Centers for Disease Control and Prevention

Coronavirus Disease 2019 (COVID-19)

Preparing for COVID-19: Long-term Care Facilities, Nursing Homes

Related Pages

Key Strategies for Long-term Care Facilities

What's New

Key Strategies to Prepare for COVID-19 in Long-term Care Facilities (LTCFs)

COVID-19 cases have been reported in all 50 states, the District of Columbia, and multiple U.S. territories; many having wide-spread community transmission. Given the high risk of spread once COVID-19 enters a LTCF, facilities must act immediately to protect residents, families, and staff from serious illness, complications, and death. Strategies include recommendations to:

- Keep COVID-19 from entering your facility
- Identify infections early
- Prevent spread of COVID-19
- Assess supply of personal protective equipment (PPE) and initiate measures to optimize current supply
- Identify and manage severe illness

Long-term care facilities concerned that a resident, visitor, or employee may be a COVID-2019 patient under investigation should contact their local or state health department immediately for consultation and guidance.

Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes

Summary of Changes to the Guidance:

Updated guidance to recommend that nursing homes:

- Act now to implement ALL COVID-19 preparedness recommendations, even before cases are identified in their community
- Address asymptomatic and pre-symptomatic transmission, implement source control for everyone entering a healthcare facility (e.g., healthcare personnel, patients, visitors), regardless of symptoms.
  - Cloth face coverings are not considered personal protective equipment (PPE) because their capability to protect healthcare personnel (HCP) is unknown. Facemasks, if available, should be reserved for HCP.
  - For visitors and residents, a cloth face covering may be appropriate. If a visitor or resident arrives to the facility without a cloth face covering, a facemask may be used for source control if supplies are available.
- Dedicate an area of the facility to care for residents with suspected or confirmed COVID-19; consider creating a staffing plan for that specific location

Background

Given their congregate nature and resident population served (e.g., older adults often with underlying chronic medical conditions), nursing home populations are at the highest risk of being affected by COVID-19. If infected with SARS-CoV-2, the virus that causes COVID-19, residents are at increased risk of serious illness.

COVID-19 cases have now been reported in all 50 states and DC; with many areas having wide-spread community transmission. Given the high risk of spread once COVID-19 enters a nursing home, facilities must **take immediate action to protect residents, families, and healthcare personnel (HCP)** from severe infections, hospitalizations, and death.

Visitors and HCP continue to be sources of introduction of COVID-19 into nursing homes. To protect the vulnerable nursing home population, aggressive efforts toward visitor restrictions and implementing sick leave policies for ill HCP, and actively checking every person entering a facility for fever and symptoms of illness continue to be recommended.

Recent experience with outbreaks in nursing homes has also reinforced that **residents with COVID-19 may not report typical symptoms such as fever or respiratory symptoms; some may not report any symptoms. Unrecognized asymptomatic and pre-symptomatic infections likely contribute to transmission in these settings.** Because of this, CDC is recommending that the general public wear a cloth face covering for source control whenever they leave their home. Updates were also made to CDC's Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings to address source control for everyone in a healthcare facility, including nursing homes. Refer to that guidance for more detailed recommendations, including when facemasks versus cloth face coverings could be used.

This interim guidance focuses on the following priorities:

- Keep unrecognized COVID-19 from entering the facility
- Identify infections early and take actions to prevent spread
- Assess current supply of personal protective equipment (PPE) and initiate measures to optimize supply
- Quickly recognize and manage severe illness

These recommendations supplement the CDC's Infection Prevention and Control Recommendations and are specific for nursing homes, including skilled nursing facilities. This information complements, but does not replace, the COVID-19 infection control recommendations and also complements preparedness resources for assisted living facilities.

This guidance is based on the currently available information about COVID-19. This guidance will be refined and updated as more information becomes available and as response needs change in the United States.

COVID-19 Preparedness Checklist for Nursing Homes and other Long-Term Care Settings [1 MB, 8 pages]

Things facilities should do now

Educate Residents, Healthcare Personnel, and Visitors about COVID-19, Current Precautions Being Taken in the Facility, and Actions They Can Take to Protect Themselves

- Provide information about COVID-19 (including information about signs and symptoms) and strategies for managing stress and anxiety.
- Review CDC's Interim Infection Prevention and Control Recommendations for Patients with Confirmed Coronavirus Disease 2019 (COVID-19) or Persons Under Investigation for COVID-19 in Healthcare Settings
- Educate and train HCP
  - Reinforce sick leave policies; **remind HCP not to report to work when ill**
  - Educate them about new policies for source control while in the facility.
  - Reinforce adherence to standard infection prevention and control measures including hand hygiene and selection and use of personal protective equipment (PPE). Have HCP demonstrate competency with putting on and removing PPE and monitor adherence by observing resident care activities

- Educate both facility-based and consultant personnel (e.g., wound care, podiatry, barber) and volunteers who provide care or services in the facility. Inclusion of consultants is important, since they commonly provide care in multiple facilities and can be exposed to or serve as a source of pathogen transmission
- Educate residents and families including, information about COVID-19; actions the facility is taking to protect them and/or their loved ones, including visitor restrictions; and actions they can take to protect themselves in the facility, emphasizing the importance of social distancing, hand hygiene, respiratory hygiene and cough etiquette, and wearing a cloth face covering.
- Have a plan and mechanism to regularly communicate with residents, family members and HCP, including if cases of COVID-19 are identified among residents or HCP.

Evaluate and Manage Healthcare Personnel with Symptoms Consistent with COVID-19

- Facilities should implement sick leave policies that are non-punitive, flexible and consistent with public health policies that allow ill HCP to stay home.
- Create or review 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.
- Review current resident services and restrict non-essential healthcare personnel, such as elective consultations, and volunteers from entering the building.
    - Consider implementing telehealth to offer remote access to care activities
- As part of source control efforts, HCP should wear a facemask or cloth face covering at all times while they are in the healthcare facility. When available, facemasks are generally preferred over cloth face coverings for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. If there are shortages of facemasks, facemasks should be prioritized for HCP and then for residents with symptoms of COVID-19 (as supply allows). Guidance on extended use and reuse of facemasks is available. **Cloth face coverings should NOT be worn instead of a respirator or facemask if more than source control is required.**
    - All HCP should be reminded to practice social distancing when in break rooms or common areas.
- As part of routine practice, HCP (including consultant personnel and ancillary staff such as environmental and dietary services) should be asked to regularly monitor themselves for fever and symptoms of COVID-19.
    - HCP should be reminded to stay home when they are ill.
    - If HCP develop fever (T≥100.0 °F) or symptoms of COVID-19 while at work they should keep their facemask on, inform their supervisor, and leave the workplace.
    - HCP with suspected COVID-19 should be prioritized for testing.
- Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19
    - **Actively take their temperature*** and document absence of shortness of breath, new or change in cough, sore throat, and muscle aches. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace.
    - *Fever is either measured temperature ≥100°F or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures (<100.0°F) or other symptoms (e.g., nausea, vomiting, diarrhea, abdominal pain, headache, runny nose, fatigue) based on assessment by occupational health or public health authorities. Additional information about clinical presentation of patients with COVID-19 is available.
    - HCP who work in multiple locations may pose higher risk and should be encouraged to tell facilities if they have had exposure to other facilities with recognized COVID-19 cases.
- Facilities should develop (or review existing) plans to mitigate staffing shortages from illness or absenteeism.
    - CDC has created guidance to assist facilities with mitigating staffing shortages.
    - For guidance on when HCP with suspected or confirmed COVID-19 may return to work refer to Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)

Enforce Policies and Procedures for Visitors

- Because of the ease of spread in a long-term care setting and the severity of illness that occurs in residents with COVID-19, facilities should immediately restrict all visitation to their facilities except for certain compassionate care reasons, such as end-of-life situations.
    - Send letters or emails [1 page] to families advising them that no visitors will be allowed in the facility except for certain compassionate care situations, such as end of life situations.

- Use of alternative methods for visitation (e.g., video conferencing) should be facilitated by the facility.
- Post signs at the entrances to the facility advising that no visitors may enter the facility.
- Decisions about visitation for compassionate care situations should be made on a case-by-case basis, which should include careful screening of the visitor for fever or symptoms consistent with COVID-19. Those with symptoms should not be permitted to enter the facility. Any visitors that are permitted must wear a cloth face covering while in the building and restrict their visit to the resident's room or other location designated by the facility. They should also be reminded to frequently perform hand hygiene.
- Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.

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

- Hand Hygiene Supplies:
  - Put 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).
  - Make sure that sinks are well-stocked with soap and paper towels for handwashing.
- Respiratory Hygiene and Cough Etiquette:
  - Tissues and trash cans are available in common areas and resident rooms for respiratory hygiene and cough etiquette and source control.
- Personal Protective Equipment (PPE):
  - Assess current PPE supply.
    - Identify health department or healthcare coalition contacts for getting assistance during PPE shortages.
    - Monitor daily PPE use to identify when supplies will run low; use the PPE burn rate calculator or other tools
  - Implement strategies to optimize current PPE supply ***even before shortages occur***
    - Bundling resident care and treatment activities to minimize entries into resident room (e.g., having clinical staff clean and disinfect high-touch surfaces when in the room)
    - Extended use of respirators, facemasks, and eye protection, which refers to the practice of wearing the same respirator or facemask and eye protection for the care of more than one resident (e.g., for an entire shift).
      - Extreme care must be taken to **avoid touching the respirator, facemask or eye protection**. If this must occur, HCP should perform hand hygiene immediately before and after contact to prevent contaminating themselves or others.
    - Prioritizing gowns for activities where splashes and sprays are anticipated (including aerosol generating procedures) and high-contact resident care activities that provide opportunities for transfer of pathogens to hands and clothing of HCP.
    - Developing a process for decontamination and reuse of PPE such as face shields and goggles
  - 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.
    - Facilities should have supplies of facemasks, respirators (if available and the facility has a respiratory protection program with trained, medically cleared, and fit tested HCP), gowns, gloves, and eye protection (i.e., face shield or goggles).
  - 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.
- Consider implementing a respiratory protection program that is compliant with the OSHA respiratory protection standard for employees if not already in place. The program should include medical evaluations, training, and fit testing.
- 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.
  - Refer to List N on the EPA website for EPA-registered disinfectants that have qualified under EPA's emerging viral pathogens program for use against SARS-CoV-2

viral pathogens program for use against SARS-CoV-2.

Dedicate Space in the Facility to Monitor and Care for Residents with COVID-19

- Dedicate space in the facility to care for residents with confirmed COVID-19. 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 COVID-19.
  - Assign dedicated HCP to work only in this area of the facility.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, prioritize for testing, transfer to COVID-19 unit if positive).
  - Closely monitor roommates and other residents who may have been exposed to an individual with COVID-19 and, if possible, avoid placing unexposed residents into a shared space with them.
- Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options may include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents could be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their exposure (or admission). Testing at the end of this period could be considered to increase certainty that the resident is not infected.
  - If an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved from their rooms to this location while undergoing evaluation.
  - All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. **Cloth face coverings are not considered PPE and should not be worn by HCP when PPE is indicated.**

Evaluate and Manage Residents with Symptoms of COVID-19

- 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 (T≥100.0 °F) and symptoms of COVID-19 (shortness of breath, new or change in cough, sore throat, muscle aches). If positive for fever or symptoms, implement Transmission-Based Precautions as described below.
  - Older adults with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19.
- The health department should be notified about residents or HCP with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or HCP with new-onset respiratory symptoms within 72 hours of each other.
  - Contact information for the healthcare-associated infections program in each state health department is available.
  - CDC has resources for performing respiratory infection surveillance in long-term care facilities during an outbreak [7 pages].
- Information about the clinical presentation and course of patients with COVID-19 is described in the Interim Clinical Guidance for Management of Patients with Confirmed Coronavirus Disease 2019 (COVID-19). CDC has also developed guidance on Evaluating and Reporting Persons Under Investigation (PUI).
  - **If COVID-19 is suspected, based on evaluation of the resident or prevalence of COVID-19 in the community,** follow the Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings. This guidance includes detailed information regarding recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. **Cloth face coverings are not considered PPE and should not be worn by HCP when PPE is indicated.**
    - Residents with suspected COVID-19 should be prioritized for testing.
    - Residents with known or suspected COVID-19 do not need to be placed into an airborne infection isolation room (AIIR) but should ideally be placed in a private room with their own bathroom.
      - Residents with COVID-19 should, ideally, be cared for in a dedicated unit or section of the facility with dedicated HCP (see section on Dedicating Space).
      - As roommates of residents with COVID-19 might already be exposed, it is generally not recommended to place them with another roommate until 14 days after their exposure, assuming they have not developed symptoms or had a positive test.
    - Increase monitoring of ill residents, 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.

        - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any with new symptoms.
    - 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**.
        - While awaiting transfer, residents should wear a cloth face covering or facemask (if tolerated) and be separated from others (e.g., kept in their room with the door closed)
        - All recommended PPE should be used by healthcare personnel when coming in contact with the resident.
    - For decisions on removing residents with COVID-19 from Transmission-Based Precautions refer to the Interim Guidance for Discontinuation of Transmission-Based Precautions and Disposition of Hospitalized Patients with COVID-19

Additional Measures:

- Cancel communal dining and all group activities, such as internal and external activities.
- Remind residents to practice social distancing and perform frequent hand hygiene.
- Have residents wear a cloth face covering or facemask whenever they leave their room, including for procedures outside of the facility.

In addition to the actions described above, these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community

- **Healthcare Personnel Monitoring and Restrictions:**
    - Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents.

- **Resident Monitoring and Restrictions:**
    - Encourage residents to remain in their room. If there are cases in the facility, restrict residents (to the extent possible) to their rooms except for medically necessary purposes.
        - If they leave their room they should wear a cloth face covering or facemask, perform hand hygiene, limit their movement in the facility, and perform social distancing (stay at least 6 feet away from others)

Definitions

- **Healthcare Personnel (HCP)**: HCP include, but are not limited to, emergency medical service personnel, nurses, nursing assistants, 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).
- **Cloth face covering**: Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. **They are not PPE and it is uncertain whether cloth face coverings protect the wearer.** Guidance on design, use, and maintenance of cloth face coverings is available.
- **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

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 the CDC/NIOSH, including those intended for use in healthcare.

Additional Resources

Recorded webinar, Preparing Nursing Homes and Assisted Living Facilities for COVID-19

Long-term Care Facility Letter [1 page] to Residents, Families, Friends and Volunteers

Nursing Home and Long-Term Care Facility Checklist

Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed COVID-19 in Healthcare Settings

Key Strategies to Prepare for COVID-19 in Long-Term Care Facilities

CMS Emergency Preparedness & Response Operations

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