**Supplemental Figure 1: English translation of the questionnaire sent to long-term care facilities.**

Directors and medical directors were asked to state if each measure was applied on the following basis (unless otherwise mentioned):

- No, never

- Yes, but insufficiently

- Yes, regularly

- Yes, always

Staff:

1. Alcohol-based hand rub (ABHR) is performed when entering premises.
2. A face mask is worn when entering premises.
3. ABHR is performed when entering changing rooms.
4. Physical distancing and maximal room occupancy are applied in changing rooms.
5. ABHR is performed before starting work.
6. Upper surfaces sanitizing is performed at least twice daily in all departments (e.g. computer keyboard).
7. Adequate ventilation is performed at least twice daily in all departments.
8. Adequate personal protective equipment (PPE) is worn following prescription for care to isolated residents.
9. Adequate PPE is available at all times for all staff when caring for residents with suspected COVID-19.
10. Physical distancing and touch avoidance (PDTA) are applied with residents whenever possible.
11. PDTA are applied with other staff members whenever possible, including during breaks.
12. PDTA are applied with visitors.
13. Physical distancing and maximal room occupancy are applied in elevators.
14. Staff change clothes before and after their meal break times.
15. ABHR or hand washing is performed before and after all break times.
16. Break times are arranged to allow for PDTA (place and time schedule).
17. Break rooms and amenities (e.g. microwave oven, coffee machines) are sanitized after all meals
18. Personal food stored in shared refrigerators is wrapped in individual plastic bags.
19. Face masks are taken off after leaving premises.
20. ABHR is performed when leaving premises.
21. Night teams follow all abovementioned measures.
22. Dedicated COVID-19 units are implemented after three residents or more are rested positive.
23. Exceptional procedures are designed to face absenteeism up to 40%.
24. Infection prevention and control (IPC) procedures in case of epidemics are protocoled.
25. IPC procedures in case of epidemics are known by staff.
26. IPC procedures in case of epidemics are applied by staff.
27. PPE stocks are monitored.
28. COVID-19 testing procedures are protocoled and are known by staff.
29. Occupational medicine services are available to staff.
30. Unformal staff support is available if no occupational medicine service is available to staff.
31. A crisis unit meets on a weekly basis.
32. Staff are rapidly informed of new measures decided by the crisis unit.
33. COVID-19 prevention plan included external care providers’ interventions.
34. IPC procedures are defined in collaboration with external IPC support teams.
35. Physical distancing during mealtimes and break times is at least one meter.
36. Staff cohorting is implemented in dedicated COVID-19 units.
37. Physiotherapists always wear N95 masks when with residents (yes/no question).
38. Staff wear N95 during prolonged oral or pharyngeal care.

Entrance

1. Visitors and staff have separate entrances.
2. Visitors can leave clothes or personal belongings in a safe closet.
3. Entry and exit paths are physically separated or delimited by floor markings.
4. Reception area is disinfected.

External care providers

1. ABHR is performed when entering premises.
2. A face mask is worn when entering premises.
3. PDTA are applied with residents whenever possible.
4. PPE is available in case of COVID cases.
5. Professional equipment is made available to visiting physicians (e. g. stethoscope)
6. Professional equipment is disinfected after each use.
7. Consultations take place in resident’s room or in a dedicated room.
8. Residents’ escort outside to take ambulances is protocoled.
9. Disinfection of computers made available to external care providers is protocoled.
10. External care providers signed a dedicated convention.
11. Face masks are taken off after leaving premises.
12. ABHR is performed when leaving premises.
13. External care providers’ rotations are scheduled.

Visitors

1. ABHR is performed when entering premises.
2. A face mask is worn when entering premises.
3. PDTA are applied with residents.
4. A face mask is worn at all times of the visit.
5. Community volunteers signed a dedicated convention.
6. Face mask is taken off after leaving premises.
7. ABHR is performed when leaving premises.
8. Exterior reception is organized (e. g. tent)
9. Visits are upon reservation only.

Group activities

1. ABHR is performed when entering premises.
2. A face mask is worn when entering premises.
3. ABHR is performed when beginning activities.
4. PDTA are applied with residents.
5. PDTA are applied with participating residents whenever possible.
6. Physical distancing and maximal room occupancy are applied in elevators.
7. Activities are organized with fixed groups of maximum five residents.
8. The surface of activities rooms and break time rooms is at least 4m² per resident.
9. Face mask is taken off after leaving premises.
10. ABHR is performed when leaving premises.

Laundry service

1. ABHR is performed by laundry staff before service.
2. Laundry staff wear PPE when handling laundry from residents with COVID.
3. PDTA are applied.
4. Laundry from COVID-positive residents is placed in hydro soluble bags before being placed in clearly identified specific bags.
5. External laundry services use hydro soluble bags.

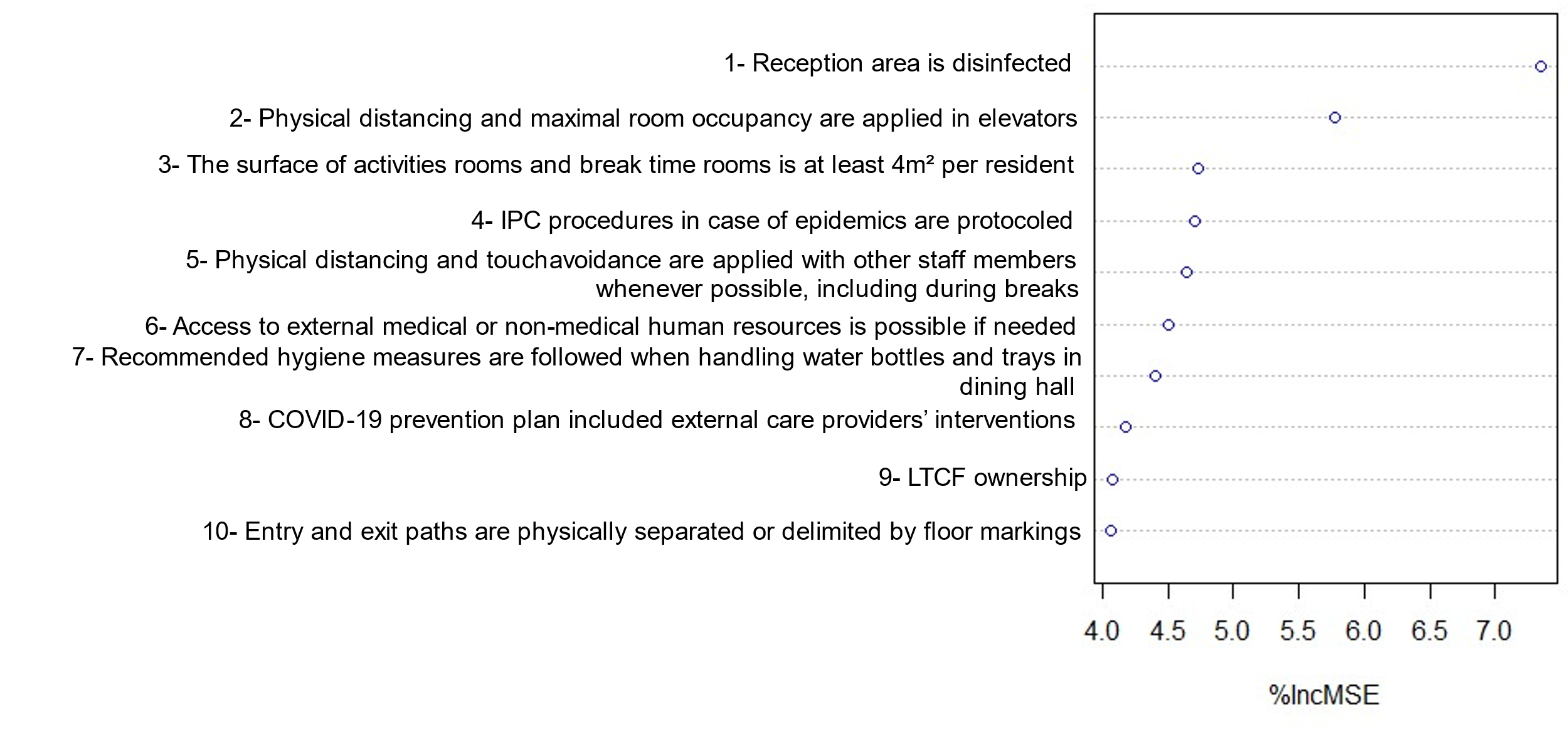
Dining hall

1. ABHR is performed by dining hall staff before service.
2. Dining hall staff enforce residents’ ABHR before meals and snacks.
3. PDTA are applied with residents.
4. Dining hall entry and exit paths allow for physical distancing.
5. PDTA are applied between residents during meals.
6. Recommended hygiene measures are followed when handling water bottles and trays.
7. A N95 mask is worn by dining hall staff when assisting COVID-negative and COVID-positive residents during their meals.

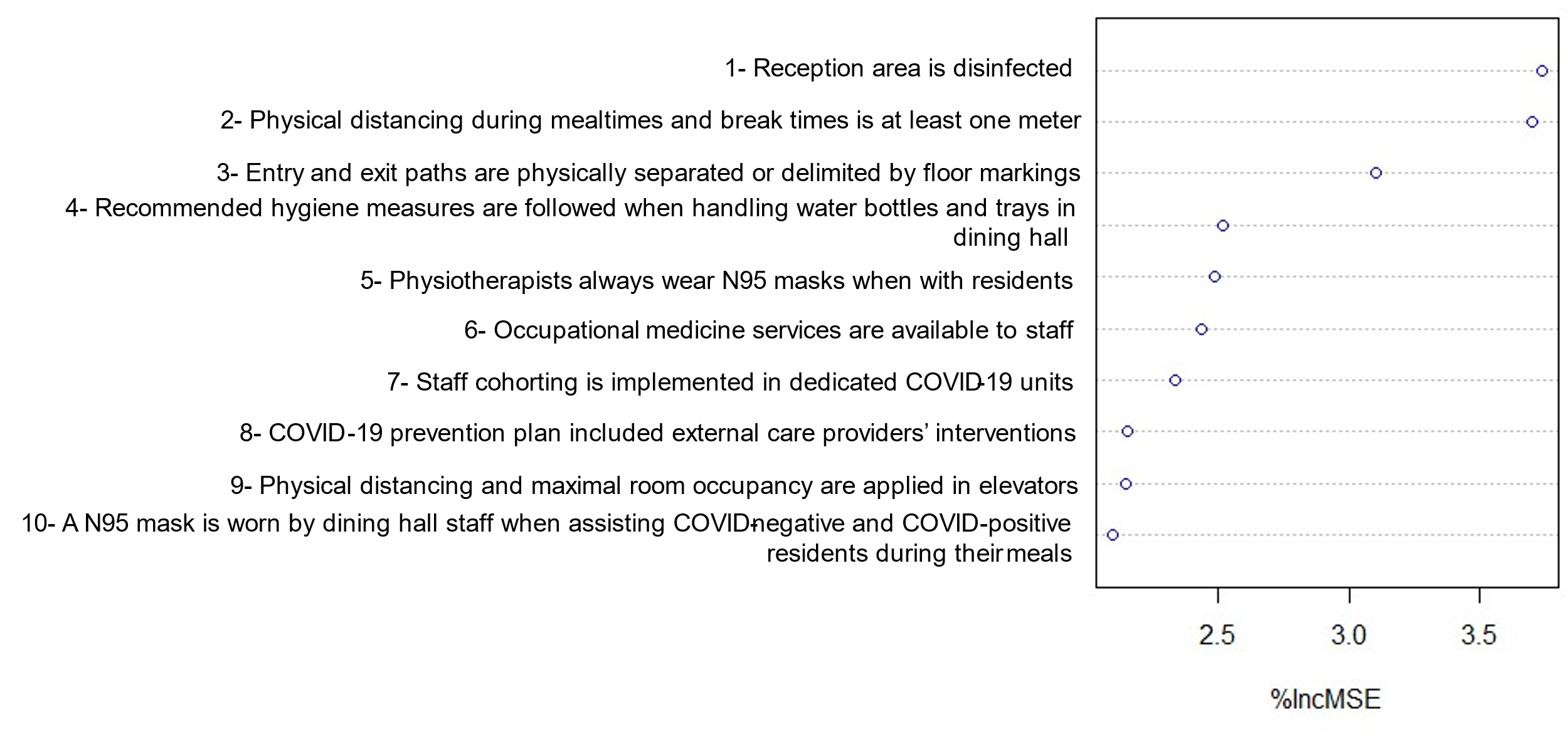
Other

1. Oxygen supplementation systems are monitored.
2. A physician is identified as COVID-referent in case no medical director is employed.
3. Access to external medical or non-medical human resources is possible if needed.
4. Knowledge of contact details for the local COVID support team and of its missions.
5. Knowledge of contact details for the on-call palliative care team and its missions.
6. Knowledge of procedure for hospital-at-home admission.
7. Knowledge of available geriatric mobile teams.
8. Knowledge of hospital departments with possible direct admission.
9. Easy access to IPC support teams.
10. Knowledge of a regional support platform to human resources.
11. Knowledge of the regional platform website.
12. Anticipation of the modalities for setting up a unit dedicated to COVID-positive residents.
13. Staff’s knowledge of protocols of care to COVID-positive residents.
14. Re-admissions from hospitalization are conditioned to a preliminary PCR test.
15. Re-admissions from hospitalizations are followed by a 7-day quarantine.

Supplemental Figure 2: The ten most important variables as identified the random forest model on the number of residents’ deaths, and percentage increase in mean square error (%IncMSE).



Supplemental Figure 3: The ten most important variables as identified the random forest model on the number of residents’ cases, and percentage increase in mean square error (%IncMSE).



Supplemental Figure 4: The ten most important variables as identified the random forest model on the number of HCP cases, and percentage increase in mean square error (%IncMSE).

