everyday health behaviors (adherence to stay-at-home guidelines to reduce risk, and adaptive coping activities) on mental health and COVID-related distress. Examples of active coping strategies were stockpiling resources, spiritual practices, or outreach to others. Descriptive statistics, bivariate correlations, and multiple regressions characterized the impact of COVID-19 on perceived mental health. Descriptive data included changes in health service access, changes in mental and physical health, reduced social engagement, increased adherence to guidelines, and increased adaptive coping activities. Significant predictors of mental health impact of the pandemic were changes in health service access ($\beta = .18$, $p < .05$), health changes ($\beta = .25$, $p < .01$), and adaptive coping activities ($\beta = .21$, $p < .05$). Findings suggest COVID-19 distress may be alleviated with improved health care access and increased social contact. Mental health challenges may also benefit from increased engagement in adaptive coping activities.

IMPACT OF THE COVID-19 PANDEMIC ON PARTICIPATION IN COMMUNITY-DWELLING OLDER ADULTS: A CROSS-SECTIONAL ANALYSIS

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Public health guidelines to prevent spreading COVID-19 place older adults at risk of loneliness and social isolation. Evidence suggests that participation protects older adults from such detrimental outcomes, therefore we aimed to identify the factors associated with participation in life roles among older adults living in the community during the COVID-19 pandemic. We conducted a telesurvey on a random sample of community-dwelling older adults living in Hamilton, Ontario, Canada, between May and July 2020. Outcome measures included participation in life roles, physical function, physical activity, mobility, mental health, nutrition, and demographics. We conducted two multivariate regression analyses with the Late Life Disability Instrument's (LLDI) frequency and limitations scales as the dependent variables. Candidate factors were organized by International Classification of Functioning, Disability, and Health (ICF) framework domains; personal factors, body functions and structures, activities, and environmental factors. A total of 272 older adults completed the telesurvey (mean age 78 ±7.3 yrs, 70% female). Age, using walking aids, driving status, household income, education, mental health, nutrition, physical function, and dwelling type explained 47.1% ($p<0.001$) of the variance observed in LLDI frequency scores. Using walking aids, driving status, receiving health assistance, mental health, and physical function explained 33.9% ($p<0.001$) of the variance observed in LLDI limitation scores. These findings highlight factors from multiple ICF domains that are associated with participation limitation and frequency among older adults during the pandemic. Our findings have implications for developing public health initiatives to mitigate the effects of the pandemic on the participation of older adults.

LONELINESS AMONG US ADULTS DURING THE EARLY PHASE OF THE COVID-19 PANDEMIC: FINDINGS FROM THE COVID-19 COPING STUDY

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We aimed to estimate the prevalence of loneliness and identify the key sociodemographic, employment, living, and health-related risk factors for loneliness among middle-aged and older adults during the early COVID-19 pandemic in the US, when shelter-in-place and social distancing restrictions were in place for much of the country. Data were collected from online questionnaires in the COVID-19 Coping Study, a national study of 6,938 US adults aged 55-110 years, from April 2nd through May 31st, 2020. We estimated the population-weighted prevalence of loneliness (scores of ≥6/9 on the 3-item UCLA Loneliness Scale), overall and according to sociodemographic, employment, living, and health-related factors. We used population-weighted modified Poisson regression models to estimate prevalence ratios (PRs) and 95% confidence intervals (CIs) for the associations between these factors and loneliness, adjusted for age, sex, race, ethnicity, and education. Overall, 29.5% (95% CI: 27.9%, 31.3%) of US adults aged 55-110 were considered high in loneliness in April and May, 2020. In population-weighted, adjusted models, loneliness was most frequent among those with depression, those who were divorced or separated, those who lived alone, those diagnosed with multiple comorbid conditions, and individuals who were unemployed prior to the pandemic. In conclusion, we identified subpopulations of middle-aged and older US adults that were highly affected by loneliness during a period when COVID-19 shelter-in-place orders were in place across most of the country. These insights may inform the allocation of recourses to mitigate loneliness during times of restricted activity.

THE EFFECT OF TESTING TURNAROUND TIME ON COVID-19 OUTBREAK SEVERITY WITHIN U.S. NURSING HOMES

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COVID-19 has brought renewed attention to infectious diseases in U.S. nursing homes (NHs). The Testing turnaround time (TAT) of SARS-CoV-2 is vital information, supporting staff ability to make decisions regarding resource allocation. Methods: Using data obtained from the National Healthcare Safety Network's COVID-19 nursing home data set, we analyzed the TAT of laboratory polymerase chain reaction (PCR) testing on outbreak severity (number of people infected) for residents and staff. A MANOVA was performed on NHs submitting data over 26 weeks (May-November 2020). The independent variable was the average TAT for the two weeks prior (<24 hours, 1-2 days, 3-7 days, or 7+ days). Results: N = 15,363 NHs. The TAT for the combined dependent variables of staff and resident COVID-19 cases. $F(10,781,354) = 3161.265$, Pillai's trace = .078, $p<.0005$, partial $\eta 2=.4$. The average outbreak severity for staff was 13.93 cases when TAT was < 24 hours, compared to 15.29 cases at 1-2 days. For residents, the difference was less pronounced but still significant. The average outbreak severity for residents was 17.07 cases when TAT was<24 hours, compared to 18.61 cases when the TAT was 1-2 days. Tukey post-hoc tests found significance for all levels of testing for residents and staff at $p<.0005$. Discussion: Time differences to receive