Table 3. Recommended agents and durations for Nursing Home Residents with Criteria to Start Antibiotics for Suspected Pneumonia				
Mild-Moderate				
	Scenario	Antibiotic to Start	Dosing and Duration (5 days)*	Considerations
1st line	Moderate illness, able to take oral medication**	Cefpodoxime	200 mg PO BID X 5 days	**Safe in mild PCN allergy** Q 24 hrs if CrCL <30; or post HD X 3 **Alternative cefuroxime 500 mg PO BID**
		Amoxicillin/ clavulanate	500 mg/125 mg TID X 5 days	Equivalent to 875/125 mg BID
2nd line	Severe contraindications to 1st line	Levofloxacin	750 mg PO Q 24 X 5 days OR if CrCL<20 or ESRD, 750 x 1 dose, then 500 mg Q 48 hours X 2 doses	Pose a higher risk for *C. difficile* infection Caution with anti-arrhythmic medications and prolonged QTc. Mild PCN allergy not an indication for quinolones
Special circumstances				
	Unable to take oral meds	Ceftriaxone IM/IV	1000 mg IM Q 24 hours X 5	Reserve IM for severe illness but reluctant to evaluate in ED/Hospital
2nd line	Deterioration on oral agents, severe illness	Ceftriaxone IM/IV AND		
		Doxycycline OR Azithromycin	100 mg BID X 5 days 500 mg X 3 days	No renal adjustment needed
	Risk for Pseudomonas***	Levofloxacin monotherapy	As above	
	Risk MRSA***	Doxy + 1st line	100 mg BID X 5 days + 1st line	Add doxy to first line agents.
	Risk of or suspect aspiration	Use either 1st line	Duration should be maintained at 5 days	Add anaerobic coverage only if abscess or empyema suspected: then amox/clavulanate, or ceftriaxone/metronidazole

* Duration is 5 days. Only extend to 7 if signs/symptoms not improved at day 5 (i.e., still fever, use of supplemental O2, unstable vital signs.

We recommend B-lactam monotherapy. 2019 ATS/IDSA guidelines recommend combination therapy (b-lactam/macrolide) for outpatients with co-morbidities, but for nursing home residents without typical community-exposure to atypical organisms, min role for combination therapy, but not contraindicated. **Co-morbidities include chronic heart, lung, liver, renal disease; diabetes, alcoholism, malignancy, asplenia.

*** for MRSA = history of clinical culture with MRSA (sputum, wound, nasal) in past year; for Pseudomonas = history of + PSA in Sputum in past year or bronchiectasis/FEV1<35%. If NOT transferring to ED to get new sputum culture, use levofloxacin (pseudomonas) or doxy + 1st line agent (for MRSA). **IF able** to order sputum microbiology, stop additional coverage if no Pseudomonas or MRSA recovered.