COVID-19 Guidelines for Assisted Living Facilities: Lessons Learned

Older adults are a population at risk for severe COVID-19 outcomes. As the pandemic struck the United States, long-term care settings were quickly seen as places where COVID-19 can spread rapidly and be deadly (Kimball et al., 2020; Roxby et al., 2020). Intervening on behalf of the older adult population became a public health priority as experts considered approaches to manage infection control (Centers for Disease Control and Prevention, 2020a,b). All older adult care settings have a congregate focus where socialization and related activities are key components to well-being. However, as differences among settings became apparent, assisted living (AL) communities posed unique challenges for planning and responding to the COVID-19 threat. A situation of surplus safety exists, reducing risk at all costs, that conflicts with the usual AL philosophy (Thomas, n.d.). In an effort to identify areas for practice improvement, the current article presents non–COVID-19 problems uncovered by adult geriatric primary care nurse practitioners caring for assisted living facility (ALF) residents, that arose due to ALF quarantine restrictions.

ASSISTED LIVING FACILITIES

ALFs’ basic philosophy encourages individualism, choice, and social engagement opportunities. Approximately 40% of older adults in long-term care reside in AL (Harris-Kojetin et al., 2016). Although >70% have some cognitive impairment, AL residents are an active group who enjoy taking trips together, with some still driving their own cars (Zimmerman et al., 2020; Zimmerman et al., 2014). AL residents remain engaged with the surrounding communities where they shop, eat meals, and often socialize with family and friends. Even those residing in ALF locked dementia units exist communally and appear to benefit from their freedom. AL provides a social hub important to the well-being of its residents.

More than 50% of AL residents are older than 80, and many have one or more comorbid conditions implicated in COVID-19, such as heart disease, diabetes, and chronic lung disease (Harris-Kojetin et al., 2016). Needless to say, AL communities attract increasingly frail older adults who benefit from 24-hour supervision for activities of daily living (ADL) care and receive two or more meals per day. However, the ALF model does not provide skilled nursing care (Zimmerman et al., 2020). Although many ALFs frequently have neighborhoods for individuals living with dementia, they do not have the same regulatory requirements as nursing homes. Regulations vary from state to state and in some locales, ALF nursing presence is not required. Families therefore assume the role of monitoring residents’ health and well-being.

Older adults in ALFs engage in limited amounts of physical activity, with the majority spending their time in sedentary activity, such as reading or watching television (Resnick et al., 2018). Through their focus on socializing, ALFs are structured to encourage physical activity, which is beneficial because inactivity leads to negative physical and mental health outcomes in older adults (Diaz et al., 2017). Physical activity is therefore naturally incorporated into residents’ days through activities, such as walking to meals and walking to attend recreational and other fun events. If an ALF resident has mobility problems or falls, physical therapy is ordered to improve ambulation ability and safety. Outpatient physical and occupational services are frequently used in ALFs to keep residents active and involved in life.

Experts creating pandemic guidelines acknowledged the uniqueness, limitations, and challenges of ALFs with regard to halting the transmission of COVID-19 and saving lives. Unprecedented restrictions on ALFs protect residents, many of whom have been spared from infection; however, residents’ families have not been allowed to visit, and most residents re-
main in their apartments, unable to enjoy movement throughout the facility that previously kept them connected, strong, and well. Subsequently, many ALF residents experience unintended consequences of quarantine—social isolation, immobility, and lack of family involvement. Lessons learned from the ALF COVID-19 experience, what went well and what did not go well, and suggestions of how we can do better are described.

COVID-19 QUARANTINE: LESSONS LEARNED

Surplus safety, a concept developed by Dr. Judah Rouch of the Erickson School and Dr. William Thomas of Eden Alternatives and Greenhouse Project, presents providers with a new way to understand older adult risk (Bowman, 2020; PHH, 2012). Three definitions of this concept include: (a) risk, which is concerned with deviation of an outcome from a particular benchmark; (b) downside risk, a type of risk involving surplus safety, where the likelihood is increased that an outcome is worse than the benchmark; and (c) upside risk, which refers to the likelihood an outcome is better than the benchmark. Furthermore, surplus safety involved in downside risk occurs through restrictive policies in care settings that might eliminate a feared outcome but in the process create new, sometimes worse, problems. In the case of current quarantines in AL communities, adaptations to completely eliminate risk of COVID-19 older adult infection by way of restrictive policies have, in many situations, resulted in more harm than good.

AL community COVID-19 guidelines for aggressive infection control to protect older adults in long-term care as set forth by federal, state, and local entities were largely successful; however, quarantine restrictions in ALFs resulted in less desirable adult outcomes. Table A (available in the online version of this article) outlines mechanisms, aside from customary infection control nursing practices with personal protective equipment (PPE) use (e.g., mask, visor, gowns, gloves as appropriate), put in place to reduce introduction and contain spread of COVID-19 in ALFs. Unfortunately, many communities limited entrance into ALFs not only by family and friends, but also by physical therapists, occupational therapists, lab technicians, skilled nurses, geriatric psychiatry personnel, and others who provide critical services for maintaining health and wellness of their residents. Jenq et al. (2020) express concerns with separating older adults from their loved ones indefinitely, noting the pandemic will likely add to loneliness and social isolation already plaguing many older people. Her team indicates high risk for non–COVID-19 deaths from outcomes such as falls, worsening chronic conditions, and deterioration of emotional health; all of which have become the reality and are expanded upon next. Table B (available in the online version of this article) shows recommended person-centered approaches to ameliorate outcomes due to non–COVID-19 problems in ALF residents.

RECOMMENDATIONS FOR PRACTICE

A prolonged period of deprived social, cognitive, and sensorimotor stimulation of isolated older adults can lead to devastating results and premature death (Mehrabi & Béland, 2020; Plagg et al., 2020). Sadly, dining rooms in ALFs closed at the beginning of the pandemic and residents are required to eat in their rooms, despite the fact that communal dining improves eating habits in older adults, whereas social isolation often causes weight loss. One recommendation is to seat residents in small groups, safely spaced apart. Often the food served in a resident’s room is less appealing because facilities use Styrofoam™ containers and food quickly becomes cold. As lack of food palatability can be a problem, staff need to be more vigilant than usual with monitoring resident consumption habits and meal quality.

Although the intent of social distancing is not social disengagement, oftentimes residents struggling with cognitive decline become disengaged, lonely, and depressed when isolated. We recommend a true buddy system, where an older person is paired with someone else in the community, and more freedom to roam. We recommend more outdoor time for residents. Outdoor activities are safer than indoor activities as long as there is a safe social distance being maintained. Getting closer to nature is beneficial for everyone, including older adults. We recommend a variety of older adult–appropriate activities with spacing that allows for social distancing while providing engagement and fun. Proper social distancing is a safe solution to the problems caused by social isolation.

Despite the fact that quarantining in a room or apartment keeps ALF residents safe, it also reduces their level of activity, leading to weakness as well as complications of immobility. Complications of immobility include traumatic falls, fractures, deep vein thromboses, and pulmonary emboli, which can lead to death. Serious consequences of isolation in quarantine require us to question whether these precautions are ultimately beneficial to residents. We recommend physical therapy and occupational therapy assessments and ongoing evaluations with identification of residents showing signs of decline to engage and strengthen them. We recommend daily personal exercise routines, such as chair exercises or other geriatric-recommended workouts, to make up for lost physical exercise caused by staying in their rooms.

Although residents’ family members live outside of the ALF and may be exposed to COVID-19 and possibly be asymptomatic carriers, their involvement in the life of their loved one is critical for identifying subtle changes. Many times, family members are the first to notice subtle changes in mood, appetite, and interests. We have seen videoconferencing
with family and friends, although fine for the short-term, it does not have the same effect as contact with real people (Crewdson, 2016). We recommend one or two special family members be allowed regular visitation with their ALF resident. We encourage family members to bring favorite foods. We recommend that family members participate in the life of their loved one by watching television with them, playing games, and finding unique and entertaining ways to pass the time.

Due to increased frailty in ALF residents, end-of-life (EOL) care with hospice and palliative services increased during the pandemic period. Home hospice or community hospice personnel serve most ALFs, coming into the facility to assist and guide EOL care. However, in some instances, certain hospice workers, such as aides who assist with ADL care, chaplains who provide spiritual support, and volunteers who provide one-on-one time for reminiscence and other pleasant activities, have been restricted from entering the facility, thereby limiting and blocking specialized care. Even more sad, family visits can be restricted and have time constraints—unbelievable but true—during a precious time when residents need family most. Such restrictions are an infringement on patient and family rights. Although visitation restrictions are for everyone’s protection, safety requirements for visitors, such as wearing PPE, decrease chance of exposure for residents. Therefore, family visits for dying residents should not be limited and time constrained because they are crucial in providing comfort during a difficult and important period in life.

**RECOMMENDATIONS FOR POLICY**

Although the intent of guidelines for ALF preparedness to manage the COVID-19 pandemic and protect residents from infection appear to decrease COVID-19 in ALFs, from our experience consequences of isolation, lack of family involvement, and immobility unintentionally increased some older adult residents’ risk for morbidity and mortality due to other unanticipated problems. Efforts are needed to eliminate surplus safety. In an evolving pandemic situation such as COVID-19, alternate policies should be instituted as our understanding of the disease and how it spreads changes. Masks for ambulatory non-cognitively impaired residents can increase their freedom within the community. Required routine COVID-19 testing of family members who frequent the community to support their older adults will decrease the likelihood of introduction and spread of disease. Currently, ALFs reduce the risk of COVID-19 transmission by vigilantly monitoring the health of health care workers and their infection control behaviors and by sanitizing surfaces (Dosa et al., 2020). ALF personnel diligently work toward having the staffing and infrastructure in place to meet the demands of a vulnerable group of older adults when and if COVID-19 enters their community (Zimmerman et al., 2020).

However, through controlling the environments and providing alternate methods for care and communication, they unknowingly strip older adults of the key elements that make their existence in the ALF worthwhile.

**CONCLUSION**

Violation of patient and family rights must be addressed. Have the restrictions gone too far for the benefit of protecting everyone? In some instances, residents are required to isolate further if they choose to leave the community for a required medical visit or treatment, whereas staff come and go each day. These new restrictions on residents appear punitive in nature. These requirements may even cause residents to refrain from getting necessary medical care.

With so little time left, efforts should be made to grant older adults the agency to make decisions surrounding their day-to-day experiences as well as to maximize time with loved ones. For older adults, wellness is more than sickness or health—it pertains to quality of life. In late life, quality equates to function—what an older person can do. We must provide person-centered care by attending to older adults’ physical, emotional, spiritual, and social needs—even amid the current pandemic. We must keep our ALF residents well, not just safe.

**REFERENCES**


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The authors have disclosed no potential conflicts of interest, financial or otherwise. The views expressed are those of the authors and do not reflect the official policy or position of Gilchrist Elder Medical Care or Greater Baltimore Medical Center.

The authors acknowledge and thank Claire Kowalewski for her personal assistance as copy editor and with manuscript preparation.

doi:10.3928/00989134-20210113-04
Table A

*Mechanisms to reduce COVID 19 in ALFs*

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<tr>
<th>CDC Recommendations for Reducing COVID-19 Infection and Spread in the ALF</th>
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<tbody>
<tr>
<td>Avoid presenteeism (employee working while sick by instituting flexible sick leave policy)</td>
<td>Social distancing</td>
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<tr>
<td>Strict isolation policies</td>
<td>Clean and disinfect high touch areas</td>
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<td>Test residents unable to comply with CDC recommendations (i.e., dementia) and those at high risk for severe complications</td>
<td>Daily symptom screening of all entering facilities</td>
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<td>Coordinate transfers to and from COVID-19 locations</td>
<td>Testing symptomatic and in certain situations asymptomatic health care workers/employees</td>
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Table B

*Patient-Centered Care in the ALF During COVID-19 Pandemic*

<table>
<thead>
<tr>
<th>COVID-19 Restriction</th>
<th>Resident Outcome</th>
<th>Recommendations for Practice</th>
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<tbody>
<tr>
<td>Social Isolation</td>
<td>Depression and Anxiety</td>
<td>Nursing assessment for changes in mood</td>
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<td>Socially distanced activities inside the facility and outdoors</td>
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<td></td>
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<td>Buddy system within the facility</td>
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<td></td>
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<td>Video conferences for contact with friends and family</td>
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<td>Family visitation</td>
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<td>Low threshold for treatment</td>
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<td></td>
<td>Gero-psychiatry consultation</td>
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<td>Dehydration</td>
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<td>Nursing assessment of hydration status</td>
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<td></td>
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<td>Drink carts with water and other fluids offered between meals</td>
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| Lack of Family Involvement | Missed signs and symptoms of decline | Frequent nursing checks throughout the day  
Family visitation  
Nurses to monitor for signs and symptoms of worsening chronic illness  
Nurses to monitor vital signs and assess for common infections, such as urinary tract, pneumonia, and skin infections |
|---------------------------|--------------------------------------|--------------------------------------------------------------------------------------------------|
| Increased Immobility      | Increased Frailty                     | Nursing to monitor for increased weakness  
Institute fall precautions  
Hospice and palliative service consults when appropriate |

- Nursing assessment of food intake
- Increase frequency of weights
- Snacks and supplements between meals
- Offer palatable food
- Provide communal eating with social distancing
| Falls | Nursing to monitor fall risk  
                     Structured routine exercises 3 times a day, 7 days a week  
                     Physical therapy for strengthening, gait training, and balance  
                     Occupational therapy for functional recommendations and adaptations |
| Deep Vein Thromboses (DVTs) and Pulmonary Emboli (PE) | Nursing to monitor for signs and symptoms of DVT or PE  
                     Low threshold for ordering venous Doppler studies  
                     Maintain resident physical activity throughout the day |