-risk exposures, is in the Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to

SARS-CoV-2.

### 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.
- 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 into the room and wipe down high-touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room.

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.

### Evaluate Residents at least Daily

- Ask residents to report if they feel feverish or have symptoms consistent with COVID-19 or an acute respiratory infection.
- 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 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.
  - Because some of the symptoms are similar, it may be difficult to tell the difference between influenza, COVID-19, and other acute respiratory infections, based on symptoms alone. Consider testing for pathogens other than SARS-CoV-2 and initiating appropriate infection prevention precautions for symptomatic older adults.
  - Refer to CDC resources 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).

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

- HCP caring for residents with suspected or confirmed SARS-CoV-2 infection should use full PPE (gowns, gloves, eye protection, and a NIOSH-approved N95 or equivalent or higher-level respirator).
- 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 remain in their current location pending return of

exposures or symptoms concerning for COVID-19, residents should remain in 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 managed as described in Section: Manage Residents who have had Close Contact with Someone with SARS-CoV-2 Infection.
- 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 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 Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.
- 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**.

# Manage Residents with Close Contact

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

- Unvaccinated residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. HCP caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator).
  - Although not preferred for healthcare settings, options for shortening quarantine are available.
- Fully vaccinated residents who have had close contact with someone with SARS-CoV-2 infection should wear source control and be tested as described in the testing section. Fully vaccinated residents and residents with SARS-CoV-2 infection in the last 90 days do not need to be quarantined, restricted to their room, or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority. Additional potential exceptions are described here

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.

# 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 to discontinue Transmission-Based Precautions should be placed in the designated COVID-19 care unit, regardless of vaccination status.
- In general, all unvaccinated residents who are new admissions and readmissions should be placed in a 14-day quarantine, even if they have a negative test upon admission.
  - Facilities located in counties with low community transmission might elect to use a risk-based approach for determining which unvaccinated 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.
- Fully vaccinated residents and residents within 90 days of a SARS-CoV-2 infection do not need to be placed in quarantine.

Guidance addressing recommended PPE when caring for residents in quarantine is described in Section: Manage Residents who 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 recommended IPC practices (e.g., 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 unvaccinated 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.
- Residents who leave the facility for 24 hours or longer should generally be managed as described in Section: Create a Plan for Managing New Admissions and Readmissions.

Guidance addressing 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.

# New Infection in Healthcare Personnel or Resident

**When performing an outbreak response to a known case, facilities should always defer to the recommendations of the jurisdiction's public health authority.**

**Respond to a Newly Identified SARS-CoV-2-infected HCP or Resident**

- Because of the 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.
  - The approach to an outbreak investigation should take into consideration whether the facility has the experience and resources to perform individual contact tracing, the vaccination acceptance rates of staff and residents, whether the index case is a healthcare worker or resident, whether there are other individuals with suspected or confirmed SARS-CoV-2 infection identified at the same time as the index resident, and the extent of potential exposures identified during the evaluation of the index resident.
  - Consider increasing monitoring of all residents from daily to every shift, to more rapidly detect those with new symptoms.
- **HCP and residents with symptoms of COVID-19**:
  - Symptomatic HCP, regardless of vaccination status, should be restricted from work pending evaluation for SARS-CoV-2 infection.
  - Symptomatic residents, regardless of vaccination status, should be restricted to their rooms and cared for by HCP using a NIOSH-approved N95 or equivalent or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face) gloves, and a gown pending evaluation for SARS-CoV-2 infection.
- **Perform contact tracing to identify any HCP who have had a higher-risk exposure or residents who may have had close contact with the individual with SARS-CoV-2 infection:**
  - All HCP who have had a higher-risk exposure and residents who have had close contacts, regardless of vaccination status, should be tested immediately as described in the testing section.
    - Restriction from work, quarantine, and testing is not recommended for people who have had SARS-CoV-2 infection in the last 90 days if they remain asymptomatic. Potential exceptions are described here and here.
  - **Unvaccinated residents who are close contacts and HCP with higher-risk exposures:**
    - Unvaccinated residents who are close contacts should be managed as described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection.
    - For guidance about work restriction for unvaccinated HCP who have higher-risk exposures, refer to Interim U.S. Guidance for Managing Healthcare Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2.
  - **Fully vaccinated residents who are close contacts and HCP with higher-risk exposures:**
    - Fully vaccinated residents who are close contacts should be managed as described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection.
    - For guidance about work restriction for fully vaccinated HCP who have higher-risk exposures, refer to Interim U.S. Guidance for Managing Healthcare Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2.

- **If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection**, contact tracing should be continued to identify residents with close contact or HCP with higher-risk exposures to the newly identified individual(s) with SARS-CoV-2 infection.
    - A facility-wide or group-level (e.g., unit, floor, or other specific area(s) of the facility) approach should be considered if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission.
    - If the outbreak investigation is broadened to either a facility-wide or unit-based approach, follow recommendations below for alternative approaches to individual contact tracing.

- **Alternative, broad-based approach:**
    - If a facility does not have the expertise, resources, or ability to identify all close contacts, they should instead investigate the outbreak at a facility-level or group-level (e.g., unit, floor, or other specific area(s) of the facility).
        - Broader approaches might also be required if the facility is directed to do so by the jurisdiction's public health authority, or in situations where all potential contacts are unable to be identified, are too numerous to manage, or when contact tracing fails to halt transmission.
    - Perform testing for all residents and HCP on the affected unit(s), regardless of vaccination status, immediately (but not earlier than 2 days after the exposure, if known) and, if negative, again 5-7 days later.
    - **Unvaccinated residents and HCP:**
        - Unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities.
        - Close contacts, if known, should be managed as described in Section: Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection.
        - For guidance about work restriction for unvaccinated HCP who are identified to have had higher-risk exposures, refer to Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2.
    - **Fully vaccinated residents and HCP:**
        - Fully vaccinated residents should be tested as described in the testing section; they do not need to be restricted to their rooms or cared for by HCP using the full PPE recommended for the care of a resident with SARS-CoV-2 infection unless they develop symptoms of COVID-19, are diagnosed with SARS-CoV-2 infection, or the facility is directed to do so by the jurisdiction's public health authority.
        - For guidance about work restriction for fully vaccinated HCP who have higher-risk exposures, refer to Interim U.S. Guidance for Managing Healthcare Personnel with SARS-CoV-2 infection or Exposure to SARS-CoV-2.
        - In the event of ongoing transmission within a facility that is not controlled with initial interventions, strong consideration should be given to use of quarantine for fully vaccinated residents and work restriction of fully vaccinated HCP with higher-risk exposures. In addition, there might be other circumstances for which the jurisdiction's public authority recommends these and additional precautions.
        - If no additional cases are identified during the broad-based testing, room restriction and full PPE use by HCP caring for unvaccinated residents can be discontinued after 14 days and no further testing is indicated.
        - If additional cases are identified, testing should continue on affected unit(s) or facility-wide every 3-7 days in addition to room restriction and full PPE use for care of unvaccinated residents, until there are no new cases for 14 days.
            - If antigen testing is used, more frequent testing (every 3 days), should be considered.

- **Indoor visitation during an outbreak response:**
- Facilities should follow guidance from CMS about visitation.
- Visitors should be counseled about their potential to be exposed to SARS-CoV-2 in the facility.
- Whether unvaccinated residents are known to be close contacts or are identified as a part of a broad-based outbreak response but not known to be close contacts, indoor visitation should ideally occur only in the resident's room, the resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible).
- Whether unvaccinated residents are known to be close contacts or are identified as a part of a broad-based outbreak response but not known to be close contacts, indoor visitation should ideally occur only in the resident's room, the resident and their visitors should wear well-fitting source control (if tolerated) and physically distance (if possible).,
- Source control and physical distancing recommendations should also be followed for vaccinated residents.

- Outdoor visitation could be allowed, but residents should wear well-fitting source control (if tolerated), maintain physical distancing from others, and not linger in common spaces when moving from their rooms to the outdoors.

# 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, dental healthcare personnel, 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, 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.** Guidance on design, use, and maintenance of cloth masks is available.

**Facemask:** OSHA defines facemasks as "a surgical, medical procedure, dental, or isolation mask that is FDA-cleared, authorized by an FDA EUA, or offered or distributed as described in an FDA enforcement policy. Facemasks may also be referred to as 'medical procedure masks'." Facemasks should be used 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. Other facemasks, 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.

**Close contact**: Being within 6 feet for a cumulative total of 15 minutes or more over a 24-hour period with someone with SARS-CoV-2 infection.

**Nursing home-onset SARS-CoV-2 infections** refers to SARS-CoV-2 infections that originated in the nursing home. It does not refer to the following:

- Residents who were known to have SARS-CoV-2 infection on admission to the facility and were placed into appropriate Transmission-Based Precautions to prevent transmission to others in the facility.
- Residents who were placed into Transmission-Based Precautions on admission and developed SARS-CoV-2 infection within 14 days after admission.

**Fully vaccinated** is defined in Interim Public Health Recommendations for Fully Vaccinated People | CDC

**Unvaccinated** refers to a person who does not fit the definition of "fully vaccinated," including people whose vaccination status is not known, for the purposes of this guidance.

## More Resources

- Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- Council of State and Territorial Epidemiologists (CSTE) Proposed Investigation/Reporting Thresholds and Outbreak Definitions for COVID-19 in Healthcare Settings
- OSHA PPE standards (29 CFR 1910 Subpart I)
- Optimizing Supply of PPE and Other Equipment during Shortages
- Improve the Fit and Filtration of Your Mask to Reduce the Spread of COVID-19
- SARS-CoV-2 Antigen Testing in Long Term Care Facilities
- Performing Broad-Based Testing for SARS-CoV-2 in Congregate Settings
- Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2
- Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 (COVID-19)
- 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
- Infection Prevention and Control Assessment Tool for Nursing Homes Preparing for COVID-19

## Previous Updates

### 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

Last Updated Sept. 10, 2021