Answers to Frequently Asked Questions About COVID-19
Information for Assisted Living Residences

Updated: July 18, 2023

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General

Is COVID-19 still a reportable disease?

COVID-19 remains a reportable illness. At the national level, COVID-19 is a notifiable disease, and the US Centers for Disease Control and Prevention (CDC) requires RIDOH to report information about COVID-19 in Rhode Island.

In Rhode Island, COVID-19 remains reportable. RIDOH relies on the partnership with providers and facilities to uphold Rhode Island’s “Reporting and Testing of Infectious, Environmental, and Occupational Diseases” regulation [216-RICR-30-05-1].

By tracking COVID-19 cases and outbreaks that are reported, RIDOH can direct resources and formulate policies that best serve our communities, including older adults and assisted living residences. This information can inform national policies when further reported to the CDC.
What is the difference between assisted living residences (ALR) that do NOT provide skilled nursing care and ALR healthcare facilities that do provide skilled nursing care or receive funding from the Center for Medicare and Medicaid Services (CMS)?

CDC has clarified the distinction between settings where skilled nursing care is provided and where it is not provided. If an ALR provides skilled care, it should follow guidance for nursing homes. An ALR that receives Centers for Medicare and Medicaid Services (CMS) funding must follow guidance issued by CMS.

In all ALR caring for residents who have COVID-19 infection, staff should be familiar with proper infection prevention and control (IPC) practices, including use of personal protective equipment to protect themselves/others from potential exposures.

Additionally, the Rhode Island Department of Health recommends that all ALR consider following more robust best practices for infection prevention and control. Rigorous infection control practices, such as universal masking, can help reduce infections in older adults. Data show that age remains the strongest risk factor for severe COVID-19 outcomes (find more information in: CDC’s Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Professionals).

Why do CDC and RIDOH recommend ALR base decisions about COVID-19 infection prevention and control protocols on transmission rates in the community rather than the presence of COVID-19 in the facility (like influenza)?

Updated CDC guidance stresses that increasing COVID-19 community transmission has been one of the strongest indicators of increasing COVID-19 incidence in long-term care settings throughout the pandemic. COVID-19 remains a highly contagious disease which may be transmitted before symptoms develop. As COVID-19 community transmission increases the potential for encountering asymptomatic or pre-symptomatic people with COVID-19 infection also likely increases. This makes it challenging to control transmission in ALR.

Tracking facility-level infections may not accurately reflect the risk to residents living in ALR due to the bidirectional visitation (regular comings and goings) of residents with family residing in the community. Using statewide transmission metrics of COVID-19 in the community provides a more comprehensive assessment of risk for those living in ALR in Rhode Island.

It is important to note that COVID-19 disproportionately impacts people who are residents in ALR: people age 65 and older, as well as people who have compromised immune systems, comorbidities, and who are not up to date with COVID-19 vaccines. Also keep in mind that as science and data evolve regarding COVID-19, so will the guidance and recommendations from CDC and RIDOH.
Healthcare Personnel

Why are N-95 masks and goggles universally recommended for staff during patient care encounters in ALR (rather than the single-use policies in hospitals and other settings)?

The CDC guidance and subsequent RIDOH recommendations advise that staff wear N-95 masks and eye protection during patient care encounters when there are periods of higher COVID-19, or other respiratory virus transmission, in the community such as when: COVID-19 hospital admission level is high (greater than 20/100,000 people); or earlier, if trends are increasing in COVID-19 wastewater surveillance, percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis, and outbreaks in long-term care settings.

There are several factors that inform this recommendation, including the greater filtration efficacy of N-95 masks compared to surgical masks, increased mortality risk for older adults with COVID-19, the nature of close contact in long-term care settings, residents’ ability to participate in mitigation strategies, the variety of ventilation systems available in the setting, and the presence of emerging COVID-19 variants.

How is a “patient care encounter” different than a “patient care area?”

A patient care encounter refers to the provision of care or resident interaction. A patient care area is any area that a patient has normal access to, and can be expected to be traversed through or in.

Source Control (Masking)

When should ALR staff wear eye protection and N-95 masks?

All ALR staff should use an N-95 mask and eye protection during patient encounters when a resident has either confirmed COVID-19 infection or symptoms of COVID-19. Staff should be familiar with infection prevention and control (IPC) practices, including proper use of masks, eye protection, and personal protective equipment (PPE), to protect themselves and others from potential COVID-19 exposures.

All ALR may use enhanced precautions—such as source control, eye protection, and PPE—at any time based on each specific facility’s policy. All ALR should consider establish policies about universal staff use of N-95 masks and eye protection:

- **In ALR that do not provide skilled nursing care**, staff should wear an N95 when indoors with others if they are at high risk of getting very sick from COVID-19 **OR** the others they are around are at high risk for getting very sick (i.e., most residents) when COVID-19 hospital admission level is medium. Everyone should wear a high-quality mask or respirator when COVID-19 hospital admission level is high
- **In ALR that do provide skilled nursing care**, staff should use N95 masks and eye protection for everyone in areas of patient care when COVID-19, or other respiratory virus transmission, is increasing in the community such as when:
COVID-19 hospital admission level is high (greater than 20/100,000 people); or earlier, if trends are increasing in COVID-19 wastewater surveillance, percent of all Rhode Island Emergency Department visits with COVID-19 diagnosis, and outbreaks in long-term care settings.

What is the difference between COVID-19 hospital admission levels and the other two earlier indicators of increasing community transmission (wastewater monitoring and percentage of all Emergency Department visits with a COVID-19 diagnosis) and how does this impact staff masking?

Updated CDC guidance, and subsequent RIDOH information, recommend that ALR review several different variables when making decisions about masking for staff. One important factor is when COVID-19, or other respiratory virus transmission, is increasing in the community. COVID-19 wastewater monitoring and percentage of all Emergency Department visits with COVID-19 diagnosis are two data indicators that provide early signals when COVID-19 is increasing in the community.

These data are updated weekly by 10 a.m. on Friday mornings on RIDOH's COVID-19 Data Response Portal. Find more detailed information about these data and indicators in the “Data Notes” section at the bottom of this web page.

Should long-term residents wear masks when out of their rooms?

Everyone in ALR, including all residents, should consider using source control (masking) when COVID-19 hospital admission level is medium or high. CDC recommends everyone wear a mask when indoors around others if they are either at high risk of getting very sick from COVID-19 or around others who are at high risk of getting very sick.

Residents should be counseled about strategies to protect themselves and others, including recommendations for source control, if they have compromised immune system or if they are at high risk for severe disease. Age (65 and older) remains one of the leading predictors for worse outcomes and CDC and RIDOH strongly encourage all residents to mask in common areas or when in close contact with others.

Can ALR restrict visitation for residents if they choose not to wear a mask?

Visitors should be encouraged to wear masks, avoid visitation when ill, and protect residents. However, visitors have the right to visit family members regardless of their willingness to mask.

ALR have a responsibility to educate, encourage, and model best practices for infection prevention and control. CDC and CMS recommend ALR consider posting information about the importance of source control.
Screening

Should residents be screened daily?

Symptom screening is at the facility’s discretion and the policy and processes implemented may vary by each facility.

RIDOH’s Center for COVID-19 Epidemiology (CCE) strongly encourages daily COVID-19 symptom screening for residents. Everyone should be screened for respiratory symptoms during respiratory virus season.

During an outbreak (defined as one or more positive cases), facilities should screen visitors for signs of symptoms in accordance with national CDC and CMS standards and/or health department recommendations. Screening may be active or passive (i.e., self-screening).

Empiric Transmission-Based Precautions

How do empiric transmission-based precautions differ from isolation and/or quarantine?

Empiric transmission-based precautions are used when ruling out a pathogen, such as the virus that causes COVID-19 infection. Isolation is used when someone has tested positive for COVID-19. Quarantine was previously used when someone was identified as a close contact exposure.

Should residents be relocated if they share a room with someone who tests positive for COVID-19?

Isolation in a private room with a private bath is recommended for anyone who tests positive for COVID-19. Residents may isolation in place if roommates who test negative are moved to a different room. Cohorting residents who test positive for COVID-19 is acceptable.

Admissions (new residents and those returning from leave longer than 24 hours)

Since admissions are no longer required to quarantine, what should they do?

All admissions (new admissions and residents returning from a leave that was longer than 24 hours) should wear a mask for 10 days. While admissions testing is at the discretion of the facility, RIDOH strongly encourages ALR to consider testing for all new admissions and residents returning to the facility after being gone more than 24 hours. This is recommended due to the vulnerability of populations served by most ALR in Rhode Island. Data show that age remains the strongest risk factor for severe COVID-19 outcomes.

If ALR use admissions testing, residents should test negative on three antigen tests taken 48 hours apart (days 1, 3, and 5). No additional precautions (besides wearing a mask for 10 days)
are recommended for admissions who are not up to date with COVID-19 vaccines and/or are arriving from an in-patient hospitalization.

The ALR is encouraged to use empiric transmission-based precautions if: the person admitted cannot follow recommendations for testing or properly wear a mask for 10 days, the person admitted has a moderately or severely compromised immune system, or the person admitted is on a unit with an uncontrolled outbreak.

Visitation

**Should visitors be screened before entering ALR?**

CMS, CDC, and RIDOH recommend screening visitors, staff, and residents at all ALR. Screening offers an opportunity to inquire if visitors have symptoms, have been exposed, or have tested positive, and a chance to educate visitors on vaccination, hand hygiene, distancing, and source control.

Screening protocols may differ across residences. Residences may choose active or passive screening processes for staff and visitors. Visitors should be educated to stay up to date with COVID-19 vaccines.

ALR are not required to have screening processes but should follow CMS, CDC, and RIDOH recommendations for infection prevention and control best practices.

Testing

**How do we report self-tests (taken at home)?**

Self-test results should be reported in the self-test portal by the person tested. Facilities should provide staff with the self-test result portal link [portal.ri.gov/s/selftest](portal.ri.gov/s/selftest) and encourage them to enter results.

In addition to encouraging staff to enter results in the self-test result, RIDOH requires nursing homes to notify RIDOH as soon as possible of known positive test results by sending an email with name, date of birth, test type, and test date to RIDOH.COVID19LTC@health.ri.gov.

Isolation

**Why is the isolation period at least 10 days for people who have compromised immune systems (i.e., many residents)?**

People who have compromised immune systems may harbor viruses longer than other people and may continue to shed virus for longer periods of time (i.e., they may be infectious for longer periods of time). A longer isolation period, along with appropriate testing and consultation with a provider, helps to reduce the risk of transmission from those who have compromised immune system patients.
systems to other residents at high risk for serious illness. Consulting with a healthcare professional can help determine duration of isolation in these situations.

CDC recommends that people who have moderately or severely compromised immune systems isolate for at least 10 days, meet clinical criteria to end isolation, and consult with a provider to determine when to end isolation.

Outbreaks

Do we expect that the outbreak definition (one or more positive cases of COVID-19) will change?

RIDOH remains aligned with CDC on the definition of an outbreak for long-term care settings.

It is still important to have a low threshold to assess and intervene for vulnerable populations. While this may evolve over time, RIDOH is not aware of plans to change the current definition of the term outbreak.

What are recommendations for group activities and gatherings, such as the main dining room, hairdresser, and such, when a facility has an outbreak?

Group activities, gatherings, hairdresser, and communal dining should be assessed by each facility, based on current COVID-19 positivity within a facility and in consultation with RIDOH staff during outbreak situations. Modifications to group activities may be made such as increasing the distance between residents in groups, cohorting, and improving ventilation if group activities do continue.

If areas or units are not in outbreak or elevated risk, these activities may continue. Quality of life is an important consideration to be balanced with the risk of COVID-19 transmission and infection.

Vaccination

Has Rhode Island adopted CDC recommendations for staying up to date with COVID-19 vaccinations, including the bivalent vaccine booster for those eligible?

Yes. Rhode Island remains aligned with CDC recommendations to remain up to date with COVID-19 vaccines.

For the best protection against COVID-19, everyone should stay up to date with COVID-19 vaccines. This means getting all recommended doses—including bivalent doses for individuals who are eligible.
For COVID-19 vaccine recommendations by age, please find more information on CDC vaccine web page. For COVID-19 vaccine recommendations for people who have weakened immune systems, please find more information on CDC vaccine web page.

Rhode Island regulations (216-RICR-20-15-7) require that healthcare workers and ALR workers who are not up to date with their COVID-19 vaccines wear a NIOSH-approved N-95 mask while working in healthcare facilities when COVID-19 prevalence rate (community transmission) is greater than or equal to ≥ 50 cases per 100,000 people per week. For more information on these regulations, please see the covid.ri.gov page on Healthcare Worker Vaccine Requirements.