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Review Article

COVID-19 Recommendations for Assisted Living: Implications for the Future



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A B S T R A C T

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Objectives: Assisted living (AL) emerged over 2 decades ago as a preferred residential care option for older adults who require supportive care; however, as resident acuity increased, concern has been expressed whether AL sufficiently addresses health care needs. COVID-19 amplified those concerns, and an examination of recommendations to manage COVID-19 may shed light on the future of AL. This review summarizes recommendations from 6 key organizations related to preparation for and response to COVID-19 in AL in relation to resident health and quality of life; compares recommendations for AL with those for nursing homes (NHs); and assesses implications for the future of AL.

Design: Nonsystematic review involving search of gray literature.

Setting and Participants: Recommendations from key governmental bodies and professional societies regarding COVID-19 in AL, long-term care facilities (LTCFs) in general, and NHs.

Measures: We collected, categorized, and summarized these recommendations as they pertained to quality of life and health care.

Results: Many recommendations for AL and NHs were similar, but differences provided insight into ways the pandemic was recognized and challenged AL communities in particular: recommending more flexible visitation and group activities for AL, providing screening by AL staff or an outside provider, and suggesting that AL staff access resources to facilitate advance care planning discussions. Recommendations were that AL integrate health care into offered services, including working with consulting clinicians who know both the residents and the LTC community.

Conclusions and Implications: Long-term care providers and policy makers have recognized the need to modify current long-term care options. Because COVID-19 recommendations suggest AL communities would benefit from the services and expertise of social workers, licensed nurses, and physicians, it may accelerate the integration and closer coordination of psychosocial and medical care into AL. Future research should investigate different models of integrated, interdisciplinary health care in AL.

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On March 11, 2020, the World Health Organization determined that the novel coronavirus outbreak had reached pandemic proportions owing to the increasing numbers of cases across the world.¹

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At that time, there were 118,000 cases and 4291 deaths across 114 countries;¹ as of February 18, 2021, there have been more than 109 million cases and 2.4 million deaths.² In the United States alone, there have been 27.6 million cases and more than 485,000 deaths, numbers that increase daily.³ Although COVID-19 can cause serious illness in people of all ages, older adults and people with comorbidities such as cardiovascular disease and diabetes are at risk for worse health outcomes and mortality if they become infected with COVID-19.⁴ In particular, this profile explains why residents of long-term care settings are at high risk of experiencing serious and life-threatening illness from this virus.

Long-term care settings include nursing homes (NHs) and assisted living (AL) communities, which provide care to more than 1.3 million

and 800,000 residents, respectively.⁵ Despite accounting for less than 1% of the US population, long-term care settings have been linked to 5% of COVID-19 cases and 34% of deaths nationwide.⁶ Although these figures purport to include both NH and AL residents, and it is estimated that 30% of COVID-19 deaths in long-term care occurred in AL and related care homes,⁷ numbers for AL are underestimated because COVID-19 data from these settings are not systematically gathered and reported.^{8,9} The reason for this lack of specificity is that unlike NHs, which are regulated federally, AL communities are regulated by each state; as such, there is no consistent national reporting of the number of cases or deaths due to COVID-19,⁹ indicating just 1 of many challenges AL communities have faced during the pandemic. Despite shortcomings in consistent reporting, preliminary data suggest that AL communities' preparation for COVID-19 has been hindered by shortages of personal protective equipment (PPE) and COVID-19 tests, and that COVID-19 outbreaks in AL communities have resulted in high hospitalization and mortality rates.⁸

The term AL refers to a diverse group of residential care communities that provide housing, meals, and supportive care; in addition, they aim to promote quality of life by emphasizing resident autonomy and opportunities for social engagement.¹⁰ AL communities vary widely in size, staffing, provision of health services, and regulations.^{11–13} Roughly 46% of communities do not have a licensed nurse on staff, despite the fact that the population served has over the past 2 decades become increasingly functionally impaired, with growing care needs.^{14,15} Instead, direct care workers provide the majority of care to residents,⁵ and more than 60% of states require less than 75 hours of formal training before they can provide resident care.¹¹

Regulation at the state level has led to considerable variation in infection control requirements for AL communities. As of 2018, 31 states had regulations that included infection control policies, and 13 required infection control programs;¹⁶ in addition, reporting requirements for outbreaks vary tremendously.¹⁷ Perhaps not surprisingly, data from 11 states suggest that viral illness outbreaks are a substantial burden in AL, partly because of gaps in infection control, including a lack of written infection control procedures, insufficient staff training on infection control practices, and inadequate staff knowledge on the appropriate use of personal protective equipment.^{17–19}

Ultimately, the COVID-19 pandemic challenges 2 broad aspects of AL: its emphasis on resident quality of life (eg, autonomy, social engagement) and the increasing importance of health care services. The latter issue has received notable attention recently,^{20,21} and COVID-19 is pushing boundaries in the debate regarding the extent to which AL needs to take more responsibility for health care. Specifically, the debate has included questions about the role of nurses and physicians in AL and whether there is a need for federal regulation regarding health care in AL given the increasing medical complexity of residents.^{20,21}

Because of the challenges posed by COVID-19 on AL, we reviewed and summarized recommendations that were issued by key organizations between March 9, 2020, and July 1, 2020, related to preparing for and responding to COVID-19 in AL, comparing them to recommendations for NHs, and critically assessing the implications for the future of AL. For the reasons above, we focused on recommendations that related to quality of life and health care.

Methods

We obtained and reviewed recommendations related to preparation for and response to the COVID-19 pandemic that target AL, long-term care facilities (LTCFs), and NHs; we included "LTCFs" because this term typically refers to both AL and NHs and was used exclusively in some recommendations. As most of the recommendations did not

specify their definition of AL (eg, based on bed size), we included all recommendations from these sources that specified AL or its synonyms (eg, residential care) but not family care or group homes. Data sources included the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), the American Geriatrics Society (AGS), the Society for Post-Acute and Long-Term Care Medicine (AMDA), the American Health Care Association/National Center for Assisted Living (AHCA/NCAL), and the Alzheimer's Association (AA), which we will collectively refer to as key organizations. Of note, recommendations from the AA were of importance given the large proportion of AL residents with cognitive impairment and dementia (ie, 42% have moderate or severe cognitive impairment).¹⁴ All relevant recommendations published or updated before July 1, 2020, were included.

To organize these recommendations, we adapted the categories from the CMS Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes.²² The CMS Toolkit has 15 categories, 11 of which became part of our domains. Two of the excluded categories reflected state actions rather than facility-level actions; the other reduction in the number of categories resulted from combining related categories. We then added 4 domains to account for issues important to AL: "Outside Healthcare Providers," "Training," "Psychosocial Support," and "Advance Care Planning." The final list of 15 domains for AL COVID-19 recommendations categorized by these foci is provided in [Table 1](#).

To facilitate assessment, we grouped recommendations based on the domain, the target setting of the recommendation (AL, LTCF, or NH—recognizing that "LTCF" may include both of the other 2 categories), and a comparison of the recommendation across the 3 target settings in terms of whether they had (1) similar wording, (2) similar intent, or (3) substantially different intent or were (4) not included elsewhere (in no other target settings).

Results

COVID-19 Recommendations Related to Resident Quality of Life

Recommendations related to resident quality of life addressed psychosocial support, visitation, and isolation ([Supplementary Table 1](#)).

Psychosocial support

Facilitating alternatives to in-person communication was consistent and essentially identical across all recommendations.^{23–30} However, recommendations regarding group activities and communal dining differed slightly among the 3 targets. Recommendations for AL did not specify a preference for canceling or for modifying group activities.^{23–25} In contrast, recommendations for NHs more specifically included canceling group activities and communal dining until reopening guidance from CMS and/or state and local officials suggested that it was acceptable to do so.^{29–31} Grief support services were to be "considered" for LTCFs, but were not specifically noted for one setting vs the other.^{32,33}

Visitation of family and close others

Of the 3 target settings, the recommendations specific to AL were the only ones that suggested encouraging residents to limit their outside visitors, as opposed to not allowing them.^{23,25} Furthermore, they left more flexibility for individual AL communities to make decisions regarding individual cases of residents who may need a specific person for more than a social visit, such as their family caregiver, depending on the local prevalence of COVID-19, which was not included in the recommendations for LTCFs or NHs.²⁵ Although the recommendations for AL and LTCFs suggested restricting visitors based on the local

Table 1
Domains of Assisted Living COVID-19 Recommendations

Quality of Life	Health Care	Other (Not Examined in This Study)
Psychosocial support*	Clothing and personal protective equipment (PPE) [†]	Communications [†]
Visitation of family and close others [†]	Screening [†]	Infection control practices [†]
Socialization and isolation [†]	Testing [†]	Reporting and mandated reporting [†]
	Outside Health care providers*	Resources [†]
	Advance care planning*	Training*
	Transfers and admissions [†]	Workforce and staffing (employed) [†]

Source: Adapted from the Centers for Medicare & Medicaid Services (CMS) Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes (<https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf>).

This study examined only domains focused on quality of life and on health care; the “other” categories are listed only for sake of completeness.

*Domains created from assisted living recommendations.

[†]Domains adapted from CMS Toolkit.

prevalence of COVID-19,^{23–25,32,34} the recommendations specifically for NHs only stated that they should not allow visitors (except in end-of-life situations) until the NH enters phase 3 of reopening.^{29,30,35} With regard to residents at the end of life, recommendations for AL and NHs suggested that visits be allowed, subject to each visitor passing through the facility's screening procedures.^{24,29,30,32}

Isolation

Across all 3 target settings, none had recommendations suggesting blanket isolation in resident rooms absent suspected COVID-19. Instead, they described similar events that trigger when isolation is advised for residents.^{23,27,29,30,36} Of note, the recommendations for NHs specified that residents who have COVID-19 should be isolated in private rooms with private bathrooms, which is not indicated in the recommendations for AL, which typically has private rooms and bathrooms.^{23,29,30} In addition, the recommendations for LTCFs acknowledged the challenge of keeping residents with dementia in their rooms, suggesting that LTCFs should create smaller spaces for these residents to roam should they display wandering behavior.²⁷

COVID-19 Recommendations Related to Health Care

Recommendations related to health care (Supplementary Table 2) addressed personal protective equipment, screening, testing, outside health care providers, advance care planning, and transfers or admissions.

Clothing and personal protective equipment

Recommendations for personal protective equipment across the 3 target settings shared many similarities regarding PPE training for staff, staff wearing facemasks, and residents wearing cloth face masks if tolerated and near others.^{23,24,27,29,36,37} Furthermore, across the 3 target settings, recommendations were similar regarding the use of PPE when COVID-19 is suspected or confirmed, concurring about staff wearing eye protection, N95 respirators, gloves, and gowns when providing care to any resident.^{23,29,34,36,37}

Screening

Although the recommendations for screening among the 3 target settings were largely similar regarding when and for what to screen, they differed in their specificity about who should be conducting the screening.^{23,24,27,29,30,34,36–38} The recommendations for LTCFs and NHs did not specify designating anyone to be in charge of screening,^{27,29,30,34,36–38} whereas the AL recommendations suggested designating at least 1 employee to be in charge of ensuring screening was uniform or considering seeking outside assistance to conduct screening.^{23,24} Furthermore, the recommendations for AL suggested setting up a central point of entry to facilitate uniform screening for all

who enter the AL, which was not included in the recommendations for LTCFs and NHs.^{23,25}

Testing

Recommendations for both AL and NHs suggested prioritizing staff and residents who are suspected of having COVID-19 for testing.²³ However, rather than including specific recommendations regarding universal testing, the recommendations for both AL and LTCFs deferred to CDC guidance on testing in NHs and to local and state health departments for testing guidance.^{23,28,37,39,40} The recommendations for NHs, which include CDC testing guidance for NHs, contained detailed guidelines for who should be tested, when they should be tested, and how often.^{29,35,36,41}

Outside health care providers

Across all 3 target settings, recommendations for outside health care providers suggested determining which ones were nonessential and restricting those from entering.^{23,25,29,30,34} In addition, all guidelines suggested monitoring personnel who work at multiple care sites for potential exposure to COVID-19 cases^{23,29,30,33,42} and using telehealth as a way to connect residents with clinicians.^{24,29,33} Although hospice workers were not specifically mentioned in the recommendations for AL, those for LTCFs and NHs indicated that hospice workers should be treated as essential health care workers.^{30,34}

Advance care planning

The recommendations for advance care planning in AL suggested that AL staff should receive training and serve as a conduit for primary care providers to have these discussions with AL residents,³⁹ whereas the recommendations for LTCFs directly suggested that staff should have these discussions with residents, particularly regarding the risks of hospitalization during COVID-19.⁴³ Recommendations for all 3 target settings suggested considering individual resident's goals of care when making transfer decisions about residents with COVID-19.^{39,43,44}

Transfers and admissions

Recommendations for LTCFs and AL suggested only accepting residents with known COVID-19 infection if they have the appropriate infection control policies and equipment. In contrast, regulations for NHs presumed that these settings should be prepared to accept such patients and provide guidelines for safely providing care. Recommendations regarding transfer decisions in AL and NHs were similar, as both suggested that the resident's goals of care and medical needs, as well as the community's ability to meet those needs, be considered.^{39,44} Specific to AL, one regulation recommended that AL-affiliated clinicians work with residents' primary care providers when making transfer decisions.³⁹

Discussion

Historically, AL has been considered to provide a “social” model of care for its residents. Although this framework is no longer sufficient or in favor to fully characterize AL,^{11,20,21,45–47} it provides important context to some AL core values, which include promoting resident autonomy and privacy and providing a space for social engagement and aging-in-place.^{10,48} Putting these values into practice is important to optimize resident quality of life. To that end, COVID-19 has presented ongoing challenges for AL to maintain resident quality of life, especially considering that 42% of AL residents have dementia, who may be particularly vulnerable to the adverse effects of social isolation and loneliness from visitor restriction and curtailing of group activities.^{14,49–51} Notably, there have been more than 44,000 additional deaths due to dementia since February 1, 2020, than would have been predicted based on previous years.⁵² This statistic underscores a need for attention to resident quality of life.

Across the 3 resident quality of life domains, COVID-19 recommendations for AL were less restrictive than those for NHs, including that individual AL communities make decisions regarding group activities and visitation based on local COVID-19 prevalence, individual AL community circumstances (eg, staffing, PPE supplies), and state and local guidance. These recommendations seem sensitive to the diversity of AL communities and the residents they serve, and inherently recognize the importance of quality of life in AL. Further, unlike the recommendations targeted to LTCF and NH, those for visitation in AL suggest encouraging residents to limit, rather than curtail, visitors, perhaps acknowledging the residential nature of these settings and emphasis on autonomy and social engagement. However, despite the flexibility in recommendations, many AL communities and residents have not always been able to exercise that choice fully, as the majority of states prohibited visitation at some point during the pandemic.⁹ When many states loosened those prohibitions during summer 2020, AL communities found ways to enable residents to see relatives in person, such as offering outdoor visits with strict masking and physical distancing requirements.^{53–55} In other instances, spouses of residents with dementia moved into or started working in the AL communities to be able to be with their spouse,⁵⁶ but this may not be a realistic option for most spouses.

Given that the average length of stay of AL residents is almost 2 years, and that they typically spend time with family and in outside activities,²¹ disruption in social engagement may be especially consequential. To maintain opportunities for social engagement for residents, some AL communities have relied on technology (eg, iPads) to enable residents to video chat with their relatives and to participate in virtual activities. However, these adaptations require investments in technological devices as well as add responsibilities to an already stretched workforce who need to facilitate these virtual conversations for those without personal devices and for residents with dementia.^{53,55,57} Adding concern to the impact of this disruption is that in general, psychosocial support in AL is limited; only 10% of communities directly employ a social worker, and the extent of social work services lags behind that available in NHs, hospice, and adult day services.⁵ Because social workers are trained to promote resident well-being,^{58–62} COVID-19 recommendations underscore the benefit of having psychosocially trained personnel such as social workers to support residents, their family members, and staff.

Regarding health care in AL, COVID-19 and related recommendations for AL have paved the way for states, such as Massachusetts, to relax state regulations and so enable AL staff to provide more health care services—such as administering injections and managing oxygen—which many AL operators want to be made permanent.⁶³ Other states already offer licensure categories that enable AL staff to provide these additional health care services, sometimes referred to as enhanced AL.⁶³ This modification of regulations offers an early

indication of how COVID-19 may lead to greater integration of health care into AL and reinforces the need to evaluate what changes will provide the greatest benefit to residents.

The recommendations for screening in AL^{23,24} indicate that there may not have traditionally been an employee on staff who was recognized as capable to oversee the screening of all residents, staff, and visitors for possible infectious illness, perhaps because of the variation in licensed nurse staffing¹⁴ and state requirements regarding infection prevention and control.^{16,17} Although processes to screen staff and visitors may be standard, monitoring AL residents for signs of COVID-19 may require more training because COVID-19 can present abnormally or asymptotically in older adults.⁶⁴

The recommendations for testing in AL explicitly defer to recommendations for testing in NH, even though testing capacity is an area where AL and NH differ more so than most. Other types of testing are more typical in communities that have licensed nurses,¹³ yet testing is a key part of reopening plans for all long-term care settings, indicating that some AL communities must adapt to conduct testing. Such adaptation may involve partnerships with local health departments and other third-party care providers to access testing, perform the tests, and process their results,^{39,65} particularly for the half of AL communities that do not have a licensed nurse on staff to conduct or delegate testing.^{12,15} Nonetheless, it is worth noting that the issues related to testing in AL extend beyond staffing, as many AL communities have faced barriers in enacting universal testing programs, including long laboratory processing time, cost, and lack of government support.⁶⁶ As with testing, vaccine distribution in AL communities rely on partnerships, such as with pharmacies in the federal Pharmacy Partnership for Long-Term Care Program for COVID-19 Vaccination.⁶⁷ However, many states have prioritized NH residents for vaccination before AL residents, resulting in delays in the vaccination of AL residents.^{68,69}

As with the recommendations for testing and screening, those for advance care planning and transfers in AL highlight the need to actively involve licensed clinicians, particularly the physicians, nurse practitioners, physician assistants, and social workers in improving medical care and decision making in AL.^{39,50} Some regulations go so far as to note the need for AL-affiliated clinicians to work with residents' primary care providers, giving a nod to evolution of the role of medical director that has been advocated by some.¹⁹ Both domains underscore the need for understanding the resident's goals of care when making medical decisions. In particular, the recommendations regarding decision making about transferring residents to a higher level of care emphasize the need for clinicians who can assess residents' medical status in the context of their goals of care as well as understand the specific AL community's ability to meet the needs of the resident.³⁹ With that said, these considerations assume that the AL community can relatively easily transfer ill residents to either NHs or hospitals. However, small AL communities and those in rural areas may face challenges transferring residents with COVID-19 to higher levels of care because of lack of established relationships with NHs and lack of local hospital bed space.⁵⁷

Limitations

The main limitations of this article are that only a select number of key organizations were included in the review and that state guidelines were not included. Although state guidelines would have added more specific information about what is required and recommended of AL communities by their regulatory bodies, we chose to limit the scope to 6 key organizations that have national reach, all of which are significant stakeholders in the care of older adults in long-term care settings and produced broad COVID-19 recommendations specifically for long-term care settings. This focus enabled us to collect and categorize all of the recommendations released by those organizations

related to COVID-19 in AL, LTCF, and NH. Nevertheless, we recognize that other sources of recommendations exist but were not included in our analysis.

Conclusions and Implications

COVID-19 recommendations for AL call for increased capacity to address residents' psychosocial and health care needs. They do not suggest that AL must or should become as medicalized as NHs, nor do they suggest that this capacity must be provided by AL staff clinicians. Long-term care providers themselves acknowledge that COVID-19 has underscored the insufficiency of current models of care,⁷⁰ and so the future may well accelerate the integration of psychosocial expertise and medical care into AL. This evolution is best informed by research on different models of integrated, interdisciplinary health care, ranging from medical directorships and onsite primary care⁴⁶ to leadership from a nonphysician and more education of staff and residents and their families,²⁰ and numerous other options. Given the variability in AL, it seems advisable that perceptions of all involved and affected stakeholders help guide this future: AL administrators, health care providers, and AL residents and families themselves. Furthermore, these adaptations and quality improvement must be based on reliable data, which has historically been a challenge for AL.^{8,9} As was recently noted, COVID-19 has brought long-term care out from "under the radar,"⁷⁰ meaning the time is ripe for change. COVID-19 recommendations for AL indicate the change that is needed when push comes to shove.

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Supplementary Table 1

COVID-19 Policies and Procedures Recommended or Required by Key Organizations Related to Resident Quality of Life in Assisted Living and Nursing Homes

Quality of Life Domains	Comparison	Target of the Policy or Procedure		
		Assisted Living (AL)	Long-term Care Facilities (LTCF)	Nursing Homes (NHs)
Psychosocial support	Similar wording	<ul style="list-style-type: none"> Facilitate alternatives to in-person visitation for residents to communicate with loved ones, such as video chatting.¹⁻⁸ 		
	Similar intent	<ul style="list-style-type: none"> Cancel or modify group activities.³ If modifying, consider conducting small group activities at staggered times to optimize physical distancing and screening residents for COVID-19 symptoms prior to each activity.^{1,2} Modify dining practices to ensure physical distancing. Such modifications include meal delivery to residents' rooms and staggered meal times.¹ 	<ul style="list-style-type: none"> Cancel group activities^{9,10} or modify group activities to follow infection control guidelines.⁴ Cancel communal dining^{9,10} and have residents eat in their rooms alone if they can do so safely.¹⁰ Consider other modifications for residents who need help when eating.¹⁰ 	<ul style="list-style-type: none"> Cancel group activities initially.^{7,8,11} Based on reopening guidance from CMS or state or local officials, consider providing small group activities with modifications to follow physical distancing and source control measures.⁷ Cancel communal dining initially.^{7,8} Based on reopening guidance from CMS or state or local officials, consider providing communal dining with modifications to follow physical distancing and source control measures.⁷
	Substantially different intent			
	Not included elsewhere			<ul style="list-style-type: none"> Consider offering grief support services to residents.^{12,13}
Visitation of family and close others	Similar wording			
	Similar intent	<ul style="list-style-type: none"> Restrict all visitors with fever, COVID-19 symptoms,^{1,3} or recent travel to a COVID-19 outbreak area.³ Visitors who are allowed to enter the AL community should wear a face covering.^{1,2} If visitors are allowed, consider establishing visiting hours, a central point of entry, and a sign-in policy.^{1,3} 	<ul style="list-style-type: none"> Restrict all visitors with fever, COVID-19 symptoms,^{9,14} or recent travel to a COVID-19 outbreak area.⁹ 	<ul style="list-style-type: none"> Restrict all visitors with fever, COVID-19 symptoms, or known exposure to COVID-19.⁷ Visitors who are allowed to enter the NH should wear face coverings, perform hand hygiene, and practice physical distancing.⁸ When restrictions are being relaxed, consider designating visiting hours, scheduling visits in advance, and restricting visits to specific areas.^{7,8}
	Substantially different intent	<ul style="list-style-type: none"> Depending on the surrounding community prevalence of COVID-19, consider restricting all visitors, except in end-of-life or other time-sensitive situations.¹⁻³ 	<ul style="list-style-type: none"> If there is community-wide transmission, restrict all visitors from entering the community, except in end-of-life situations.^{9,12} 	<ul style="list-style-type: none"> Restrict all visitors from entering the NH, except in end-of-life situations.^{7,8} NH can consider allowing visitors in phase 3 of reopening when the NH has no new cases for 4 weeks, no staff shortages, adequate supplies of PPE and COVID-19 tests, and local hospitals have bed capacity.¹⁵
	Not included elsewhere	<ul style="list-style-type: none"> Encourage residents to limit outside visitors.^{1,3} If there are no COVID-19 cases in the surrounding community, consider allowing residents to have a specific visitor who is needed for more than routine social visits.³ 		

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Supplementary Table 1 (continued)

Quality of Life Domains	Comparison	Target of the Policy or Procedure		
		Assisted Living (AL)	Long-term Care Facilities (LTCF)	Nursing Homes (NHs)
Socialization and isolation	Similar wording Similar intent	<ul style="list-style-type: none"> If COVID-19 is suspected or confirmed in an AL resident, isolate that resident in his or her room, and encourage all other residents to self-isolate in their respective rooms.¹ 	<ul style="list-style-type: none"> If COVID-19 is suspected or confirmed in LTCF staff or residents, isolate all residents in their rooms.⁵ 	<ul style="list-style-type: none"> If COVID-19 is suspected or confirmed in a NH resident, isolate that resident in a private room with a private bathroom, perhaps on a COVID-19 designated unit,^{7,8} and encourage all other residents to self-isolate in their rooms as much as possible.^{7,16}
	Substantially different intent Not included elsewhere		<ul style="list-style-type: none"> If resident isolation in rooms is not possible, such as with persons with dementia who wander, enforce physical distancing among residents and establish smaller areas for wandering.⁵ 	<ul style="list-style-type: none"> If COVID-19 is identified in a staff member, isolate all residents to whom this staff member provided care.¹⁶

This table includes paraphrased COVID-19 recommendations for AL, LTCF, and NH from 6 sources (Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the American Geriatrics Society, the Society for Post-Acute and Long-Term Care Medicine, the American Health Care Association/National Center for Assisted Living, and the Alzheimer's Association). Where boxes are empty, no recommended policies or procedures existed.

Supplementary Table 2

COVID-19 Policies and Procedures Recommended or Required by Key Organizations Related to Health Care in Assisted Living and Nursing Homes

Health Care Domains	Comparison	Target of the Policy or Procedure		
		Assisted Living (AL)	Long-term Care Facilities (LTCFs)	Nursing Homes (NHs)
Clothing and personal protective equipment (PPE)	Similar wording	<ul style="list-style-type: none"> • If tolerated, residents should wear cloth face coverings when in communal areas or when in close proximity to other people.¹⁻⁵ • Staff should wear a facemask at all times in the AL, if available.^{1-4,6} • Staff should be trained on selection, donning, and doffing of PPE.^{1,4,6-8} 		
	Similar intent	<ul style="list-style-type: none"> • If gown supply is limited, prioritize them for high-contact care activities, such as helping with ADL. Consider extended use or reuse of PPE if there are shortages.¹ • If COVID-19 is suspected or confirmed in a resident, staff should wear eye protection and an N95 respirator (or facemasks if respirators are not available) when in close contact with any resident.¹ • If COVID-19 is suspected or confirmed in a resident, staff should also wear gloves and a gown when in direct contact with any resident.¹ 	<ul style="list-style-type: none"> • Prioritize N95 masks for staff caring for residents with COVID-19 and for procedures that may cause aerosolization of particles.⁷ Consider extended use of PPE if there are shortages.³ • If COVID-19 is suspected or confirmed in a resident, staff should wear an N95 respirator (or facemasks if respirators are not available), eye protection, gloves, and gown when providing care to any resident.^{5,7} If there is community-wide COVID-19 activity, staff should use gloves and facemasks when caring for any resident.⁷ 	<ul style="list-style-type: none"> • If gown supply is limited, prioritize them for high-contact care activities, such as helping with ADL. Consider extended use and limited reuse of PPE if there are shortages.^{4,6} • If COVID-19 is suspected or confirmed in a resident, staff should wear an N95 respirator (or facemasks if respirators are not available), eye protection, gloves, and a gown when providing care to any resident.^{4,6}
	Substantially different intent Not included elsewhere		<ul style="list-style-type: none"> • When helping residents who are at high risk of choking when eating, staff should wear facemasks, gloves, eye protection, and gowns.⁹ 	<ul style="list-style-type: none"> • When caring for new admissions with unknown COVID-19 status, staff should wear an N95 respirator (or facemasks if respirators are not available), eye protection, gloves, and a gown.⁴ • Staff who work on a COVID-19 care unit should wear an N95 respirator and eye protection at all times and should wear gloves and a gown when entering resident rooms.⁶
Screening	Similar wording			
	Similar intent	<ul style="list-style-type: none"> • Educate staff that COVID-19 may present differently in older adults^{1,8} and in persons with dementia.² 		
	Substantially different intent	<ul style="list-style-type: none"> • Designate at least 1 facility employee to be in charge of screening other employees, third-party personnel, and visitors on entry for fever and symptoms of COVID-19.^{1,2} Consider if outside assistance is needed for this duty.² • Designate at least 1 facility employee to be in charge of screening residents daily for fever and symptoms of COVID-19.^{1,2} Consider if outside assistance is needed for this duty.² 	<ul style="list-style-type: none"> • Screen employees, third-party personnel, and visitors on entry for fever and symptoms of COVID-19.^{5,7,9} • Screen residents daily for fever and symptoms of COVID-19.^{5,7} Consider increasing this screening to 2-3 times daily when COVID-19 is in the LTCF.³ 	<ul style="list-style-type: none"> • Educate staff that COVID-19 may present differently in older adults.⁴ • Screen employees, third-party personnel, and visitors upon entry for fever, symptoms of COVID-19, and any known exposures to someone with COVID-19.^{4,10} • Screen residents daily for fever and symptoms of COVID-19.^{4,10} Assess their oxygen saturation using pulse oximetry.⁴ Consider increasing this screening to every shift for asymptomatic residents and 3 times daily for ill residents when COVID-19 is in the NH.^{4,6}
Not included elsewhere	<ul style="list-style-type: none"> • Consider establishing 1 central point of entry to facilitate uniform screening of all who enter the AL.^{1,11} 	<ul style="list-style-type: none"> • LTCFs should reassess and enhance surveillance programs to identify cases of COVID-19.⁷ 		

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Supplementary Table 2 (continued)

Health Care Domains	Comparison	Target of the Policy or Procedure		
		Assisted Living (AL)	Long-term Care Facilities (LTCFs)	Nursing Homes (NHs)
Testing	Similar wording	<ul style="list-style-type: none"> Residents suspected of having COVID-19 should be prioritized for testing.^{1,4,6,12} Staff suspected of having COVID-19 should be prioritized for testing.^{1,4,6,12} 		
	Similar intent	<ul style="list-style-type: none"> Refer to CDC testing guidance for nursing homes.¹ Work with local and state health departments to access appropriate COVID-19 tests.⁸ 	<ul style="list-style-type: none"> Work with local and state health departments to develop testing strategies and access appropriate COVID-19 tests.^{5,13,14} In the absence of state guidance, refer to CDC testing guidance for nursing homes.¹⁴ 	<ul style="list-style-type: none"> Create a testing plan that aligns with state and federal requirements and addresses triggers for testing, access to tests, and capacity to test residents and staff.^{4,15}
	Substantially different intent Not included elsewhere		<ul style="list-style-type: none"> Decisions regarding universal testing should be individualized to each LTCF based on their surrounding community prevalence of COVID-19, local testing capacity, and goals of testing.¹⁶ 	<ul style="list-style-type: none"> Before reopening, NHs should perform initial testing on all residents and staff, followed by regular testing thereafter.^{12,15} After identifying COVID-19 in a resident or staff member, conduct facility-wide testing, if testing is available, or test all other residents and staff who came in contact with the person with confirmed COVID-19.^{6,12,15} Repeat this testing every 3-7 d until there have been 14 d since the last positive result.^{6,12} Testing should have rapid turnaround times (less than 48 h).¹²
Outside health care providers	Similar wording	<ul style="list-style-type: none"> Personnel who work in multiple settings should let the LTCF know if they have been to other care sites with COVID-19 cases.^{1,4,10,17,18} 	<ul style="list-style-type: none"> Consider phone calls and telemedicine for clinicians who are no longer physically entering the LTCF.¹⁷ Restrict both employed and outside nonessential staff from entry.⁷ Hospice personnel should be considered essential.¹⁷ 	<ul style="list-style-type: none"> Consider telemedicine for clinicians who are no longer physically entering the NH.⁴ Determine which staff, both outside and employed, are nonessential and can have their services delayed.⁴ Restrict nonessential personnel from entering the NH.¹⁰
	Similar intent	<ul style="list-style-type: none"> Consider phone calls and telemedicine for clinicians who are no longer physically entering the AL community.² Determine which staff, both outside and employed, are nonessential and can have their services delayed. Restrict nonessential personnel from entering the AL community.^{1,11} 	<ul style="list-style-type: none"> If therapists enter the LTCF, consider ways to mitigate potential spread of COVID-19, such as by conducting therapy sessions in resident rooms and canceling any group therapy.¹⁸ 	<ul style="list-style-type: none"> Educate and train outside and employed staff on infection control and PPE.⁴
Advance care planning	Similar wording		<ul style="list-style-type: none"> Have advance care planning discussions with residents and their families regarding the risks of hospitalization during the COVID-19 pandemic and update advance directives accordingly.¹⁹ 	<ul style="list-style-type: none"> Consider resident's goals of care and advance directives when deciding whether to transfer a resident with COVID-19 to the hospital.²⁰
	Similar intent	<ul style="list-style-type: none"> Consider resident's goals of care when deciding whether to transfer a resident with COVID-19 to a hospital or nursing home.⁸ 		
	Substantially different intent Not included elsewhere	<ul style="list-style-type: none"> Access training and resources from local and state health departments to promote advance care planning discussions by coordinating with primary care providers.⁸ 		

Transfers/Admissions	Similar wording Similar intent	<ul style="list-style-type: none"> • If the AL is no longer able to care for a resident with COVID-19 safely, that resident should be transferred to a different care site that can care for them and follow proper infection control practices.¹ • AL communities should only accept residents who test positive for COVID-19 from other care sites if they can isolate that resident, have adequate supplies of PPE, and have effective infection control protocols.⁸ 	<ul style="list-style-type: none"> • LTCF should only accept residents from hospitals if they have adequate staffing levels and PPE. Otherwise, they should halt all admissions from hospitals until they have adequate staffing levels and PPE.^{19,21} In addition, LTCF should only accept hospitalized patients if they can isolate or cohort those individuals.²¹ 	<ul style="list-style-type: none"> • If the NH is not able to care for a resident with COVID-19 safely, that resident should be transferred to another facility that can care for them and follow proper infection control practices.^{4,10} NH should consider the resident's goals of care, any advance directives, and the resident's medical needs when deciding to transfer to the emergency department.²⁰ • New admissions with a positive COVID-19 test should be cohorted on a COVID-19 unit, and staff should wear an N95 respirator, eye protection, gown, and gloves when caring for these residents.^{6,20} • A resident with COVID-19 can stay in the NH if the resident does not need more care than the NH can provide and can follow proper infection control protocols for caring for residents with COVID-19.¹⁰ • For new admissions without a positive COVID-19 test, place the resident in single-person room or separate observation area. Staff should wear an N95 respirator, eye protection, gown, and gloves when caring for these residents. These residents should stay in this observation area until they have been afebrile and asymptomatic for 14 days.^{4,6} • If a resident has a new-onset suspected or confirmed COVID-19, the NH should consider halting admissions until they can assess the extent of transmission.⁶
	Substantially different intent	<ul style="list-style-type: none"> • A resident with COVID-19 can stay in the AL if he or she can perform his or her own ADL, request assistance, isolate in rooms, be checked on by AL staff or home health agency staff regularly, receive meals in their room.¹ If the resident needs more help, on-site or consultant personnel may provide supplemental care to allow him or her to stay in the AL.^{1,8} 	<ul style="list-style-type: none"> • An LTCF resident with COVID-19 does not have to be hospitalized but should be put in contact precautions and follow CDC guidance for COVID-19 cases in LTCF.¹⁹ • Assume that new admissions without a negative COVID-19 test have COVID-19.¹⁹ 	
	Not included elsewhere	<ul style="list-style-type: none"> • AL-affiliated clinicians should work with the resident's primary care provider and consider the resident's goals of care when making transfer decisions.⁸ 		

This table includes paraphrased COVID-19 recommendations for AL, LTCF, and NH from 6 sources (Centers for Disease Control and Prevention, the Centers for Medicare & Medicaid Services, the American Geriatrics Society, the Society for Post-Acute and Long-Term Care Medicine, the American Health Care Association/National Center for Assisted Living, and the Alzheimer's Association). Where boxes are empty, no recommended policies or procedures existed.