COVID-19 Infection Prevention Guidance for Long-Term Care Facilities

This guidance, based on CMS guidance and CDC recommendations, applies to all long-term care facilities where healthcare is delivered, such as nursing homes. This may also apply to assisted living facilities, and adult care homes. This guidance serves as a summary of the CDC guidance for Infection Prevention and Control Recommendations for Healthcare Personnel and Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 as well as the CMS Testing in Long-Term Care and CMS Visitation in Nursing Homes guidance.

Vaccination of staff and residents is currently the best way to protect this population. Facilities should offer vaccines regularly to all residents and staff to ensure they stay up to date.

In general, long-term care settings (excluding nursing homes) whose staff provide only non-skilled personal care (e.g., assistance with activities of daily living such as dressing and bathing) should follow community/general public strategies based on COVID-19 Community Levels and recommendations for congregate settings (pending update by CDC). Anyone who provides healthcare in one of these settings should follow the guidance for healthcare facilities. For more information about determining which guidance your facility should follow, please refer to the Setting-Specific Considerations section of the updated CDC guidance. When a new case of COVID-19 occurs among residents or staff in non-skilled long-term settings, the facility is recommended to follow the outbreak testing guidance below to the extent feasible.

Key Considerations and Updates

- **CDC COVID-19 Data Tracker** - provides two different metrics that guide practices, depending on the setting:
  - “Community Transmission” – for Healthcare-Related Strategies
  - “COVID-19 Community Levels” – for Community-Related Strategies
- Quarantine (empiric transmission-based precautions) is no longer required for new admissions or exposures; however, these individuals should wear source control. See Quarantine section below for more details.
- Testing should now be performed using 3 serial tests (described further in the Testing section) on anyone who has not tested positive for SARS-CoV-2 in the prior 30 days.
- Routine screening testing of staff is no longer required.
- Symptom screening for staff and visitors is no longer required. Facilities should utilize signage to advise of infection prevention strategies.
- Vaccination status is no longer used to inform source control, screening testing, or post-exposure recommendations.
Visitation

- DHHS continues to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure.

- Per CMS and DHHS, facilities must allow indoor visitation at all times and for all residents. Outdoor visitation can also be considered as it has a lower risk of potential COVID-19 exposure as outdoor settings allow for increased space and airflow.

- Visitors with recent infections and exposures:
  - Facilities should provide guidance (e.g., posted signs at entrances) about recommended actions for visitors who have a positive viral test for COVID-19, symptoms of COVID-19, or have had close contact with someone with COVID-19.
  - Visitors with confirmed COVID-19 infection or compatible symptoms should defer non-urgent in-person visitation until they meet [CDC criteria for healthcare settings to end isolation](https://www.cdc.gov/coronavirus/2019-ncov/hcp/resident-guidance.html).
  - If visitors have had close contact with someone with COVID-19 infection in the past 10 days, they should wear a well-fitting facemask for source control. If they cannot wear source control, it is safest to defer non-urgent in-person visitation until 10 days after their exposure.

- Facilities are encouraged to offer testing for visitors or for visitors to be tested prior to coming to the facility. Facilities are also encouraged to educate and encourage visitors to become vaccinated.

- Facilities may offer well-fitting facemasks or other appropriate source control, if available; however, facilities are not required to provide source control for visitors.

- Facilities should ensure visitation is conducted in a manner that does not increase risk to other residents, including:
  - Encourage physical distancing during peak times of visitation and large gatherings.
  - Visitors who are unable to adhere to the core principles of COVID-19 infection prevention should not be permitted to visit or should be asked to leave.

- Community Transmission and Masking
  - If the facility’s county COVID-19 [Community Transmission](https://www.cdc.gov/coronavirus/2019-ncov/community/transmission/index.html) is high, everyone in a healthcare setting should wear face coverings or masks.
  - If the facility’s county COVID-19 Community Transmission is not high, the safest practice is for residents and visitors to wear face coverings or masks, however, the facility could choose not to require visitors wear face coverings or masks while in the facility, except during an outbreak. The facility’s policies regarding face coverings and masks should be based on recommendations from the CDC, state and local health departments, and individual facility circumstances.
  - Regardless of Community Transmission, residents and visitors may choose not to wear face coverings or masks and/or have close contact (including touch) when alone in the resident’s room or in a designated visitation area. Residents (or their...
representative) and their visitors should be educated about the risks of physical contact and not wearing masks prior to the visit. If a roommate is present during the visit, it is safest for the visitor to wear a face covering or mask.

- Visiting residents in isolation or quarantine:
  - Residents with SARS-CoV-2 infection should be encouraged to limit in-person visitation while they are infectious. Counsel residents and their visitor(s) about the risks of an in-person visit. Encourage use of alternative mechanisms for resident and visitor interactions such as video-call applications on cell phones or tablets, when appropriate.
  - Before visiting residents, visitors should be made aware of the potential risk of visitation and precautions necessary in order to visit the resident.
  - Visits should occur in the resident’s room and the resident and their visitor should wear a well-fitting facemask, if tolerated.
  - In general, quarantine is no longer required following exposure to SARS-CoV-2, but individuals should wear a facemask for source control for 10 days following the exposure. If a resident cannot wear a facemask following exposure, they may be placed in quarantine and restricted to their room. In this event, visitors should follow the above recommendations for visiting residents with SARS-CoV-2 infection.

- Visiting during an outbreak investigation:
  - Visitors should be made aware of the potential risk of visiting during an outbreak investigation.
  - Visitors should wear face coverings or masks during visits and visits should ideally occur in the resident’s room. Visitors should only go to and from the resident’s room and/or designated visiting areas.
  - Visitors should physically distance themselves from other residents and staff, when possible.

Source Control

Source control refers to use of respirators or well-fitting facemasks or cloth masks to cover a person’s mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing.

When SARS-CoV-2 Community Transmission is high, source control is recommended for everyone in a healthcare setting when they are in areas of the healthcare facility where they could encounter residents.

- Staff could choose not to wear source control when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms) if they do not otherwise meet the criteria described below and COVID-19 Community Levels are not also high. When COVID-19 Community Levels are high, source control is recommended for everyone.
When SARS-CoV-2 Community Transmission is not high, healthcare facilities can choose not to require universal source control. However, even if source control is not universally required, it remains recommended for individuals in healthcare settings who:

- Have suspected or confirmed SARS-CoV-2 infection or other respiratory infection (e.g., those with runny nose, cough, sneeze); or
- Had close contact (residents and visitors) or a higher-risk exposure (staff) with someone with SARS-CoV-2 infection in the last 10 days; or
- Reside or work on a unit or area of the facility experiencing a SARS-CoV-2 outbreak; or
- Have otherwise had source control recommended by public health authorities

Individuals might also choose to continue using source control based on personal preference, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease.

Personal Protective Equipment (PPE)

When SARS-CoV-2 Community Transmission is high, facilities should consider implementing broader use of respirators and eye protection by staff during resident care encounters, including use of eye protection for all resident care encounters and use of NIOSH-approved N95 or higher level respirators for all aerosol-generating procedures.

- Use of N95 respirators may also be indicated in other situations where additional risk factors for transmission are present (e.g., patient is unable to use source control and the area is poorly ventilated).
- To simplify implementation, facilities may consider implementing N95 respirators for staff during all resident care encounters, or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission.
- Universal use of source control during an outbreak could be discontinued as a mitigation measure once no new cases have been identified for 14 days.

When SARS-CoV-2 Community Transmission is not high, staff should follow standard precautions, in addition to any transmission-based precautions required by any known or suspected communicable conditions the resident may have.

Appropriate PPE should always be used when caring for residents with suspected or confirmed COVID-19, or who are on empiric transmission-based precautions following exposure to COVID-19.

Testing

A series of three screening tests is now recommended for asymptomatic individuals following close contact or a high-risk healthcare exposure to someone with SARS-CoV-2 infection, regardless of test type used (i.e., PCR/NAAT vs. antigen). Individuals should be tested immediately after being identified as a contact (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.
Due to challenges in interpreting the result, testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of a PCR/NAAT (nucleic acid amplification test) is recommended. This is because some people may remain PCR/NAAT positive but not be infectious during this period.

**Testing should be performed in the following situations:**

- **Anyone experiencing symptoms** should be promptly tested. Refer to [CDC guidance](https://www.cdc.gov) for additional information about management of symptomatic staff.

- **Routine screening testing** is no longer required but may be implemented at facility discretion.

- **Newly admitted residents and residents who have left the facility for >24 hours** should be tested upon admission in counties where [Community Transmission](https://www.cdc.gov) is high; admission testing at lower levels of Community Transmission is at the discretion of the facility.
  - If testing is conducted upon admission, the resident should be tested on the date of admission and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.

- **Asymptomatic residents with close contact with someone with SARS-CoV-2, regardless of vaccination status, and staff with higher-risk exposures** should be tested using a series of three viral tests.
  - Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.
  - Further guidance for [Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2](https://www.cdc.gov) is available.

- **Outbreak testing** is initiated when a single new case of COVID-19 occurs among residents or staff to determine if others have been exposed. An outbreak investigation would not be triggered when a resident with a known COVID-19 infection is admitted directly into isolation, or when a resident known to have close contact with someone with COVID-19 is admitted directly into quarantine/empiric transmission-based precautions and develops COVID-19 before precautions are discontinued. Facilities have the option to perform outbreak testing through two approaches, contact tracing or broad-based testing. Further information can be found [here](https://www.cdc.gov).

1) **Perform contact tracing** to identify any staff who have had a higher-risk exposure or residents who may have had close contact with an individual with SARS-CoV-2 infection.
   - All staff with higher-risk exposure and residents with close contacts should be tested immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.
   - If testing of close contacts reveals additional staff or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact or staff with higher-risk exposures to the newly identified individuals.
2) Broad-based approach (e.g., unit, floor, or other specific area(s) of the facility) may be utilized if a facility does not have the expertise, resources, or ability to identify all close contacts or if initial contact tracing has not halted COVID-19 transmission.

- Perform testing of all residents and staff as soon as possible and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.

**Duration of outbreak testing:**

- If no additional cases are identified during contact tracing OR the broad-based testing, no further testing is indicated.
- If additional cases are identified, strong consideration should be given to shifting to the broad-based approach, if not already being performed. As part of the broad-based approach, testing should continue every 3-7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered.

**Testing Recommendations Summary Table**

<table>
<thead>
<tr>
<th>When to Test</th>
<th>Who to Test</th>
<th>Duration/Frequency of Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anyone Experiencing Symptoms</td>
<td>Anyone experiencing symptoms</td>
<td>As soon as possible</td>
</tr>
<tr>
<td>Routine Screening Testing</td>
<td>No longer required</td>
<td>N/A</td>
</tr>
<tr>
<td>New Admissions and Residents that Have Left the Facility</td>
<td>Newly admitted residents and residents who have left the facility for &gt;24 hours, when county has high Community Transmission</td>
<td>At admission and, if negative, 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.</td>
</tr>
<tr>
<td>Exposures and Close Contact to Someone with SARS-CoV-2</td>
<td>Asymptomatic residents with close contact to someone with SARS-CoV-2 and staff with higher-risk exposures</td>
<td>Immediately (but not earlier than 24 hours after the exposure) and if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.</td>
</tr>
<tr>
<td>Outbreak Testing: Contact Tracing</td>
<td>Residents who are close contacts of someone with SARS-CoV-2 infection and staff who had a higher-risk exposure</td>
<td>All identified contacts should be tested immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. 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.</td>
</tr>
<tr>
<td>Outbreak Testing: Broad-based</td>
<td>All residents and HCP on the affected unit/ in the affected facility</td>
<td>Immediately (but not earlier than 24 hours after the exposure, if known) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.</td>
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</table>
Quarantine - (Empiric Transmission-Based Precautions)

Isolation and Quarantine - Use of Transmission-Based Precautions

- When someone is suspected or positive for SARS-CoV-2 infection, **isolation** is used to protect others from acquiring the virus. In healthcare settings, isolation is initiation by placing the resident on Transmission-Based Precautions.
- When someone has been exposed (a resident or visitor with a close contact to someone infected with SARS-CoV-2 or staff who had a higher-risk exposure), **quarantine may be** used to protect others in case the person becomes infected following their exposure. In healthcare settings, quarantine is initiated by placing the resident on Empiric Transmission-Based precautions.

**Admissions**: Quarantine (empiric use of transmission-based precautions) is generally not necessary for admissions and residents who leave the facility for greater than 24 hours; however, they should wear source control for the 10 days following admission/return.

**Exposures**: In general, asymptomatic residents do not require empiric use of Transmission-Based Precautions while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. These residents should still wear source control for 10 days following exposure and be tested (unless they have recovered from SARS-CoV-2 infection in the prior 30 days).

Examples of when Quarantine/Empiric Transmission-Based Precautions following close contact may be considered include:

- Resident is unable to be tested or wear source control as recommended for the 10 days following their exposure
- Resident is moderately to severely immunocompromised
- Resident is residing on a unit with others who are moderately to severely immunocompromised
- Resident is residing on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

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Outbreak Response When a New Facility-Onset Case of COVID-19 is Identified

Does the facility have the expertise, resources, or ability to identify all close contacts?

Yes

Perform Individual Contact Tracing
Identify staff with higher-risk exposures and residents with close contact to the individual with SARS-CoV-2.

No

Perform Broad-based testing
Test all staff and residents immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.

Were new cases identified?

Yes

No further testing is indicated.

No

Close Contacts
Should be tested immediately (but not earlier than 24 hours after exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test.

Test results after serial testing

Positive

• If testing reveals additional residents or staff with SARS-CoV-2 infection, contact tracing should continue to identify residents with close contact or staff with higher-risk exposure to the newly identified individual(s).
• Strong consideration should be given to shifting to the broad-based approach if additional cases are identified. A broad-based approach should be considered if all potential contacts cannot be identified or managed with contact tracing, or if contact tracing fails to halt transmission.

Negative

If no new cases are identified, no further testing is indicated.

Outbreak Response:
• Residents and staff should wear source control.
• Consider implementing universal PPE use.
• Visitors should wear source control and only go to and from the resident’s room or a designated visiting area.
• Communal activities may continue but source control should be used and physical distancing maintained whenever possible, unless directed otherwise by public health.

No further testing is indicated.