COVID-19 Outbreak Response Method in Long-Term Care Facilities (LTCFs)

The following is a summary of the exclusion from work, isolation precautions, testing recommendations, and quarantine recommendations for an outbreak of SARS-CoV-2 in a LTCF. Source control is recommended more broadly for those residing or working on a unit or area of the facility experiencing a COVID-19 outbreak. Universal use of source control could be discontinued as a mitigation measure once the outbreak is over (e.g., no new cases of SARS-CoV-2 infection have been identified for 14 days.

CDC continually updates guidance and recommendations may change accordingly. Additional information is available in CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease (COVID-19) Pandemic, and in the CMS's 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.

Scenario	Work Exclusion or Isolation Recommendations	Testing Recommendations	Quarantine Recommendations for Exposures
Identification of healthcare personnel (HCP) with a positive test for SARS-CoV-2	Exclude from work; duration varies based on severity of illness, immunocompromised status, and staffing capacity°	• If able to identify close contacts†: test all close contacts immediately (but not sooner 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. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 based on the FDA recommendations* • If additional cases are identified or if unable to identify close contacts†: broad-based testing approach (unit-wide or facility-wide). Test immediately (but not sooner than 24 hours after 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. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 based on the FDA recommendations*	Asymptomatic individuals do not require empiric use of Transmission-Based Precautions (residents) or to be excluded from work (for HCP) while being evaluated for SARS-CoV-2 following close contact with someone with SARS-CoV-2 infection. • These individuals should still wear source control for 10 days post exposure • They should be tested (series of 3 tests) except those who have recovered from SARS-CoV-2 infection in the prior 30 days • Monitoring of symptoms ○ Prompt isolation or exclusion from work if symptoms develop or test positive for SARS-CoV-2
Identification of a resident^ with a positive test for SARS-CoV-2	Place resident in a single-person room with the door kept closed (if safe to do so), ideally with a dedicated bathroom. Facilities could consider		Empiric Transmission-Based Precautions following close contact may be considered if: • Individual is unable to be tested or wear source control as recommended for the 10 days following their exposure • Individual is moderately to severely

	designating entire units within the facility, with dedicated†† HCP, to care for residents with SARS-CoV-2 infection when the number of residents with SARS-CoV-2 infection is high. 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.	• If new cases are identified: continue testing every 3-7 days until 14 days with no new cases. ○ If using antigen tests, more frequent testing (every 3 days) should be considered.	immunocompromised • Individual is residing (or cares for residents) on a unit with others who are moderately to severely immunocompromised • Individual is residing (or cares for residents) on a unit experiencing ongoing SARS-CoV-2 transmission that is not controlled with initial interventions

° With the conventional strategies, healthcare personnel with mild to moderate illness who are not moderately to severely immunocompromised could return to work 7 days after symptoms first appeared and

- If a negative viral test is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7), **and**
- At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and**
- Symptoms (e.g., cough, shortness of breath) have improved.

HCPs who were asymptomatic throughout their infection and are not moderately to severely immunocompromised could return to work once at least 7 days have passed since the date of their first positive viral test if a negative viral test* is obtained within 48 hours prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5-7).

Additional CDC guidance addressing return to work criteria in the setting of significant healthcare worker shortages due to COVID-19 can be found in CDC's Strategies to Mitigate Healthcare Personnel Staffing Shortages. This guidance describes **contingency** and **crisis** capacity strategies.

†Close contacts include any residents, visitors, or staff who were less than 6 feet of the positive individual for a total of at least 15 minutes or more over a 24-hour period. People with COVID-19 can pass the SARS-CoV-2 virus to their close contacts starting from 2 days before they become sick (or 2 days before they test positive if they never had symptoms) until it is safe to be around other people (stop isolation).

^An outbreak investigation would not be triggered when a resident with known COVID-19 is admitted directly into TBP, or when a resident known to have close contact with someone with COVID-19 is admitted directly into TBP and develops COVID-19 before TBP is discontinued.

*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 nucleic acid amplification test (NAAT) is recommended for these individuals.

†† Dedicated means that HCP are assigned to care only for these residents during their shifts. Dedicated units and/or HCP might not be feasible due to staffing crises or a small number of residents with SARS-CoV-2 infection. If cohorting is to occur, only residents with the same respiratory pathogen should be housed in the same room. Multidrug-resistant organism colonization status and/or presence of other communicable diseases should also be taken into consideration during the cohorting process.