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

Updated: November 25, 2022

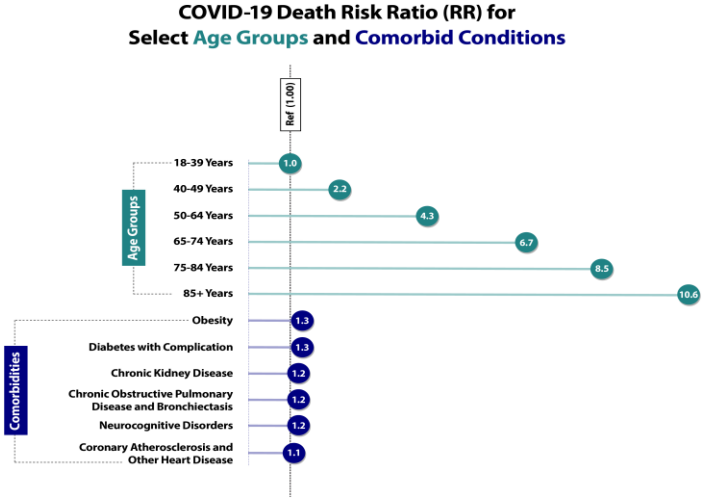
Overall

What is difference between traditional assisted living residences (ALR) [non-healthcare facilities] and ALR that receive funding from the Centers for Medicare & Medicaid Services (CMS) [healthcare facilities]?

The Centers for Disease Control and Prevention (CDC) clarified the distinction between settings where skilled-nursing care is provided and where it's not. If an ALR provides skilled care, they should follow guidance for nursing homes. ALR that receive CMS funding must follow CMS guidance.

If an ALR has residents with COVID-19 infection, the staff should be familiar with proper infection prevention and control (IPC) practices, including use of personal protective equipment, to protect themselves and others from potential exposures.

Additionally, the Rhode Island Department of Health (RIDOH) recommends that all ALR follow best practice for IPC. Best practice includes additional precautions than those outlined for the general public and community settings due to the populations served by most ALRs in Rhode Island. Data show that **age remains the strongest risk factor for severe COVID-19 outcomes**.



Reference: CDC's Underlying Medical Conditions Associated with Higher Risk for Severe COVID-19: Information for Healthcare Professionals

Healthcare Personnel

Are recommendations for use of N-95s and face shields/goggles by healthcare personnel (HCP) based on vaccination status or previous infection history?

Facilities should implement broad use of respirators and eye protection by HCP during patient care encounters when Rhode Island community transmission (case rates) is high (≥ 100 cases per 100,000 people per week). Eye protection recommendations are not based on individual's vaccination status.

However, Rhode Island regulations (216-RICR-20-15-7) require that healthcare workers and assisted living residence workers are up to date with their COVID-19 vaccines or wear a National Institute for Occupational Safety and Health (NIOSH)-approved N-95 mask while working in healthcare facilities when COVID-19 prevalence rate (community transmission) is substantial or higher (≥ 50 cases per 100,000 people per week).

What is the definition of "patient care encounter?"

In line with CDC's guidance, the Rhode Island Department of Health (RIDOH) recommends that staff should wear eye protection during "patient care encounters." A patient care encounter refers to when staff are within arm's reach of residents to interact and provide care (e.g., medication administration, bathing, meals, repositioning, transferring, etc.). For consideration, any staff member who would be identified as a close contact for COVID-19 exposure because they were within six feet for cumulative period of 15 minutes or more within 24 hours would also be considered as having a patient care encounter.

Source Control (Masking)

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

Nursing homes and ALR should consider masks for everyone in areas of patient care and broad use of respirators and eye protection by staff in patient care encounters when community transmission (case rates) is high (≥ 100 cases per 100,000 people per week).

Rhode Island regulations (216-RICR-20-15-7) require that healthcare workers and ALR workers are up to date with their COVID-19 vaccines or wear a NIOSH-approved N-95 mask while working in healthcare facilities when COVID-19 prevalence rate (community transmission) is substantial or higher (≥ 50 cases per 100,000 people per week).

Additionally, staff should follow recommendations for masking at all community transmission levels when they're exposed to someone with COVID-19 or there's an uncontrolled outbreak.

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

Everyone in nursing homes and ALR, including residents, should use source control (masking) when Rhode Island community transmission (case rates) is high (≥ 100 cases per 100,000 people per week).

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

Can nursing homes or ALR require visitors and residents to wear masks?

No. Nursing homes and ALR have a responsibility to educate, encourage, and model best practices for IPC. Residents and visitors may decide to remove source control during a visit when in a private area (away from staff and other residents). Facilities should educate visitors, residents, and staff, that source control is the top mitigation strategy to protect all.

What's the difference between community transmission and COVID-19 Community Levels regarding masking for staff?

In many circumstances, ALR staff should base decisions about masking at work on Rhode Island community transmission (case rates) when following best practice recommendations for IPC. Community Transmission is updated on the Congregate Care page on RIDOH's COVID-19 Data Response Portal.

- All ALR staff should wear NIOSH-approved N-95 masks/respirators and eye protection in patient care areas **when community transmission (case rate) is high** (≥100 cases per 100,000 people per week).
- Per Rhode Island law, all healthcare personnel who are not up to date with their COVID-19 vaccines **must** wear N-95 masks when prevalence/**community transmission (case rate) is substantial or higher (≥ 50 cases/100,000 people per week)**. For more information on these regulations, please see the covid.ri.gov page on Healthcare Worker Vaccine Requirements.

However, ALR staff who **provide non-skilled personal care** may follow community prevention strategies which are based on COVID-19 Community Levels. Rhode Island county COVID-19 Community Levels are updated on RIDOH's COVID-19 Response Data Portal.

- At all COVID-19 Community Levels, ALR staff who provide non-skilled personal care and test positive for COVID-19 should wear a mask if they return to work before completing 10 full days of isolation at home (in line with recommendations for isolation).

Screening

Should residents be screened daily?

Daily assessments of all residents are still required. The protocols may differ across facilities if they are documented and trackable.

Best practice is screening everyone for respiratory symptoms, especially during respiratory virus season.

Empiric Transmission-Based Precautions

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

Empiric transmission-based precautions are used when you are ruling out a pathogen, like 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 a close contact exposure.

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

Isolation in a private room with a private bath remains best practice for anyone who tests positive for COVID-19. Roommates who test negative should be moved to prevent continued exposure and risk. Cohorting residents who test positive for COVID-19 is acceptable.

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

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

In line with best practice for IPC, all admissions (new admissions and residents returning from a leave that was longer than 24 hours) should **wear a mask for 10 days** and **test negative on three antigen tests taken 48 hours apart**. No extra precautions are recommended for admissions who aren't up to date with their COVID-19 vaccines and/or arriving from an in-patient hospitalization.

The residence is encouraged to use empiric transmission-based precautions if an admission can't follow recommendations for testing or wearing a mask for 10 days, are moderately or severely

immunocompromised, or are on a unit with an uncontrolled outbreak.

Should ALR test admissions on the day of admission and again later, despite exposure and or vaccination status?

Yes, CDC and RIDOH recommend new admissions (and residents return after more than 24 hours) use source control for 10 days and are tested three times (day 1, 3, 5), regardless of vaccination status. This is now recommended because science and data show that immunity wanes and that previous immunity due to infection is less informative because many people have had infection.

Visitation

Should visitors be screened before entering ALR?

CMS, CDC, and RIDOH all recommend screening visitors, staff, and residents in ALR. Screening offers an opportunity to inquire if visitors have symptoms, exposures, tested positive, and 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 their COVID-19 vaccines.

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

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 encourage staff to self-report. RIDOH requires ALR to notify RIDOH 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.

Outbreaks

Do we expect that the outbreak definition will change (i.e., more than one case)?

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

COVID-19 remains a reportable disease. It's still important to have a low threshold to assess and intervene for vulnerable populations. While this may evolve over time, we're not aware of plans to

change the definition currently.

Vaccination

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

Yes. Rhode Island remains aligned with CDC's recommendations to remain up to date with COVID-19 vaccines, including the bivalent vaccine booster if eligible. RIDOH strongly encourages everyone to stay up to date with their COVID-19 vaccines as a leading tool to protect against serious illness.

Currently, Rhode Island does not require residents or staff to get the bivalent vaccine booster dose. However, 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 substantial or higher (≥ 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.

Does contracting COVID-19 change the recommendations for staying up to date with COVID-19 vaccines, including booster doses?

In line with CDC recommendations, a clinical decision can be made to postpone vaccination for up to 90 days after testing positive. However, the bivalent vaccine booster is due on day 91 to be considered up to date with COVID-19 vaccines.

Data shows that the vaccine booster dose offers broader protection even after COVID-19 infection, as measured by antibodies. While infection does "boost" an immune response in the clinical sense, it should never be documented as a booster.