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COVID-19 Information for Assisted Living Residences

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The purpose of this document is to serve as **COVID-19 guidance for Rhode Island assisted living residences (ALR).** It incorporates the Rhode Island Department of Health's (RIDOH) recommendations based on guidance from the Centers for Disease Control and Prevention (CDC) for long-term care settings whose staff provide non-skilled personal care.* The document also provides guidance on best practices for infection prevention and control (IPC) in higher-risk congregate settings.

This document includes guidance on the following topics:

- Isolation
- Testing
- Visitation
- Therapeutics
- Empiric Transmission-Based Precautions
- Source Control and Universal Personal Protective Equipment
- Vaccination

ALR whose staff provide non-skilled personal care* should follow community prevention strategies based on COVID-19 Community Levels. In addition, RIDOH recommends that all ALR follow best practice for infection prevention and control. Best practice includes additional precautions to 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.**

**Non-skilled personal care consists of any non-medical care that can reasonably and safely be provided by non-licensed caregivers. It may also include the kind of health-related care that most people do themselves, like taking oral medications.*

ALR that maintain waiver beds certified by the Centers for Medicare & Medicaid Services (CMS) should follow recommendations in the COVID-19 Information for Nursing Homes based on community transmission rates.

Visiting of shared healthcare personnel (HCP) who enter the setting to provide healthcare to one or more residents should follow the healthcare IPC recommendations in the COVID-19 Guidance for Nursing Homes.

Isolation

Residents and Staff

(Those who aren't in residences with or directly providing skilled-nursing care)

Isolation starts on the first day of symptoms (day 0) or on the day of a positive test if there are no symptoms (asymptomatic) (day 0).

Symptomatic person
Isolate until:

- At least 5 full days have passed since symptoms first appeared **AND**
- Fever-free for at least 24 hours, without fever-reducing medications **AND**
- Symptoms have improved.

Asymptomatic person

- Isolation may end when at least 5 full days have passed since the date of their first positive test result.

Day 6-10 isolation

- Wear a high-quality mask around others, even at home.
- Do not visit places where you are unable to wear a mask, such as restaurants.
- Do not travel.
- Do not visit people who have compromised immune systems or who are at high risk for severe illness.
- People who cannot wear a mask, including children younger than age 2 and people of any age with certain disabilities, should isolate for 10 days.

Removing your mask before day 10:

- If you have negative results from two consecutive antigen tests taken 48 hours apart, you may remove your mask sooner than day 10.
- If your antigen test results are positive, you may still be infectious. You should continue wearing a mask and wait at least 48 hours before taking another test.
  - Continue taking antigen tests at least 48 hours apart until you have negative results from two consecutive tests. This may mean you need to continue wearing a mask and testing beyond day 10.

- People who have moderate to severe illness from COVID-19 or who have moderately to severely compromised immune systems[1] isolate for at least 10 days **AND** consult a healthcare provider about when you can end isolation.

- People who were asymptomatic and develop symptoms during isolation should return to isolation if you were asymptomatic when you tested positive for COVID-19 and develop symptoms during the isolation period.

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[1] CDC defines immunocompromise as:

- Currently getting chemotherapy for cancer
- Being within one year out from receiving a hematopoietic stem cell or solid organ transplant
- Untreated HIV infection with CD4 T lymphocyte count lower than 200
- Primary immunodeficiency (PI)
- Taking immunosuppressive medications (e.g., drugs to suppress rejection of transplanted organs or to treat rheumatologic conditions such as mycophenolate and rituximab
- Taking more than 20 mg a day of prednisone, for more than 14 days
- Other condition(s) as determined by the treating healthcare provider

For best practice recommendations for IPC, RIDOH recommends ALR consider implementing the following recommendations.

Empiric Transmission-Based Precautions

(Used in addition to standard precautions while awaiting a clear diagnosis)

In addition to standard precautions for IPC, ALR should use empiric transmission-based precautions to mitigate COVID-19 transmission when ruling out COVID-19 infection for symptomatic residents, close contact exposures, and admissions. ALR should consult primary care providers or use on-site clinical judgment about empiric transmission-based precautions if residents remain symptomatic.

CDC provides detailed information about empiric transmission-based precautions.

Symptomatic Residents

- Quarantine and mask around others until COVID-19 is ruled out through diagnostic testing.
    - Empiric transmission-based precautions and masking may be discontinued when residents test negative for COVID-19: If using antigen tests, residents should have at least two negative results from consecutive antigen tests taken 48 hours apart or at least one PCR test.
- If a symptomatic resident is never tested, the decision to discontinue empiric transmission-based precautions and source control can be made based on symptom onset and isolation recommendations.

Close Contact Exposure Regardless of Vaccination Status

- Asymptomatic residents usually do not require use of empiric transmission-based precautions after close contact with someone with COVID-19. However, they should:
    - Wear masks for 10 days; **AND**
    - Test negative on three tests taken 48 hours apart (the first test taken no sooner than 24 hours after exposure).
        - Residents who tested positive for COVID-19 within the past 30 days should not get tested.
- Empiric transmission-based precautions may be considered after close contact when a resident
    - Is unable to be tested or wear masks for 10 full days following exposure;
    - Has a moderately to severely compromised immune system;
    - Resides on a unit with others who have moderately to severely compromised immune systems; **OR**
    - Resides on a unit experiencing ongoing COVID-19 transmission that has not been controlled with initial interventions.
- If empiric transmission-based precautions are used, residents should quarantine and wear source control around others until COVID-19 infection is ruled out. Empiric transmission-based precautions for residents may be discontinued after:
    - 10 full days if they don't develop symptoms;
      OR

- Seven full days following exposure if they test negative on three consecutive tests:
  - Antigen or PCR tests should be taken 48 hours apart following exposure – typically on days 1, 3, and 5 (the first test should be at least 24 hours after exposure).

Admissions/Residents Returning to the Facility After More Than 24 Hours

- Residents arriving at the residence as admissions (new admissions to the residence and those returning after leaving for more than 24 hours will be referred to as "admissions" in this guidance) should wear masks for 10 full days.
- Testing is recommended upon arrival at the residence. Residents should test negative on three consecutive antigen tests taken 48 hours apart.
  - Resident admissions should be tested upon arrival when community transmission is high (greater than or equal to 100 cases per 100,000 people).
    - Testing admissions when community transmission is lower is at the discretion of the facility.
- Empiric transmission-based precautions are not required for residents who leave the facility for less than 24 hours (e.g., for medical appointments or community outings).

* **Note on testing**: Individuals with symptoms of COVID-19 who test negative on at least one viral test most likely do not have an active infection at the time the sample was collected. If using nucleic acid amplification tests (NAAT) or PCRs, one negative test is sufficient in most circumstances. If using an antigen test, one negative test result should be confirmed through another negative test result from either a PCR or antigen test taken 48 hours later.

Testing

- ALR should base decisions about testing on revised CDC guidance for symptomatic, post-exposure, and outbreak testing:

When to Test for COVID-19	
Trigger	**Staff and Residents**
When a symptomatic individual is identified:	All staff and residents with signs or symptoms of COVID-19 must be tested, regardless of vaccination status.
When a COVID-19-positive staff or resident is newly identified in a residence that can identify close contacts:	Test all staff and residents who had a close contact or higher-risk exposure with a COVID-19-positive individual, regardless of vaccination status.
When a COVID-19-positive staff or resident is newly identified in a residence that is unable to identify close contacts:	Test all staff and residents facility-wide or at a group level (e.g., unit, floor, or other specific areas of the residence), regardless of vaccination status.
Routine Testing:	Usually not recommended. If implementing a screening testing program, it should not be based on vaccination status of the individuals being screened.

- For outbreaks, ALR should follow current guidance for outbreak testing and COVID-19 Case and Outbreak Reporting Protocol. Staff should be encouraged to report results of self-tests taken at home through the self-test portal.

On-Site Testing

- ALR should consider using antigen tests for testing. In addition to Clinical Laboratory Improvement Amendments-certified antigen point-of-care testing at the residence, staff may use antigen self-tests at home.
- Antigen tests deliver accurate and rapid results. To provide the greatest assurance that someone doesn't have COVID-19, residences should follow US Food and Drug Administration (FDA) guidelines:
    - Asymptomatic individuals with close contact exposure and admissions/residents returning to the residence after more than 24 hours should take three consecutive antigen tests 48 hours apart.
    - Symptomatic individuals should take two consecutive antigen tests 48 hours apart.

Source Control and Universal Use of Personal Protective Equipment (PPE)

Source Control

- ALR should use source control for everyone in areas of patient care when community transmission levels are high (greater than or equal to 100 cases per 100,000 people).
  - Residences may offer well-fitting facemasks as a source control option for visitors but should allow the use of a mask or respirator, that is not visibly soiled, with higher-level protection.
  - Source control options for healthcare personnel include:
    - National Institute for Occupational Safety and Health (NIOSH)-approved particulate respirator with N-95 filters or higher;
    - Respirator approved under standards used in other countries that are similar to NIOSH-approved N-95 filtering facepiece respirators (Note: These should not be used instead of NIOSH-approved respirator when respiratory protection is indicated);
    - Barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks; or
    - Well-fitting facemask, such as a surgical or procedural mask.

- Rhode Island regulations (216-RICR-20-15-7) require that healthcare workers or assisted living residence workers shall be up to date with their COVID-19 vaccines, meaning a person has received all recommended doses of COVID-19—including a booster dose when eligible—or wear a NIOSH-approved N-95 mask while working in healthcare facilities during a period in which the COVID-19 prevalence rate in the State is greater than or equal to 50 cases per 100,000 people per week.

Universal Use of PPE by HCP

- Residences should implement broad use* of respirators and eye protection by HCP during patient care encounters when community transmission is high (greater than or equal to 100 cases per 100,000 people).
  - NIOSH-approved particulate respirators with N-95 filters or higher should be used for:
    - All aerosol-generating procedures;
    - All surgical procedures that might pose higher risk for transmission if the resident has COVID-19;
    - Areas where residents are unable to use source control and the area is poorly ventilated, healthcare-associated transmission is identified, or universal respirator use by HCP working in affected areas is not already in place; and
  - Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) worn during all patient care encounters.

*When community transmission is high (greater than or equal to 100 cases per 100,000 people), residences may implement **universal use of NIOSH-approved particulate respirators with N-95 filters or higher for HCP during all patient care encounters** or in specific units or areas of the residence at higher risk for COVID-19 transmission.

Visitation

- Per 42 CFR § 483.10(f)(4), a resident has the right to receive visitors of their choosing at the time of their choosing, and in a manner that does not impose on the rights of another resident, such as a clinical or safety restriction. Find detailed information about visitation in the CMS QSO-20-39 NH – Revised 9.23.2022.

COVID-19 Vaccination

- Vaccination remains one of the best strategies to prevent severe COVID-19 infection.
- Everyone should stay up to date with their COVID-19 vaccines, including booster doses.
- Long-term care facility residents who are not up to date with their COVID-19 vaccines when they arrive at a long-term care facility should follow CDC guidance for COVID-19 vaccination.
- CDC and the CDC's National Healthcare Safety Network have additional reporting requirements for long-term care facilities.
- Per Rhode Island regulation 216-RICR-20-15-7 for Immunization, Testing, and Health Screening for Healthcare Workers, **healthcare workers are required:**
    - **To be up to date** with all CDC-recommended doses of FDA-approved or authorized COVID-19 vaccine

      OR
    - Wear an N-95 mask at each healthcare facility when Community Transmission level statewide is greater than or equal to 50 cases per 100,000 people per week, as reported by RIDOH.
- Per CMS 86 FR 61555 (as of October 12, 2022) all Medicare and Medicaid certified providers, suppliers, and healthcare workers are required to receive the primary series (e.g., two doses of Pfizer, Moderna, or Novavax, or one dose of Johnson & Johnson) of a COVID-19 vaccine.

Therapeutics (Treatments/Medications)

- As a RIDOH standard of care, ALR should:
    - Offer therapeutics to every resident who has recently been diagnosed with COVID-19

      OR
    - Record why therapeutics were not indicated or appropriate.
- Find detailed information about therapeutics for COVID-19 in the National Institutes of Health's COVID-19 treatment guidelines.
- Find information about accessing therapeutics in Rhode Island on RIDOH's COVID-19 therapeutics web page.
- Supply of preventative and treatments therapeutics can be found via the COVID-19 Therapeutics Locator.