

# Coronavirus Disease 2019 (COVID-19)

## Responding to Coronavirus (COVID-19) in Nursing Homes

Considerations for the Public Health Response to COVID-19 in Nursing Homes

### Background

This guidance is intended to assist nursing homes and public health authorities with response and cohorting decisions in nursing homes. This guidance supplements but does not replace recommendations included in the [Interim Additional Guidance for Infection Prevention and Control for Patients with Suspected or Confirmed COVID-19 in Nursing Homes](#).

All facilities should adhere to current CDC [infection prevention and control recommendations](#), including universal source control measures; visitor restrictions; screening of residents and HCP; and [promptly notifying the health department](#)  [164 KB, 3 pages]  about any of the following:

- Resident or HCP with suspected or confirmed COVID-19,
- Resident with severe respiratory infection resulting in hospitalization or death, or
- $\geq 3$  residents or HCP with new-onset respiratory symptoms within 72 hours of each other.

These situations should prompt further investigation and testing for SARS-CoV-2, the virus that causes COVID-19.

### Resident Cohorting

#### Considerations for establishing a designated COVID-19 care unit for residents with confirmed COVID-19

- Determine the location of the COVID-19 care unit and create a staffing plan before residents or HCP with COVID-19 are identified in the facility. This 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 COVID-19 among residents but have not developed a COVID-19 care unit, should work to create one unless the proportion of residents with COVID-19 makes this impossible (e.g., the majority of residents in the facility are already infected).
- Ideally the unit should be physically separated from other rooms or units housing residents without confirmed COVID-19.
  - Depending on facility capacity (e.g., staffing, supplies) to care for affected residents, the COVID-19 care unit could be a separate floor, wing, or cluster of rooms.
- Assign dedicated HCP to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents. HCP working on the COVID-19 care unit should ideally have a restroom, break room, and work area that are separate from HCP working in other areas of the facility.
  - To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the unit.
  - Assign environmental services [EVS] staff to work only on the unit.
    - If there are not a sufficient number of EVS staff to dedicate to this unit despite efforts to [mitigate staffing shortages](#), restrict their access to the unit. Also, assign HCP dedicated to the COVID-19 care unit (e.g., NAs) to perform 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.
  - Ensure that high-touch surfaces in staff break rooms and work areas are frequently cleaned and disinfected (e.g., each shift).
  - Ensure HCP practice source control measures and social distancing in the break room and other common areas (i.e., HCP wear a facemask and sit more than 6 feet apart while on break).

- Place signage at the entrance to the COVID-19 care unit that instructs HCP they must wear eye protection and an N95 or higher-level respirator (or facemask if a respirator is not available) at all times while on the unit. Gowns and gloves should be added when entering resident rooms.
- Ensure that HCP have been trained on infection prevention measures, including the use of and steps to properly put on and remove recommended personal protective equipment (PPE).
- If PPE shortages exist, implement [strategies to optimize PPE supply](#) on the unit, such as:
  - Bundle care activities to minimize the number of HCP entries into a room.
  - Consider extended use of respirators (or facemasks if respirators are not available), eye protection, and gowns. Limited reuse of PPE may also be considered.
  - [Consider prioritizing gown use](#) for high-contact resident care activities and activities where splash or spray exposures are anticipated.
- Assign dedicated resident care equipment (e.g., vitals machine) to the cohort unit. Cleaning and disinfection of shared equipment should be performed between residents and the equipment should not leave the cohort unit.

## Considerations for new admissions or readmissions to the facility

- Newly admitted and readmitted residents with confirmed COVID-19 who have not met [criteria for discontinuation of Transmission-Based Precautions](#) should go to the designated COVID-19 care unit.
- Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit.
  - If Transmission-Based Precautions have been discontinued, but the resident with COVID-19 remains symptomatic (i.e., persistent symptoms or chronic symptoms above baseline), they can be housed on a regular unit but should remain in a private room until symptoms resolve or return to baseline. These individuals should remain in their rooms to the extent possible during this time period. If they must leave their rooms, facilities should reinforce adherence to universal source control policies and social distancing [e.g., perform frequent hand hygiene, have the resident wear a cloth face covering or facemask (if tolerated) and remain at least 6 feet away from others when outside of their room].
- Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown. Options include placement in a single room or in a separate observation area so the resident can be monitored for evidence of COVID-19.
  - All [recommended COVID-19 PPE](#) should be worn during care of residents under observation, 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.
  - Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic SARS-CoV-2-infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. **Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home.**
- New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty.

## Response to Newly Identified SARS-CoV-2-infected HCP or Residents

### HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset

- Prioritize these HCP for SARS-CoV-2 testing. Exclude HCP with COVID-19 from work until they have met all [return to work criteria](#).
- Determine which residents received direct care from and which HCP had unprotected exposure to HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset.
  - Residents who were cared for by these HCP should be restricted to their room and be cared for using [all recommended COVID-19 PPE](#) until results of HCP COVID-19 testing are known. If the HCP is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.
  - Exposed HCP should be [assessed for risk and need for work exclusion](#)

• EXPOSED HCP SHOULD BE ASSESSED FOR RISK AND NEED FOR WORK EXCLUSION.

- If testing is available, asymptomatic residents and HCP who were exposed to HCP with COVID-19 should be considered for testing (see information on testing below). If testing identifies infections among additional HCP, further evaluation for infections among residents and HCP exposed to those individuals should be performed as described above.

## Resident with new-onset suspected or confirmed COVID-19

- Ensure the resident is isolated and cared for using [all recommended COVID-19 PPE](#). Place the resident in a single room if possible. Alternatively, if an observation area has been created, residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room on that unit pending results of SARS-CoV-2 testing.
  - Cohorting residents on the same unit based on symptoms alone could result in inadvertent mixing of infected and non-infected residents (e.g., residents who have fever, for example, due to a non-COVID-19 illness could be put at risk if moved to a COVID-19 unit).
  - If cohorting symptomatic residents, care should be taken to ensure infection prevention and control interventions are in place to decrease the risk of cross-transmission.
- If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit.
- Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for SARS-CoV-2 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit).
  - Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.
- Consider temporarily halting admissions to the facility, at least until the extent of transmission can be clarified and interventions can be implemented.
- 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 infections.
  - Consider increasing monitoring of asymptomatic residents from daily to every shift to more rapidly detect any residents with new symptoms.
- Counsel all residents to restrict themselves to their room to the extent possible.
- HCP should use [all recommended COVID-19 PPE](#) for the care of all residents on affected units (or facility-wide if cases are widespread); this includes both symptomatic and asymptomatic residents.
  - If HCP PPE supply is limited, implement [strategies to optimize PPE supply](#), which might include extended use of respirators, facemasks, and eye protection and limiting gown use to high-contact care activities and those where splashes and sprays are anticipated. Point prevalence surveys (PPS) could be utilized to prioritize PPE supplies (see section on use of PPS).
- Notify HCP, residents, and families and reinforce basic infection control practices within the facility (e.g., hand hygiene, PPE use, environmental cleaning).
  - [Promptly \(within 12 hours\) notify HCP, residents, and families about identification of COVID-19 in the facility](#)  [\[164 KB, 3 pages\]](#)  :
    - Provide educational sessions or handouts for HCP, residents, and families
    - Maintain ongoing, frequent communication with residents, families, and HCP with updates on the situation and facility actions
  - Monitor hand hygiene and PPE use in affected areas
- Maintain all interventions while assessing for new clinical cases (symptomatic residents):
  - Maintain [Transmission-Based Precautions](#) for all residents on the unit at least until there are no additional clinical cases for 14 days after implementation of all recommended interventions.
  - If testing is available, asymptomatic residents and HCP who were exposed to the resident with COVID-19 (e.g., on the same unit) should be considered for testing
  - The incubation period for COVID-19 can be up to 14 days and the identification of a new case within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions implemented to control transmission.

## Use of Testing to Inform the Response to COVID-19 in Nursing Homes

### Considerations for use of COVID testing to inform cohort decisions

- If testing supplies or capacity are limited, testing of [symptomatic HCP](#) and [symptomatic](#) residents should be prioritized.
  - If unit-wide or facility-wide testing is not available in response to newly identified SARS-CoV-2 infected residents or HCP, moving any residents other than those confirmed to have COVID-19 should be done with caution given the risk of asymptomatic infection; in those situations, all recommended COVID-19 PPE should be used during care of all residents on the affected unit or facility.
- If testing capacity allows, use of point prevalence surveys (PPSs) following identification of newly identified SARS-CoV-2 infected residents or HCP could be particularly important. PPSs can help identify asymptomatic or pre-symptomatic residents with COVID-19 to guide movement into COVID-19 designated spaces.

For additional information on testing in response to COVID-19 in nursing homes please refer to [Considerations for Use of Test-Based Strategies for Preventing SARS-CoV-2 Transmission in Nursing Homes](#).