Considerations for the public health response to residents with COVID-19 in nursing homes

At baseline facilities should adhere to current CDC recommendations including:

- Screening healthcare personnel (HCP) at beginning of **every shift** for fever and respiratory symptoms. Temperature should be taken.
    - HCP with a temp ≥100.0 or symptoms should be sent home immediately and prioritized for SARS-CoV-2 testing
- Restricting all visitors, nonessential staff, and volunteers
- Canceling group activities, communal dining, and outside trips
- Screening residents for symptoms and fever, at least daily.
    - Residents with a temp ≥100.0 F or repeated low-grade temps (>99 F) or symptoms should be placed in a single-room if possible, and cared for using recommended personal protective equipment (PPE) including gown, gloves, N95 or higher-level respirator (or facemask if respirator is not available or HCP are not fit-tested) and eye protection (goggles or face shield) pending further evaluation. These residents should be prioritized for testing.
    - Long-term care residents with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include: new or worsening malaise, new dizziness, diarrhea, or sore throat. Identification of these symptoms should prompt isolation and further evaluation for COVID-19

When a resident or healthcare worker with suspected or confirmed COVID-19 is identified, facilities should be instructed to notify the local or state health department. Facilities should also notify the health department about any residents with severe respiratory infection or if the facility identifies more than 2 cases of respiratory illness among residents and/or HCP in 72 hours. These situations should prompt further investigation and testing for SARS-CoV-2.

If a healthcare worker worked while ill with symptoms consistent with COVID-19:

1. Prioritize the healthcare worker for SARS-CoV-2 testing.
2. Residents that were cared by the ill healthcare worker while they were symptomatic should be restricted to their room, followed for fever and respiratory symptoms at least daily (should already be in place), wear facemasks if leaving their room, and be cared for using recommended PPE [N95 respirator (or facemask if respirator not available or HCP are not fit-tested), gloves, eye protection and gown] until results of the healthcare worker's testing are known. If COVID-19 is diagnosed in the healthcare worker, residents should be cared for using recommended PPE until 14 days after last exposure and prioritized for testing if they develop symptoms.

If a COVID-19 resident is identified in a facility:

1. Ensure the resident is isolated and cared for using recommended PPE [N95 respirator (or facemask if respirator not available or HCP are not fit-tested), gloves, eye protection and gown]. Place the resident in a single room if possible. The facility should conduct surveillance to actively identify other symptomatic residents and HCP (should already be in place). They should increase assessment of residents from daily to every shift.
    a. Consider asking the facility to temporarily halt admissions, at least until the situation can be clarified and interventions can be implemented
2. Ask the facility to counsel residents on the affected unit (or in the facility if cases widespread) to restrict themselves to their room. HCP should use all recommended personal protective equipment (PPE) for the care of all residents in affected areas (or facility); this includes both symptomatic and asymptomatic

residents. If HCP PPE supply is limited, consider extended use of facemasks and eye protection and limit gown use to high-risk procedures. Change gloves and perform hand hygiene between residents

3. Reinforce basic infection control practices within the facility (i.e., hand hygiene, PPE use, environmental cleaning).
    a. Provide educational sessions or handouts for HCP and residents/families
    b. Maintain ongoing, frequent communication with residents, families and HCP with updates on the situation and facility actions
    c. Monitor hand hygiene and PPE use in affected areas
4. Advise the facility to institute:
    a. Increased vitals/assessments of COVID-19 residents to detect clinically deteriorating residents more rapidly (e.g., Q shift). Include assessment of pulse oximetry as part of vital signs, if not already being done. Educate providers about the potential for rapid clinical deterioration in residents with COVID-19
    b. Consider increasing from daily to Q shift surveillance for new symptomatic residents among residents not known to be infected with SARS-CoV-2.
5. COVID-19 residents could share rooms with other similarly infected residents. These residents could also be cohorted together in a designated location with dedicated HCP providing their care. Roommates of COVID-19 patients should be considered potentially infected and 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.
6. Maintain all interventions while assessing for new clinical cases (symptomatic residents):
    a. Ideally maintain precautions for all residents on the unit until no additional clinical cases for 14 days or until cases subside in community
    b. COVID-19 residents could be accepted back into the facility if the facility can care for the resident using recommended interventions and single rooms or they can room share with another COVID-19 resident
    c. Removing COVID-19 residents from Transmission-Based Precautions should follow current recommendations (https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html)
    d. Facility should keep in mind that the incubation period can be up to 14 days and the identification of new case within a week to 10 days of starting the interventions does not necessarily represent a failure of the interventions to control transmission

Use of testing/point prevalence surveys (PPS):

1. Testing of symptomatic HCP and residents is currently prioritized by HHS (https://www.cdc.gov/coronavirus/2019-nCoV/hcp/clinical-criteria.html). Broadening use of testing might be particularly important in residents with only mild symptoms who would not meet current testing criteria
2. PPS might be of use in four situations:
    a. While initiating an investigation, a point prevalence survey might help define the scope of transmission by identifying asymptomatic residents. Although this intervention might further define the initial scope, it is less likely to impact the interventions as full precautions should already be instituted on affected units for both symptomatic and asymptomatic residents
    b. If widespread ongoing transmission is identified despite initial interventions, a PPS could help define the scope of the outbreak and might help target interventions (e.g., cohorting COVID-19 residents)

c. To evaluate for asymptomatic COVID-19 residents on other units if efforts have been focused on a single unit
d. If PPE resources are extremely limited, PPE could be diverted to COVID-19 residents while other crisis methods to interrupt transmission (dust masks or face shields without mask or N95) might be used for asymptomatic residents that test negative for SARS-CoV-2

Note: Negative test results do not ensure lack of transmission. COVID-19 exposed residents should continue to be monitored for symptoms with use of PPE for all resident care for 14 days after the interventions were implemented.