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House of Representatives
COMMONWEALTH OF PENNSYLVANIA

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING
Topic: COVID-19 Plans for Long Term Care Facilities
G-50 Irvis Office Building – Harrisburg, PA
July 16, 2020

AGENDA

2:00 p.m. Welcome and Opening Remarks

2:10 p.m. Panel One:
- Sarah Boateng, Executive Deputy Secretary, Pennsylvania Department of Health
- Keara Klinepeter, Special Advisor to the Secretary of Health, Pennsylvania Department of Health
- Kristin Ahrens, Deputy Secretary of the Office of Developmental Programs, Pennsylvania Department of Human Services

2:30 p.m. *Questions & Answers*

2:50 p.m. Panel Two:
- Matt Yarnell, President, SEIU Healthcare PA
- Emma Grahm, Certified Nursing Assistant
- Elyse Ford, Vice President, District 1199C

3:10 p.m. *Questions & Answers*

3:30 p.m. Panel Three:
- Misty Dion, CEO, Center for Independent Living of North Central PA
- Justin Bell, Nursing Home Survivor
- Norma Robertson-Dabrowski, Nursing Home Transition Administrator, Liberty Resources

3:50 p.m. *Questions & Answers*

4:00 p.m. Closing Remarks

House Democratic Policy Committee Hearing
COVID-19 in Long-Term Care Facilities
July 16, 2020

Testimony of:

Sarah Boateng
Executive Deputy Secretary

Keara Klinepeter
Special Advisor to the Secretary

House Democratic Policy Committee Hearing
July 16, 2020

Good afternoon Chairman Sturla, Representative Hohenstine, and members of the House Democratic Policy Committee. My name is Sarah Boateng and I am the Executive Deputy Secretary for the Department of Health. Joining me is Keara Klinepeter, Special Advisor to the Secretary. We are pleased to be with you this afternoon to discuss the Wolf Administration's work to protect the vulnerable populations who reside in long-term care facilities as we continue to deal with COVID-19.

While COVID-19 is still a novel, or new virus, there is much we have learned since its initial reports out of China, its introduction to the US in February, and its arrival in Pennsylvania in March. At that time, we were only seeing the beginning of more widely available testing capacity and were only at the beginning of the decline of new daily cases. Thankfully, our outlook has improved, daily case counts are still below the peak we saw in April, but we have not yet defeated this invisible enemy and continue to take action.

Many have worked tirelessly all across the Commonwealth, from within PEMA at our Department Operations Center to each County or Municipal Health Department to every hospital, to reduce transmission of this deadly virus. That is also true in nursing homes and other long-term care facilities where our heroic frontline workers are caring for our most vulnerable.

The Department of Health (DOH) has worked hard to support these facilities. Whenever a long-term care facility reports even a single case of COVID-19, the Department of Health considers it an outbreak, conducts an assessment of the situation, and offers up a variety of resources. These resources include having the facility work with Department of Health staff to identify measures to slow and stop the spread, utilize the services of ECRI, our infection control consultant; or deploying the Pennsylvania National Guard to assist with staffing.

DOH has also worked to fill gaps in the need for personal protective equipment (PPE) for these facilities. Working tirelessly along with the Department of General Services and PEMA, DOH has pushed out over 2,400 shipments of PPE to long-term care facilities. These long-term care-specific shipments included 2,837,070 N95 masks (or equivalent), 1,185,200 procedure masks, 1,057,100 gloves, 340,700 face shields, and 315,254 gowns.

To achieve the goal of stopping this spread, we have worked with partners such as DHS and DMVA to offer staffing assistance, testing, or infection control consultations and best practices in cohorting positive residents. We have also recently partnered with Omnicare, a CVS company, to help facilities achieve the goal of universal testing by the July 24th deadline set by DOH. We will continue these efforts within the Department and with all those we partner with for the benefit of the residents.

Additionally, we have heard from concerned family members, who have not been able to be present with their loved ones since early this year. These stories are heartbreaking. However, the pause on visitation was a necessary measure to prevent rampant spread of the virus into these facilities. Realizing that emotional and mental health are just as important as physical health, we have begun the process of resuming safe visitation at facilities who develop a reopening plan and meet certain testing, staffing, and other prerequisites. Some of these include facility-wide testing for both staff and residents, cleaning protocols, and being COVID-free for 14-day intervals.

We take the safety of these residents very seriously and strive to do all we can to ensure facilities have the guidance needed to ensure that safety. Our guidance draws on national standards and is informed by approaches throughout the country, but balances with the realities of the long-term care system's

needs specific to Pennsylvania. It is our hope that facilities are able to meet these benchmarks and allow residents and their loved ones to reconnect in a safe socially distanced manner – but closer than over an iPad.

As you can see by all of these activities, long-term care facilities have been and will continue to be a priority of Department of Health and the Wolf Administration. Thank you for your time and am happy to take questions.

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July 16, 2020

State and CMS Survey Guidance for Skilled Nursing Facilities during the COVID-19 Pandemic

On June 3, 2020, Governor Tom Wolf renewed the Proclamation of Disaster Emergency issued on March 6, 2020, to enable agencies to respond promptly to the novel Coronavirus disease (COVID-19) for 90 days. To slow the spread of coronavirus disease 2019 (COVID-19) into Pennsylvania, and consistent with the guidance issued by the Centers for Medicare and Medicaid Services (CMS) the Department of Health (Department) issued guidance on March 31, 2020, ***State and CMS Survey Guidance for Health Care Facilities during the COVID-19 Pandemic***, to identify the Department's prioritization of survey activities.

As mitigation efforts have helped to curtail the spread of COVID-19, the Department has instituted a plan for the reopening of the Commonwealth. The reopening plan institutes three phases with differing degrees of restrictions. The three separate phases are coordinated by color (red, yellow, and green) to indicate most restrictive to least restrictive.

This guidance supersedes the previously issued guidance to the extent that the previously issued guidance it applied to skilled nursing care facilities.

The purpose of this guidance is to inform facilities how the Department will conduct surveys of facilities located in counties that have moved to the yellow and green phases of the Governor's reopening plan. This guidance is effective immediately.

Coordination with CMS on Prioritization of Survey Activities

The Department acts as the State Survey Agency (SSA) for CMS. Accordingly, when acting in its dual capacity as SSA and the state regulatory authority, the Department will follow CMS directives, including those relating to prioritizations of surveys. CMS directives for SSAs relating to skilled nursing care facilities are incorporated by reference in this guidance.

State Licensure Surveys

Initial Licensure Surveys

The Department will conduct initial licensure surveys, regardless of the reopening phase of the county where the facility is located (red-yellow-green). Initial licensure surveys will take place on-site, though the Department may conduct portions of the survey off-site if an off-site survey would not affect patient safety or quality assurance.

In addition to the guidance in this section, the Department will follow CMS directives for initial licensure/certification surveys. Unless otherwise directed, the Department will prioritize initial licensure surveys based upon date of request.

License Renewal Surveys

Any skilled nursing facility license due to expire on or before August 31, 2020, including those that were extended under the initial survey guidance issued on March 31, 2020, will be extended an additional 90 days from the date of expiration. This extension includes provisional licenses.

The Department will conduct license renewal surveys for facilities located in counties designated as in the "yellow" or "green" phase of reopening. License renewal surveys will take place on-site, though the Department may conduct portions of the survey off-site if an off-site survey would not affect patient safety or quality assurance.

Skilled nursing facility state license renewal surveys will be scheduled based upon the expiration date of the facility's license if the CMS recertification date is not the same as the license expiration date.

If a license that was extended is renewed upon completion of a license renewal survey, the renewed license will reflect the original expiration date and not the extended license date. For example, if the facility license would have expired on April 31, 2020, and pursuant to the Department's guidance was extended for two 90-day periods to October 31, 2020, the renewed license the facility receives will reflect a renewal term from the original license expiration date (April 31, 2020) or April 30, 2021to April 30, 2022.

Complaint Surveys

Complaint surveys will continue to be conducted for all facilities, regardless of the phase of reopening of the county where the facility is located. Complaints containing allegations that a facility caused or is likely to cause serious injury, harm, impairment, or death to a resident will continue to be conducted on-site.

Complaint surveys in response to allegations that do not rise to that level will generally take place on-site, though the Department may conduct portions of the survey off-site if an off-site survey or review would not affect patient safety or quality assurance.

The Department will follow the most current CMS directives, as applicable, including prioritization.

Occupancy Surveys

Occupancy surveys conducted by the Department's Divisions of Nursing Care Facilities (DNCF) and Safety Inspection (DSI) that are not part of an initial licensure survey will be completed in accordance with the following guidance:

DNCF Occupancy Surveys

DNCF will conduct occupancy surveys for facilities in counties in the "yellow" or "green" phase of reopening. Occupancy surveys may also be conducted for facilities in counties in the "red" phase of reopening if the area being surveyed has not been occupied by patients since March 1, 2020 and Department staff would not have to enter or pass through any occupied spaces to conduct the survey.

DNCF occupancy surveys will be conducted on-site for all alterations, renovations, or construction relating to patient care areas. Other DNCF occupancy surveys will occur on-site unless DNCF determines that an off-site review would not compromise quality assurance or patient safety.

DSI Occupancy Surveys

DSI will conduct occupancy surveys for facilities in counties in the "yellow" or "green" phase of reopening. DSI occupancy surveys may also be conducted for facilities in counties in the "red" phase of reopening if the area being surveyed has not been occupied by patients since March 1, 2020 and Department staff would not have to enter or pass through any occupied spaces to conduct the survey.

DSI occupancy surveys will be conducted on-site unless DSI determines that an off-site review would not compromise quality assurance or patient safety.

Closure Surveys

Nursing Care Facility closure surveys will not be prioritized by the Department for the duration of the Governor's Disaster Proclamation. Closure surveys may occur in facilities located in counties in "yellow" or "green" phase of reopening if the facility has been unoccupied by patients or residents for at least 14 days. Closure surveys will occur on-site unless the Department determines that portions of the closure plan can be verified off-site without compromising quality assurance, patient safety, or community impact.

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CMS Prioritization of Survey Activities and State Licensure Surveys

The Department will use the following prioritization criteria when determining which facilities to survey in the "green" phase of reopening:

Complaint Surveys

The Department will follow CMS guidance for prioritizing surveys for complaint investigations. In addition to following CMS guidance, the Department may take other factors into consideration when choosing to prioritize a facility for surveying. For example, if the Department identifies a trend in allegations that indicates an increased risk of harm to residents or receives corroborating information about regarding the allegation, then the Department may increase the prioritization of that complaint.

Standard Recertification Surveys

For standard recertification surveys, the Department will prioritize surveys based on the following factors:

1. Facilities that have had a significant number of COVID-19 positive cases;
2. Special Focus Facilities;
3. Special Focus Facility candidates;
4. Facilities that are overdue for a standard survey (less than 15 months since last standard survey, license expiration in less than 12 months or Provisional licenses expiration in less than 6 months) and a history of noncompliance at the harm level (citations of "G" or above) with the below items:
    a. Abuse or neglect
    b. Infection control
    c. Violations of transfer or discharge requirements
    d. Insufficient staffing or competency
    e. Other quality of care issues (e.g., falls, pressure ulcers, etc.)

Other Information

When a Department surveyor has need to enter a facility for any of the reasons stated above, the surveyor will follow appropriate infection control measures as provided by the Centers for Disease Control and Prevention (CDC) guidance and comply with the facility's screening protocols. The facility shall make all reasonable attempts to provide necessary Personal Protective Equipment (PPE) to the surveyor.

With the Governor's authorization as conferred in the Proclamation of Disaster Emergency on March 6, 2020, as amended on June 3, 2020, all statutory and regulatory provisions that would

impose an impediment to implementing this guidance are suspended. Those suspensions will remain in place while the Proclamation of Disaster Emergency remains in effect.

Testimony of Matt Yarnell

Introduction

- Our union brings together 45,000 healthcare workers across the Commonwealth, including 109 Nursing Homes and over 10,000 homecare workers who provide care to seniors and those with disabilities in nursing homes and home settings.
- Started as a nursing home aide in Center County, quickly learned I wanted – and needed – to fight for a better system.
    - Those challenges I faced then are nothing compared to what caregivers face now.
- The global pandemic shined a spotlight on this fragile system. 4,700 nursing home resident deaths to COVID-19.
- Nursing home workers have been sounding the alarm for decades.
    - We need better funding for bedside care.
    - We need to stop the rapid spread of COVID in our nursing homes by providing paid sick time and having proper PPE, and
    - Nursing homes must have better staffing.

We have a funding challenge

- Medicaid funding has been flat
- Costs continue to rise
- HB2510, passed into law - appropriated $245 million dollars to Skilled Nursing Homes throughout Pennsylvania, a one-time payment to cover costs incurred and to be incurred during the COVID-19 crisis
- CARES Act funding must have transparency - make sure it reaches the bedside for resident care and essential worker pay.
    - We support legislation from Senator Katie Muth for ***Nursing Home Transparency*** that will provide monthly reporting how CARES Act dollars are being spent.
    - On **funding as part of the DHS budget**, we are advocating for additional funding to be allotted to providers based on quality incentive metrics including increased staffing, increased wages, affordable health insurance, training, and positive labor relations.

The rapid spread of COVID in our nursing homes must be contained. To do this, workers need paid sick time and proper PPE.

- The Families First Coronavirus Response Act included two weeks of paid leave for some workers who must isolate or quarantine due to COVID-19.
    - But this law excluded all healthcare workers and first responders, despite their role on the frontlines of the healthcare crisis.
- Many nursing home workers do not have paid sick time – even if they've worked there for years. Home care workers, who provide essential care to people in their own homes, do not have any paid time off at all.
- Many nursing home workers live paycheck to paycheck. This means choosing between staying home when they are sick, or feeding their families.
- Culture built around not taking sick time
    - Workers disciplined – even fired – for calling out sick.
    - Residents need care, workers don't want to 'turn their backs' on them, even if that means working when they should be home. Workers shoulder the burden, when in fact it's the industry that needs to change.
    - In a pandemic, this is too dangerous. 70% of all deaths associated with COVID in Pennsylvania occurred with long term care facilities
- Passing public health emergency leave *(HB2391/SB1109*) that would fill the gaps left by federal legislation by guaranteeing that all employees will receive emergency paid sick leave. Allows workers to quarantine when they fall ill w COVID.
    - Stems the spread both inside the facilities and to their communities.
    - Helps stop workforce shortages
- Must have long term stockpile PPE
    - Members wrapped in garbage bags, reusing masks.
    - Urging that nursing homes to conduct regular testing for both residents and workers on a monthly basis.

We must improve staffing in our nursing homes

- Regs were being discussed before COVID. Long fight.
    - Need to go from 2.7 to 4.1, which is what the federal government and consumer advocacy groups recommend as the minimum.
- Recommend legislation that would create safe patient limits ratios for nursing home care
    - Already happening in other states.
    - A minimum ratio will improve care and provide continuity of care, which is essential in the long term care setting.

COVID-19 and the Nursing Home Workforce
Issues and Solutions for Permanent Preparedness

Testimony of Emma Grahm

My name is Emma Grahm. I work in a long term care facility and I have been a CNA for over 30 years.

I am here today to share my experience working in a nursing home during this global pandemic and to tell you that my coworkers, my residents, and I deserve better.

We were not prepared for COVID-19, and that lack of preparedness caused nursing homes to be stuck in a dangerous cycle.

We were not given adequate PPE to keep ourselves and our residents safe and to stop the spread throughout our homes.

When this started, we were expected to reuse disposable gowns and were only given surgical masks, rather than N95s. This story is not uncommon and too many workers in long term care facilities have gotten sick due to a lack of PPE.

As healthcare professionals, we knew that it was important to have a plan for infection control. My coworkers and I advocated for ourselves, with the strength of our union, to demand adequate PPE, including using disposable gowns one time and having0 N95 masks. Unfortunately, not all nursing home workers have been able to do that.

When healthcare workers don't have adequate PPE, we risk our own health and risk spreading the virus from resident to resident. We have seen this happen across Pennsylvania.

In addition to stockpiled PPE, we need universal, regular, and rapid COVID testing throughout long term care facilities. For a virus that can be asymptomatic and contagious for weeks, testing is necessary to stop the spread. If we test positive, we need to know we can stay home and get better, **without losing pay.**

Too many nursing home workers don't have paid sick time. Despite putting our health and safety on the line every day, we are still struggling to make ends meet, let alone if we get sick and miss an entire paycheck or more. If I got sick and missed work without pay, I'd fall behind on my bills, and I don't think I'd be able to catch up.

The need for paid sick time goes for ALL workers. **We will not stop the spread of this virus until ALL working people have the ability to stay home and get better when they are sick.**

Our lack of preparedness for this virus has shown a spotlight on an issue that has been a problem in my industry for years: staffing.

On my floor, we have between 2-4 CNAs on any given shift to care for 34 residents. These residents need their vitals taken, they need to be observed, we need to do reports so our relieving shift is prepared to provide continuity of care. Our residents also need to be changed, and bathed, and fed. Being spread so thin leaves very little room for us to spend quality time with our residents.

Now I want you to imagine what happens when any number of us gets sick? Do you think we are able to stay home, quarantine, and get better before coming back to work? What would happen to our residents if we had even less people to take care of them?

This is nearly impossible even under normal circumstances, let alone with the extra precautions we need to take to keep ourselves and our residents safe from COVID. I have already worked double shifts this week to help out my coworkers, because if we didn't work overtime, our floor might only have 2 CNAs for those 34 residents.

We show up everyday to provide the highest quality care for our residents -- because that's what they deserve. **As the people providing that care, we deserve to be cared for, too.** That means stockpiled PPE in all long term care facilities, universal testing, paid sick time, and safe staffing.

Thank you for your time.

Testimony of Elyse Ford

Good afternoon, distinguished members of the House Democratic Policy Committee. My name is Elyse Ford and I am the Vice President of District 1199C. We are an affiliate of the National Union of Hospital and Healthcare Workers, representing more than 10,000 individuals in major healthcare institutions around the Philadelphia region. I have been with District 1199C for 14 years, first serving as a field organizer before becoming an administrative organizer, negotiating contracts and monitoring working conditions for employees. In 2018, I was appointed Nursing Home Division Director, where I oversaw 48 long-term care facilities in the Philadelphia region. Last year I was elected to serve as Vice President of 1199C. I am proud to serve such a courageous group of members and fight for their right to work in a safe, healthy, and productive environment.

I sit here today to talk about a very important matter: the health and safety of both care workers and patients in long-term care facilities during the ongoing coronavirus crisis. Though we continue to grow and learn more in our response to this virus, we are still in a very precarious position and we must remain vigilant in protecting ourselves and our communities.

Recently, I testified in front of Philadelphia City Council about a serious issue facing many care workers: paid sick leave. Without adequate paid leave, workers who become ill and are forced to self-isolate are left without pay for days or weeks at a time; this period can be devastating, especially for those with children or other family members to care for at home. Fortunately, I can report at this time that, by and large, our members have been able to manage their sick time and avoid issues on that front. We have also been able to mitigate problems with acquiring adequate stock of personal protective equipment, or PPE. Having PPE available is extremely important to controlling the spread of cases from worker to worker and worker to patient. However, when the pandemic first started, our union had to fundraise and buy our own PPE. This should not have been the case.

Unfortunately, there are other issues that have arisen recently and need to be tackled.

One of those issues is staffing shortages and layoffs at facilities. One facility in Broomall recently faced serious layoffs, forcing National Guard troops to come in and temporarily fill open vacancies. COVID has created a sort of vicious cycle, which goes something like this:

1) An increase in cases leads to fewer residents in care homes
2) Fewer residents in care homes leads to fewer care workers needed
3) Fewer care workers leads to understaffing when workers need to take extended time to recover from COVID-19

Many facilities are understaffed to begin with because of our state's low staff to patient ratio, which means that further reductions in staffing levels leaves care facilities critically undermanned and struggling to stay afloat. In addition, Gov. Wolf waived the requirement to permit long-care facilities to continue operations even if the facility could not provide the basic 2.7 direct resident care for each resident (PPD). There is currently a bill sponsored by Rep. Gary Day HB2607 that is working to address this issue.

Another issue we have encountered concerns inspection, maintenance, and cleaning of care homes. Another local facility - Harston Hall - recently dealt with an outbreak of more than 50 cases among residents and staff. In the aftermath of this outbreak, proper deep cleaning still did not occur. Management asked certified nursing assistants to perform housekeeping duties to supplement - and sometimes replace - the work of housekeepers and avoid additional bodies going in and out of rooms. Rather than carry out a deep clean, Harston Hall opted for half measures.

Many facilities initially separated patients by COVID and non-COVID floors. After a certain period of time, owing to problems with hazard pay and other issues, care homes ended this practice and transferred residents. This led to a mix of COVID patients with non-COVID patients. With testing mainly confined to those with symptoms, asymptomatic individuals were unknowingly contaminating and spreading the disease.

A third issue that has plagued many of our members in recent weeks and months is access to affordable healthcare options. Though care workers have insurance options available through their employers, often those plans are too expensive; many members instead opt for plans on the open market. Unfortunately, those plans do not always provide the best coverage options.

I recently spoke with one of our members who was diagnosed with COVID-19 and has been forced to use a ventilator for her breathing ever since. She has been unable to work for weeks, but is still on the hook for a monthly $300 fee for the ventilator she has to use. The cost has become an extreme burden and has severely threatened quality of life for her and her family. I know she is not the only one - many members have health insurance bills of several hundreds of dollars a month. Salaries have mostly remained flat; some facilities offer minimal hazard pay, but many more do not.

The final issue I want to address specifically today is mental health. It is an ever-present issue for healthcare workers, but one that has only gotten worse during this pandemic. Members who have tested positive but since recovered are still scared to return to work. There are others who may not have tested positive, but have had to watch as their patients and coworkers go through the harrowing ordeal. Our members are having panic and anxiety attacks about returning to work, with some searching for ways to avoid the workplace without consequences. For all healthcare workers, especially those in care homes with elderly patients, this job is challenging enough without the lingering dark cloud of a deadly virus constantly lingering overhead.

These are not the only issues we face in the healthcare industry. There are others, and they pop up almost daily. Solving these issues requires more than a quick fix. There will be long-term consequences for the entire industry. There will be more layoffs at hospitals and care homes. Patients will opt for home care instead of a facility, which will cause dramatic shifts in job demand. There will be a drop in the desire and interest to pursue positions in healthcare. Many who considered becoming a CNA or nurse practitioner will look elsewhere, to a job with fewer stressors and better benefits.

I know I have painted a bit of a grim picture for the industry today, but these matters must be taken seriously if we are to make the necessary changes. This must be a collaborative effort between care workers, employers, elected officials, and other key stakeholders.

Together we can find solutions to our problems. I look forward to working with each and every one of you in the coming days and weeks to find those solutions.

Testimony of Misty Dion, CEO CILNCP

I'd like to thank State Rep. Joe Hohenstein, for convening this hearing and the opportunity to testify on the devastation that has taken place in Pennsylvania's long term care settings such as nursing facilities and other institutions. My name is Misty Dion, I am the CEO for the Roads to Freedom Center for Independent Living, of North Central PA. I am the President of Pennsylvania's Independent Living Council, and member of PA ADAPT & National ADAPT. I've spent the last decade and a half supporting nursing facility residents in their transition to the community. Like many CILs, including Liberty Resources here in Philadelphia, we have a long & successful track record of improving the lives of these residents while helping PA balance its long-term care towards integrated & cost-saving community-based services & supports (HCBS). On average, 3 individuals can be served in the community with HCBS to every 1 person in an institution. HCBS waivers provide more individualized care than nursing facilities; and they allow our most at risk population to follow CDC safety guidelines and avoid deadly illnesses like the COVID-19 virus.

Our State & Local Governments have failed in their response to this Pandemic disaster. Instead of mandating long-term care ombudsmen and transition coordinators access to long term care facilities and expediting HCBS eligibility determinations for these residents; our state and local government made the choice to allow our most at risk population to succumb to this deadly virus. Pennsylvania lifted reporting requirements, infectious control policies and granted healthcare facilities immunity from civil liability while these facilities continued to lock out essential support providers like us. Instead of using the flexibilities afforded by CMS, under "Appendix K" and section 1135 Waivers to develop a mechanism for appropriate disaster response; they were used to approve the admissions of COVID positive patients directly from the hospital into these facilities.

In response to the Governor's declared disaster on May 13th, Roads to Freedom CIL offered it's Disaster Relief & Relocation Program to Lycoming County Commissioners & its Emergency Management Agency. At that time, PA's COVID-19 death toll was at 3,943 and 69% of them , or 2,705 people died while trapped in nursing facilities. All 9 of Lycoming County's COVID-19 deaths at that time resided at Jersey Shore Manor Care owned by ProMedica, an $8b corporation that didn't adequately supply PPE to its employees, let alone to its residents. Lycoming County and its Emergency Management Agency directed me to the State, stating that "care for nursing facility residents are not their responsibility" although their disaster declaration clearly states otherwise.

On May 27th, along with County Officials we reached out to State Representative Everett to get guidance from Pennsylvania Emergency Management Agency (PEMA) on the procedures related to using FEMA funds to coordinate a response to this disaster. In the meantime the COVID-19 cases continued to increased to 3,469 people statewide and 19 deaths in Lycoming County still, all from one facility. On June 10th, we received assurance from FEMA that funds are available to cover costs associated with Relocation such as: Food, Shelter & Wrap Around Services under Category B funds but there was **no** identified mechanism or structure to draw down these funds without State and County coordinated support.

On June 25th and July 10th we, along with the Statewide Long Term Care Facility Disaster Response & Relocation Task Force, continued these discussions with DOH, DHS, FEMA & PEMA with no resolution. Now, it has been reported that at least 4,703 long-term care residents statewide and 23 in Lycoming County, have died without having the option to relocate and follow CDC precautions. Unfortunately, we know this number is a low estimate as many facilities have stopped reporting their data for COVID-19 infections & deaths among their residents & staff, all while our State DOH stand idly by permitting them to do so with immunity. This is unconscionable, inhumane and unacceptable.

Clearly the absence of emergency relocation strategies is not due to logistical or practical barriers. Rather, they result from a lack of political will to support and safeguard this population. People in congregate settings must be given protections and protocols that are commensurate with the broader population, including equitable supports, social-distancing and adequate PPE. Residents locked inside these facilities are dying at such high

rates because they are enclosed inside a space the size of a parking lot and forced to share a room with 1 to 3 other people. In many cases, residents have to share a bathroom with even more people. They do not have adequate access to a phone and due to prison-like visitation restrictions, have been segregated from any and all outside supports, including their loved ones.

COVID-19 is still a life-threatening emergency, its a disability rights issue, civil rights issue and a racial justice issue. Disability Rights Advocates Statewide are calling for more than just sympathy and sorrow at the death rate. We are here to demand an emergency response to a disaster. Feeling bad while leaving people to die in institutions is unacceptable. We have a sound solution and we are calling on our state and local officials led by Governor Wolf, to rescue people from these hazardous settings. It's time for emergency relocations to hotels or dormitories if necessary, to prevent the loss of additional lives. It's time to reduce the facility population; reduce the crowding that fuels the pandemic. If this were a fire, a flood, or a hurricane… buildings and whole communities would be relocated. So, it is time to get people out. The data clearly shows the affect this virus has on people living in these types of congregate settings. Tiny portions of our population roughly the size of Jim Thorpe or Edwardsville, account for almost 70% of all COVID deaths in PA. If almost 70% of all PA's COVID deaths happened in one of those cities… the Governor would see the emergency and would mobilize money, resources and even the National Guard to address it. We'd see action, not just sad faces.

While additional protective measures against the Coronavirus within institutions must be implemented to mitigate risk, they have proven incapable of overcoming the inherent failures of those settings at reducing rates of infection and deaths to levels found in the general Population. Testing, reporting and access to the facilities are essential and organized emergency relocations must be a core component of our state's Medicaid and Disaster Response strategies for people who are institutionalized. Pennsylvania must use "Appendix K" and the 1135 Waivers to develop an effective emergency response to comply with federal civil rights requirements under the soon to be 30 year old Americans with Disabilities Act & section 504 of the Rehabilitation Act to include relocation to non-institutional settings with needed services and supports from healthcare professionals. Since room, board and other support can be covered in (unlicensed and otherwise non-appropriate) facilities, it stands to reason it should be covered in other more integrated and safer community settings. These civil rights are not waived or any less binding due to disasters and emergencies.

As you carry out the remainder of your day think about your retirement. When you acquire your disability either from an accident or through the natural progression of life; where do you want to live? In your own home, **or** in a death trap? Help end this institutional bias in our LTC system. We are prepared to save lives… before this disaster sweeps through more counties one facility at a time, killing off more of our loved ones. Act today to coordinate efforts between DHS's Office of Long Term Living, DOH & PEMA to deploy Medicaid Providers, like us statewide.

Like DOH Secretary Levine -- allow us, the chance to relocate and save our Mothers too. Thank you.

Testimony of Justin Bell

Good afternoon, My name is Justin Bell, I currently live in the community with home and community-based waiver services. Up until earlier this year, I was institutionalized in a nursing home. Actually, I was stuck in there for 4 years, and those 4 years where the worst years of my life. If it were not for me speaking my mind and the staff from Roads to Freedom CIL; who relocated me, I would not be able to share my story with you today.

The Governor passed the state of emergency due to the COVID outbreak and it gave the nursing home a free pass, to do and act how ever they wanted. There was a lot of neglect of residents that were unable to advocate for themselves. Due to the nursing home being on lock down I was unable to see my family, I was fortunate enough to have access to a phone and my own tablet to contact my family, but not everyone had that luxury. Still, it wasn't the same as a face to face visits and I felt alone.

The lock down resulted in even more of a lack of care for myself and others. There was no way to social distance, no rules for the staff or administration during lock down. The aids went out on smoke breaks in groups without properly washing their hands. I tried to share my concern with the administration in hopes they would be able to rectify the hazard, but it didn't stop. I would use the call bell and sometimes it took as long as an hour to come to my room. Because of this, I slept in my chair the last 2 years. I am a quadriplegic and the feeling of being stranded in bed for hours on end made me very scared. I felt claustrophobic… so I felt like sleeping in my chair was my only option. My personal hygiene was neglected due to the avoidance of aids doing there job responsibilities. I was on the 3 to 11 shower schedule and someone came up with a rule that no one could shower after 9pm. Due to the rule I would reach out multiple times through out the afternoon asking for a shower, and I was avoided or given an excuse. I personally would have to search for staff and ask them for a shower and it still was not a guarantee that I could get a shower before the 9pm.

I am fortunate to say, I am a COVID survivor! I contracted the virus due to the lack of training, sanitation and the inability to socially isolate from COVID positive residents. There was a hallway that they stored COVID positive residents, 2 to a room. There was a makeshift wooden wall separating the hallway from the other residents, but it didn't matter. I was given 1 mask to wear and hand sanitizer dispensers around the building were often empty. Staff didn't wear appropriate PPE or follow the necessary steps to stop the spread. At one time during the pandemic, I watched the hose used to wash bed pans, be used to fill the water pitchers in the COVID unit. Nursing homes have turned into death camps. There is nowhere to go to self-isolate. Relocation is the key! In the nursing home, I couldn't say who and when someone could enter my space, the staff would not even knock when entering my room, they would just walk in… Thanks to Roads to Freedom's Relocation program, now I can!

Give my friends, still locked in these institutions, a chance to survive. Respond to this disaster by mandating these facilities offer relocations options for everyone. Work with local responders like CIL's and Nursing Home Transition Entities across Pennsylvania to access FEMA funds so my friends can experience the life of Freedom that we celebrated less than 2 weeks ago. Thank you for giving me the chance to finally be heard. Please take the necessary steps to save lives and respond to this disaster before another few thousand lives are taken.

THE PARTNERSHIP
FOR INCLUSIVE DISASTER STRATEGIES

The Partnership for Inclusive Disaster Strategies (The Partnership) is the ***only*** U.S. disability-led organization [and one out of *only two* global] with a focused mission on equal access, disability rights and full inclusion of people with disabilities, older adults, and people with access and functional needs before, during, and after disasters and emergencies.

People with disabilities are 2-to-4 times more likely than their non-disabled peers to be injured or die in disasters[1]. As experts in disability rights before, during, and after disasters and emergencies we, at The Partnership, know this is primarily due to inadequate community-wide planning and access to emergency and disaster assistance.

With over 40% of the nation's COVID-19 deaths in nursing facilities[2] and 70% of Pennsylvania's COVID-19 deaths in nursing facilities[3] - this pandemic has exposed the lack of planning, mitigation, and response institutions such as nursing facilities, group homes, state hospitals, prisons and other congregate institutional settings, have in place. The pandemic has shed light on the magnitude and impact of the institutional bias that society places on people with disabilities and older adults, which has led to the deaths of tens of thousands people with disabilities in nursing facilities and other institutional facilities. For years, The Partnership has advocated for the civil rights of people with disabilities during disasters and emergencies, including the improper use of Blanket Waivers to expedite institutionalization during disasters and emergencies.

It is time to recognize the fire the pandemic is within nursing facilities and other institutional facilities, and relocate the people inside to SAVE LIVES NOW!

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[1] https://www.un.org/development/desa/disabilities/issues/whs.html

[2] https://www.nytimes.com/interactive/2020/us/coronavirus-nursing-homes.html

[3] https://www.pressandjournal.com/stories/pa-attorney-general-shapiro-says-he-has-opened-criminal-investigations-into-several-nursing-homes,92617

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THE PARTNERSHIP
FOR INCLUSIVE DISASTER STRATEGIES

We are 17 weeks into the pandemic, and COVID-19 has taught us it is time to renew disaster response for people in nursing facilities. With the rampant spread of infection in congregate facilities, No longer can we relocate people from one facility to another during an emergency. Instead, the response needs to include the independent living philosophy, and enforce the Olmstead decision across the country. It is long overdue, we need to pursue cohort setting (one person to a room), and relocate high-risk people into non-congregate settings with wrap around services in the most integrated setting appropriate to their needs.

Centers for Independent Living are the experts in relocating and transitioning people out of nursing facilities and other institutional "care" settings, and into people's own homes with the services and supports needed to maintain safety, health and independence.

It is time to include Centers for Independent Living in the emergency response to the fire this pandemic has spread in nursing facilities throughout Pennsylvania and the country.

- People with disabilities make up 26% of our country's population - that's 1 in 4 people living with a disability.
- People with disabilities make up 100% of the nursing facility population.
- People with disabilities and older adults are the highest risk of infection and death.

The time is now, to stop with old practices that do not work. We need to act now to save lives, and listen to and work with the disability rights experts with the lived experience and knowledge on how to do this right.

Resources to look to:

Getting It Wrong: An Indictment with a Blueprint for Getting It Right
The Partnership for Inclusive Disaster Strategies

Preserving Our Freedom - Ending Institutionalization of People with Disabilities During and After Disasters
National Council on Disability

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THE PARTNERSHIP FOR INCLUSIVE DISASTER STRATEGIES

Legislative Recommendations for Public Health Emergencies and Disasters

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PETITION

OF AMERICAN CIVIL LIBERTIES UNION, SERVICE EMPLOYEES INTERNATIONAL UNION, AMERICAN ASSOCIATION OF PEOPLE WITH DISABILITIES, AUTISTIC SELF-ADVOCACY NETWORK, DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, NATIONAL COUNCIL ON INDEPENDENT LIVING, PARTNERSHIP FOR INCLUSIVE DISASTER STRATEGIES AND WORLD INSTITUTE ON DISABILITY

INTRODUCTION

Less than one-half of one percent of the U.S. population lives in a nursing home.[1] Yet, to date, according to data published by the U.S. Department for Health and Human Services (HHS), at least 29,497 residents and staff of nursing homes in the United States have died of the coronavirus[2]—27 percent of total deaths to date.[3] Staff death rates exceed even those of staff working in federal prisons and meat packing facilities, based on the data that have been reported.[4]

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[1] *See* National Center for Health Statistics, HHS, *Long-Term Care Providers and Services Users in the United States, 2015-2016* [hereinafter *Long-Term Care Statistics*], at 76 (Feb. 2019) (identifying 1,347,600 nursing home residents in the United States in 2016); *U.S. and World Population Clock*, U.S. Census (last visited June 22, 2020) (calculating United States population as of Dec. 31, 2016 was 324,070,652).

[2] CMS, *COVID-19 Nursing Home Data* [hereinafter *CMS Nursing Home Data*] (last updated June 18, 2020), https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg (including data submitted as of week ending June 7, 2020).

[3] *Coronavirus Disease 2019 (COVID-19) in the U.S.*, Centers for Disease Control and Prevention (last visited June 22, 2020), https://www.cdc.gov/coronavirus/2019-ncov/cases-updates/cases-in-us.html (reporting daily death count, which was 109,192 as of June 7, 2020).

[4] *Compare Employees on nonfarm payrolls by industry sector and selected industry detail*, U.S. Bureau of Labor Statistics (June 5, 2020), https://www.bls.gov/news.release/empsit.t17.htm (reporting 1,534,300 workers employed in nursing home facilities) *and CMS Nursing Home Data, supra* note 2 (data current as of June 18, 2020 showing 534 staff deaths, or a 0.036% staff death rate) *with COVID-19*

- **Creating the tinderbox and letting it burn.** Before COVID-19, HHS knew that many nursing homes did not have proper infection control procedures. It knew that nursing homes were understaffed. It knew that staff were not properly trained. When COVID-19 surfaced in this country, HHS knew nursing homes were ill-prepared to manage the crisis. But in response to the pandemic, HHS eased inspections, lifted reporting requirements, waived training requirements, and failed to prioritize PPE and testing.

- **Failing to reduce crowding in nursing homes and other congregate settings for people with disabilities**, both before the COVID-19 pandemic, and once the pandemic hit. The Supreme Court's *Olmstead* decision created an obligation to reduce the institutionalization of people with disabilities. CMS has Home and Community Based Service programs to expand and support community living. Yet, HHS did little to advance this mandate. In the face of COVID-19, HHS should have recognized the dangers in these congregate settings; it should have recognized that a lower census would make social distancing possible. But HHS has taken little action to divert people from entering nursing homes or other congregate settings for people with disabilities or to increase appropriate discharges from such settings for those residents who wish to move to the community.

- **Issuing incomplete, inconsistent, and confusing guidance**, that, in its omissions and directives, responds more to the needs of nursing home owners than nursing home residents and staff. For example, HHS instructs nursing homes to admit residents without testing for COVID-19, but does not require these new admissions to be separated from others – criteria that keep up the population of the home at the expense of the health and well-being of the residents. The guidance to other congregate settings for people with disabilities is even more threadbare. For example, CDC tells group home administrators that they "may want to consider screening residents, workers, and essential volunteers for signs and symptoms of COVID-19."[28]

This week marks the twenty-first anniversary of *Olmstead v. L.C.*, the landmark Supreme Court decision for the disability rights community. In this decision, the United States Supreme Court recognized that "unjustified institutional

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updated June 5, 2020), https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.

[28] CDC, *Guidance for Group Homes for Individuals with Disabilities* [hereinafter *Guidance for Group Homes*] (last reviewed May 27, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/group-homes.html.

Requested Actions:

CMS and CCSQ should:

(1) Rescind and modify the QSO-20-29-NH to:

(a) Include infection prevention and control standards in the inspection survey protocol consistent with the above noted inadequacies;

(b) Include for all facilities the "standard" inspection survey elements that assess abuse, neglect, and exploitation; and

(c) Require the survey for all congregate settings for people with disabilities that are subject to CMS oversight and inspection.

(2) Rescind and modify its guidance of June 1 to require a Root Cause Analysis, and notification of the State Long-Term Care Ombudspeople, for every deficiency associated with Infection Control requirements.

(3) Given the suspension of the "Standard" survey, respond to all complaints and facility-reported incidents at the "actual harm" as well as "immediate jeopardy" level.

II. REDUCE THE CENSUS IN CONGREGATE SETTINGS

HHS, and its agencies, have completely failed to wield the many policy and funding tools at their disposal to ensure that residents of nursing homes and other congregate settings for people with disabilities have alternative and safer places to stay and receive care. Despite HHS's legal obligation to support independent living wherever and whenever possible,[80] and despite the existence of programs such as Home and Community Based Services,[81] HHS has failed to direct, support, or encourage states and nursing homes and other congregate settings for people with disabilities to safely and appropriately reduce their nursing home population.[82]

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[80] *Olmstead v. L.C.*, 527 U.S. 581 (1999); Section 504 of the Rehabilitation Act, 29 U.S.C. § 794.

[81] *Home & Community Based Services*, Medicaid.gov https://www.medicaid.gov/medicaid/home-community-based-services/index.html (last visited June 22, 2020).

[82] The CDC has required such consideration in correctional and detention facilities. *See* CDC, *Interim Guidance on Management of Coronavirus Disease 2019 (COVID-19) in Correctional and Detention Facilities* (reviewed May 7, 2020), https://www.cdc.gov/coronavirus/2019-ncov/community/correction-detention/guidance-

Despite the alarming death rates in the homes, the inability of many facilities to comply with basic prevention and inspection measures (social distancing, regular testing, PPE), staffing shortages, and preexisting deficiencies in infection control compliance—HHS has taken more steps to support nursing home operators than to support nursing home residents. Indeed, since the onset of the pandemic, CMS has waived the one program that is intended to divert people with disabilities from nursing homes, the PASSR program (Pre-Admission Screening and Annual Resident Review).[83] Pursuant to their obligations under Section 504 of the Rehabilitation Act, the agencies must take all steps to reduce the population of nursing homes and other congregate settings for people with disabilities, in a framework that prioritizes the health and safety of residents and staff.

Requested Actions:

(1) CMS should immediately rescind the waiver of the PASRR program.

(2) As part of the IFC, HHS and CMS should require that no congregate setting for people with disabilities should accept new residents who have not been through diversion assessment and planning and make clear that, at least during the pendency of this pandemic, if an appropriate housing option other than a congregate facility is available, and the resident consents, that housing options should be the first choice for placement.

(3) In conjunction with the IFC, and in furtherance of taking all appropriate steps to reduce the census for those residents who wish to move to the community, HHS and CMS should:

(a) Issue guidance setting forth for states all options available to support alternatives to nursing homes and other congregate settings for people with disabilities, including programs to pay family members for support; waivers for Home and Community Based Services; Community First Choice waivers; and innovative and effective alternatives to hospitalization, such as "Hospital at Home" programs,[84] emergency personal assistance registries, and cohorting in alternative housing while transitioning to the

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correctional-detention.html (requiring facilities to "[e]xplore strategies to prevent over-crowding of correctional and detention facilities during a community outbreak").

[83] *CMS Blanket Waivers*, *supra* note 59, at 16.

[84] Sarah Klein, *"Hospital at Home" Programs Improve Outcomes, Lower Costs But Face Resistance from Providers and Payers,* The Commonwealth Fund (last visited June 22, 2020), https://www.commonwealthfund.org/publications/newsletter-article/hospital-home-programs-improve-outcomes-lower-costs-face-resistance.

community.[85]

(b) Issue guidance to states affirmatively confirming family members may serve as paid support workers within both agency-managed and self-directed service programs and reminding states of the availability of Appendix K waivers to permit payment to family members.

(c) Commit in writing to provide states with at least 90 days' notice prior to expiration of Appendix K waivers to provide states with sufficient time to make permanent those changes first allowed in Appendix K and state plan amendments due to the public health emergency.

(d) Issue guidance to states directing them to grant immediate access to Independent Living Center staff, Aging and Disability Center Ombudspeople, Protection and Advocacy staff, and others with expertise in transitioning people from institutions to the community, so that they may speak directly to all residents in congregate facilities, either in-person (with appropriate PPE provided) or via the internet, to introduce an offer of assistance for relocating and an assessment of each person's desire to move to a safer location, either temporarily or with the option to make a permanent transition to the community.

(e) Exercise their authority to issue 1915(c) waivers,[86] 1915(i) and

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[85] Silvia Yee, DREDF Policy Recommendations for Reducing COVID-19 Nursing Home Deaths Through Innovative HCBS (May 21, 2020) https://dredf.org/2020/06/04/dredf-policy-recommendations-for-reducing-covid-19-nursing-home-deaths-through-innovative-hcbs/.

[86] CMS has the statutory authority to support states in provision of Home & Community Based Services. As the federal Medicaid website states, "Within broad Federal guidelines, States can develop home and community-based services waivers (HCBS Waivers) to meet the needs of people who prefer to get long-term care services and supports in their home or community, rather than in an institutional setting." *Home & Community-Based Services 1915(c)*, Medicaid.gov, https://www.medicaid.gov/medicaid/home-community-based-services/home-community-based-services-authorities/home-community-based-services-1915c/index.html (last visited June 21, 2020). These are known as 1915(c) waivers. *See State Waivers List*, Medicaid.gov, https://www.medicaid.gov/medicaid/section-1115-demo/demonstration-and-waiver-list/index.html?f%5B0%5D=waiver_authority_facet%3A1571&search_api_fulltext=&items_per_page=10&f%5B0%5D=waiver_authority_facet%3A1571&page=4#content#content#content (last visited June 21, 2020). According to the website:

"States can offer a variety of unlimited services under an HCBS Waiver program. Programs

JUDGE DAVID L. BAZELON CENTER FOR MENTAL HEALTH LAW

During the Pandemic, States and Localities Must Decrease the Number of Individuals In Psychiatric Hospitals, By Reducing Admissions and Accelerating Discharges

In recent weeks, as the nation has faced the historic challenge of COVID-19 significant attention has been paid to the public health risks of confining people in close quarters in jails and prisons. Health and correctional professionals have described the risks – to inmates, staff, and local communities – and urged de-carceration efforts, and the Bazelon Center has urged states and localities to dramatically reduce the number of people with mental illness in jail.[1] Much less attention has been paid to the public health risks of confining people in psychiatric hospitals. That must change. Serious efforts must be made to reduce the population of psychiatric hospitals.

The Public Health Risk

Like those incarcerated, patients in psychiatric facilities live in close quarters, and many have health conditions that place them at risk. Indeed, people with serious mental illness have more medical issues than the population at large. Staff often do not have access to personal protective equipment. Staff shortages may develop, compromising patient care and safety. Asymptomatic staff and newly admitted patients can bring the virus into the facility, where it can rapidly spread. As the virus spreads, staff can bring the virus to their families and communities.

Psychiatric hospitals, like correctional facilities, are potential incubators for the virus. While the danger has been recognized,[2] little information is available about the steps states, localities, and the hospitals themselves are taking to mitigate the danger. The American

[1] Bazelon Center for Mental Health Law, The Urgency of Reducing the Jail Population During the COVID-19 Crisis (April 6, 2020), http://www.bazelon.org/wp-content/uploads/2020/04/04-06-20-BC-Statement-on-Jail-Diversion-During-COVID-19.pdf.

[2] Dinah Miller, M.D., Coronavirus on the Inpatient Unit: A New Challenge for Psychiatry, MDedge (March 3,2020), https://www.mdedge.com/psychiatry/article/219014/schizophrenia-other-psychotic-disorders/coronavirus-inpatient-unit-new (noting, among other things, that "psychiatry units are not set up to have aggressive infection control, staff and patients don't typically wear protective gear…"); Jeffrey Geller & Margarita Abi Zeid Daou, Patients With SMI in the Age of COVID-19: What Psychiatrists Need to Know, Psych. Online (Apr 7, 2020) [hereinafter What Psychiatrists Need To Know] (stating that "the hospital is at high risk not only to have an infection sweep through it, but also to be a center that seeds a community"), https:// psychnews.psychiatryonline.org/doi/10.1176/appi.pn. 2020.4b39.

Psychiatric Association's compilation of state actions to address the pandemic identifies action to mitigate risk in correctional facilities but not in psychiatric facilities.[3]

Actions Needed

Psychiatric hospitals should of course follow public health guidance issued by the Centers for Disease Control (CDC) and other experts, including for quarantining those exposed to the virus.[4] In addition, however, ***states, localities, and hospitals should take aggressive action to reduce the number of people confined in psychiatric hospitals*.** The federal government's Substance Abuse and Mental Health Services Administration (SAMHSA) has urged, with respect to admissions, that "[b]ecause of the substantial risk of coronavirus spread with congregation of individuals in a limited space such as in an inpatient or residential facility… outpatient treatment options [should] be used to the greatest extent possible. Inpatient facilities should be reserved for those for whom outpatient measures are not considered an adequate clinical option, i.e., for those with mental disorders that are life-threatening, (e.g.: the severely depressed suicidal person)."[5]

Additionally, discharges should be accelerated.[6] To facilitate a decrease in the psychiatric inpatient population, the federal government, states, and localities should increase their support of community providers of outpatient mental health treatment. The federal government has increased the share it pays for most Medicaid funded services, including community services.[7] Restrictions on telemedicine have largely been lifted. However, community providers, already strapped before the pandemic, need greater funding and greater access to technology and personal protective equipment.

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[3] American Psychiatric Association, Practice Guidance for COVID-19, State-By-State Guide (Apr. 10, 2020), https://www.psychiatry.org/psychiatrists/covid-19-coronavirus/practice-guidance-for-covid-19. There is an overlap between individuals involved in the criminal justice system and those in psychiatric hospitals. State hospitals especially have high numbers of forensic patients. Additionally, a substantial number of individuals with serious mental illness cycle in and out of both jails and hospitals.

[4] CDC COVID-19 guidance documents are collected at https://www.cdc.gov/coronavirus/2019-ncov/communication/guidance-list.html?Sort=Date%3A%3Adesc.

[5] SAMHSA, Considerations for the Care and Treatment of Mental and Substance Use Disorders in the COVID-19
Epidemic (March 20, 2020), https://www.samhsa.gov/sites/default/files/considerations-care-treatment-mental-substance-use-disorders-covid19.pdf. As SAMHSA stated: "There are many [outpatient] options for treating mental and substance use disorders which have an evidence base and/or are best practices." *Id*.

[6] Dr. Geller and Dr. Daou advise state hospital leaders to use as a resource the CDC's guidance for correctional facilities. "We make no statement here that state hospitals are like jails and prisons, but these are the best guidelines available that address how to manage a population locked in a facility in close quarters where all the previous day-to-day rules need to be changed." What Psychiatrists Need To Know, *supra* note 2.

[7] The CARES Act included a provision increasing the federal matching rate by 6.2 points.

Access to housing must be increased, including to meet the needs of people with serious mental illness who in other circumstances would be hospitalized. Newly available housing subsidies made available through the CARES Act should be used. Vacant hotel rooms and college dorms should be used. Trailers including those provided by the Federal Emergency Management Agency (FEMA) and even recreational vehicles should be deployed as needed.

In many cases, families will offer to temporarily house and care for relatives being discharged from or not admitted to hospitals. More will do so if support is available from community providers. Many nursing home residents are being discharged to live with families. The same can happen with psychiatric patients.

Reductions in inpatient care should be informed by local circumstances, including whether there have been confirmed COVID-19 cases at the hospital. Hospitals should act quickly to reduce the number of inpatients before the virus has entered the facility. Whether or not there are confirmed cases at the facility, health precautions should be implemented as part of the discharge process, including, as appropriate, supporting individuals to self-quarantine upon discharge. In addition, individuals being discharged should be fully briefed on community resources, ongoing and newly created, that are available to them, and they should receive a cell phone with prepaid minutes if they would not otherwise have a way to communicate remotely with community providers. Community providers, as feasible, should virtually participate in discharge planning.

Individualized Decisions

In identifying individuals to discharge and in triaging admissions, consideration should be given to:

- The individual's access to housing, the type of housing to which the individual has access (and if congregate, the risks there), and, if housing is not available, the individual's experiences while homeless,
- The individual's ability for self-care, including with available support from family, friends, neighbors, and community providers,
- The individual's ability, with available support, to take precautions during the pandemic, including physical distancing and wearing a mask,[8] and
- The individual's access to medications and the impact if access is lacking.

[8] "Some state departments of mental health have set up designated residences where individuals who test positive for the virus but are not in need of hospital care can live." What Psychiatrists Need To Know, *supra* note 2.

Communities face many challenges as a result of the COVID-19 pandemic, including the challenge of mitigating the pandemic's effects on mental health. One challenge that needs to receive more attention is reducing the number of people confined in psychiatric facilities.

June 22, 2020

FOR IMMEDIATE RELEASE – NATIONAL GOVERNORS ASSOCIATION

NATIONAL CALL TO ACTION:

EMERGENCY RELOCATION OF CONGREGATE SETTING RESIDENTS; SAVE LIVES NOW!

Congregate settings are inherently unsafe, especially during a pandemic. The stark and horrifying reality of this is painfully evident now as the COVID-19 pandemic tears through these facilities. Many of the people in these facilities are black and brown and most are poor. All are at inordinate risk and are dying in disproportionate numbers. **This must stop. We can help**. People with disabilities living in our communities, in their own homes, have a radically lower infection rate than people living in congregate settings. We know that home and community based services are a cost effective solution.

We, the undersigned, including people with disabilities, disability advocates, Independent Living Centers, disability organizations, and our allies - do hereby issue this Call to Action to IMMEDIATELY relocate people with disabilities confined in congregate facilities infected by COVID-19 infection.

We not only expect but **demand** that the full weight and force of Federal, State, and Local government is mobilized immediately, with the fierce urgency of now, to enforce disability civil rights laws and relocate people from congregate settings as life-saving and life-sustaining imperatives. The following steps must happen now:

- Relocate residents to safe, non-congregate, cohort settings that house no more than one person per room
- Identify residents who want to transition to Home & Community Based Services (HCBS)
- Require that institutions / long-term care facilities grant access to essential CIL staff and transition coordinators in order to implement these relocation plans
- Expedite HCBS eligibility determinations for those who want to remain in the community OR who refuse to return to an unsafe congregate setting
- Work with your Department of Commissioners, etc. to utilize alternative funds (such as FEMA Public Assistance Category B funds) to cover the costs of care, shelter and food during disaster relocations
- Immediately lift the restrictions on visitations. Data shows visits from family are critical to the well-being and quality of life of people housed in these congregate settings. Not allowing visitations is contributing to the increases in death

The undersigned call for a multi-pronged approach to preventing additional abuse and neglect in congregate settings due to pandemic policies and responses. The first prong is to divert people with disabilities from ever going to congregate facilities by ensuring that they have adequate support at home and in the community. The second is to support people in congregate facilities, with and without COVID-19, in transitioning back

to the community with adequate health care, infection control, daily living support, and opportunities for improved pandemic outcomes.

Many local Centers for Independent Living have the expertise to spearhead immediate transitions out of congregate settings. But this requires the full support, backing and reimbursement measures of agencies as laid out by, for example, FEMA Public Assistance Emergency Protective Measures, Category B (p. 57). The FEMA language states that funds cover: evacuate and shelter individuals to meet their life-saving and life sustaining needs; their rights to be served in the most integrated setting appropriate to their needs; as well as all other mechanisms available to meet the emergency protection obligations of recipients and sub recipients of federal financial assistance.

We demand that CILs and / or other transition personnel have immediate access to congregate settings as part of the Strike Teams that have been created and implemented. It is imperative that we be able to identify, evaluate and coordinate plans for relocation to accessible hotels, dorms, and other structures suitable for safe supports and occupancy.

It is wholly unacceptable to continue the current position that proposes to make congregate settings "better." This is NOT the answer. We must liberate our brothers and sisters and siblings from these congregate settings and into permanent, sustainable, integrated, accessible and affordable housing with the support and services they require to maintain their health, safety, independence and dignity. This is the only acceptable answer.

The organizations listed below have signed on in support and in solidarity of the Emergency Relocation of Congregate Setting Residents

Access Living, IL

ADAPT Delaware

ADAPT Indiana

Alliance for Community Services

Ann Arbor Center for Independent Living

Association of Programs for Rural Independent Living

Atlantis ADAPT, CO

Atlantis Community, Inc., CO

Center for Public Representation, DC

Chicago ADAPT

Colorado Cross-Disability Coalition

Davis Integrated Services, LLC

Democratic Disability Caucus of Florida

DIRECT Center for Independence, Inc. AZ

Everybody Counts Center for Independent Living, IN

Georgia ADAPT

Gulf Coast ADAPT

Illinois Network of Centers for Independent Living

Jane Addams Senior Caucus

Kansas ADAPT

Lake County Center for Independent Living, IL

Liberty Resources

LIFE Center for Independent Living, IL

Mass ADAPT

Montana ADAPT

National ADAPT

National Council on Independent Living

North Central PA ADAPT

Northwestern Illinois Center for Independent Living

Not Dead Yet

Olmstead Network

Pennsylvania Council on Independent Living

PA ADAPT

Progress Center for Independent Living, IL

REACH Resource Centers on Independent Living TX

Roads to Freedom CIL

Shriver Center on Poverty Law, IL

Southern Illinois Center for Independent Living

Southwest Center for Independence, CO

Statewide Independent Living Council of Illinois

Task Force for Attendant Services, IL

The Coelho Center for Disability Law, Policy and Innovation, CA

The Going Home Coalition

The Partnership for Inclusive Disaster Strategies, PA

Washington ADAPT

World Institute on Disabilities, DC

Nursing Homes and Assisted Living (Long-term Care Facilities [LTCFs])

Nursing homes, skilled nursing facilities, and assisted living facilities, (collectively known as long-term care facilities, LTCFs) provide a variety of services, both medical and personal care, to people who are unable to manage independently in the community. Over 4 million Americans are admitted to or reside in nursing homes and skilled nursing facilities each year and nearly one million persons reside in assisted living facilities. Data about infections in LTCFs are limited, but it has been estimated in the medical literature that:

- 1 to 3 million serious infections occur every year in these facilities.
- Infections include urinary tract infection, diarrheal diseases, antibiotic-resistant staph infections and many others.
- Infections are a major cause of hospitalization and death; as many as 380,000 people die of the infections in LTCFs every year.

Preparing for COVID-19

- Long-term Care Facilities, Nursing Homes
- Assisted Living Facilities

U.S. GOVERNMENT ACCOUNTABILITY OFFICE

441 G St. N.W.
Washington, DC 20548

May 20, 2020

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate

Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic

Dear Senator Wyden:

The Coronavirus Disease 2019 (COVID-19) originated in late 2019 as a new and highly contagious respiratory disease causing severe illness and death, particularly among the elderly.[1] Because of this, the health and safety of the nation's 1.4 million nursing home residents—who are often in frail health and living in close proximity to one another—has been a particular concern. One of the first major outbreaks reported in the U.S. occurred in a Washington State nursing home in February 2020. Since then, there has been a rapid increase in the number of COVID-19 cases in U.S. nursing homes, with estimates of more than 25,000 deaths as of May 2020.[2]

The Centers for Medicare & Medicaid Services (CMS), an agency within the Department of Health and Human Services (HHS), is responsible for ensuring approximately 15,500 nursing homes nationwide meet federal quality standards to participate in the Medicare and Medicaid programs. These standards require, for example, that nursing homes establish and maintain an infection prevention and control program.[3] To monitor compliance with these standards, CMS enters into agreements with agencies in each state government—known as state survey agencies—and oversees the work the state survey agencies do.

In general, CMS requires that state survey agencies conduct standard surveys, or evaluations, approximately once each year of the state's nursing homes and investigate both complaints

[1]Patel, A., Jernigan, D.B. "Initial Public Health Response and Interim Clinical Guidance for the 2019 Novel Coronavirus Outbreak—United States, December 31, 2019–February 4, 2020." *CDC Morbidity and Mortality Weekly Report*. vol. 69: 140–146 (2020).

[2]For examples, see Kaiser Family Foundation, "State Reports of Long-Term Care Facility Cases and Deaths Related to COVID-19 (as of May 7, 2020)," May 7, 2020. Also, see K. Yourish, K.K.R. Lai, D. Ivory, and M. Smith, "One-Third of All U.S. Coronavirus Deaths are Nursing Home Residents or Workers," *New York Times*, May 11, 2020.

[3]At a minimum, nursing homes must (1) have a system to prevent, identify, report, investigate, and control infections and communicable diseases for all residents, staff, volunteers, visitors, and others providing services in the home; (2) have written standards, policies, and procedures for their infection prevention and control program; (3) have antibiotic use protocols and a system to monitor antibiotic use; and (4) have a system for recording incidents identified under the home's infection prevention and control program and any corrective actions taken. 42 C.F.R. § 483.80(a)(1)-(4) (2019).

from the public and facility-reported incidents regarding resident care or safety.[4] If a surveyor from a state survey agency determines that a nursing home violated a federal standard during a survey or investigation, a nursing home receives a deficiency code specific to that standard, known as a deficiency. Surveyors then classify cited deficiencies into categories according to scope (the number of residents potentially affected) and severity (the potential for or occurrence of harm to residents).[5]

When nursing homes are cited with deficiencies, federal enforcement actions can be imposed to encourage homes to make corrections.[6] In general, for deficiencies with a higher scope and severity, CMS may impose certain enforcement actions so that the enforcement actions are implemented—that is, put into effect—immediately.[7] For other deficiencies with a lower scope and severity, the nursing home may be given an opportunity to correct the deficiencies, which, if corrected before the scheduled effective date, can result in the imposed enforcement action not being implemented. Nursing homes are required to submit a plan of correction that addresses how the home would correct the noncompliance and implement systemic change to ensure the deficient practice would not recur.[8]

In light of the COVID-19 pandemic, you asked us to examine CMS's oversight of infection prevention and control protocols and the adequacy of emergency preparedness standards for emerging infectious diseases in nursing homes, as well as CMS's response to the pandemic. This report describes the prevalence of infection prevention and control deficiencies in nursing homes prior to the COVID-19 pandemic. Future GAO reports will examine more broadly infection prevention and control and emergency preparedness in nursing homes and CMS's response to the COVID-19 pandemic, including recent actions CMS has announced.[9]

To describe the prevalence of infection prevention and control deficiencies in nursing homes prior to the COVID-19 pandemic, we reviewed CMS guidance and analyzed data on nursing

[4]By law, every nursing home receiving Medicare or Medicaid payment must undergo a standard survey during which teams of state surveyors conduct a comprehensive on-site evaluation of compliance with federal quality standards. These surveys must occur at least once every 15 months, with a statewide average interval for surveys not to exceed 12 months.

[5]CMS categorizes deficiencies into one of three scope categories based on whether the incident was: (1) an isolated occurrence; (2) a part of a pattern of behavior; or (3) a widespread behavior. CMS categorizes deficiencies into one of four severity categories based on whether the deficiency constitutes: (1) no actual harm with a potential for minimal harm; (2) no actual harm with a potential for more than minimal harm, but not immediate jeopardy; (3) actual harm that is not immediate jeopardy; or (4) immediate jeopardy to resident health or safety.

[6]CMS guidance does not require enforcement actions be imposed for all deficiencies. Enforcement actions include, but are not limited to, directed in-service training, fines known as civil money penalties, denial of payment, and termination from the Medicare and Medicaid programs.

[7]The scope and severity of a deficiency is one of the factors that CMS may take into account when imposing enforcement actions. CMS may also consider a nursing home's prior compliance history, desired corrective action and long-term compliance, and the number and severity of all the nursing home's deficiencies.

[8]The plan of correction serves as the nursing home's allegation of compliance. Depending on the severity of the deficiency cited, surveyors revisit the nursing home to ensure that the home actually implemented its plan and corrected the deficiency.

[9]See, for example, CMS, Center for Clinical Standards and Quality/Quality Safety & Oversight Group, *Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons under Investigation) among Residents and Staff in Nursing Homes*, QSO-20-26-NH (April 19, 2020).

home deficiencies cited by surveyors in all 50 states and Washington, D.C., from 2013 through 2017 provided by CMS for a prior GAO report, with a particular focus on deficiencies related to infection prevention and control.[10] Using these data, we analyzed the deficiency code used by state surveyors when a nursing home fails to meet CMS's requirements for infection prevention and control.[11] Also using CMS's data, we determined the most common type of deficiency among nursing homes, the number of nursing homes that had infection prevention and control deficiencies, as well as the number of homes with repeated infection prevention and control deficiencies over the 5-year period from 2013 through 2017 and the characteristics of those homes.

We also used CMS's data to identify the enforcement actions associated with these deficiencies. CMS's data also included narratives written by state surveyors describing the deficiencies they identified. We reviewed examples of these narratives written by state surveyors to illustrate infection prevention and control deficiencies with varying severity levels. In addition to the 2013 through 2017 data we obtained from CMS for a prior report, we also examined the number of nursing homes that had infection prevention and control deficiencies in 2018 and 2019 by analyzing publicly available data from CMS's Nursing Home Compare website.[12] We assessed the reliability of each of the datasets used in our analyses by checking for missing values and obvious errors and reviewing relevant CMS documents and other documentation from our prior report that used these data. We determined the data were sufficiently reliable for the purposes of this reporting objective.

This report focuses on the prevalence of infection prevention and control deficiencies in nursing homes in the years prior to the COVID-19 pandemic. It does not examine CMS's actions to

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[10]GAO, *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse*, GAO-19-433, (Washington, D.C.: June 13, 2019). This report is our most recent analysis of CMS nursing home deficiency data, part of a broader GAO body of work examining weaknesses in CMS oversight of nursing homes. For brief summaries of GAO reports on the health and welfare of the elderly in nursing homes and other settings since 2015, including any recommendations, see *Nursing Homes: Better Oversight Needed to Protect Residents from Abuse*, GAO-20-259T, (Washington, D.C.: Nov. 14, 2019).

For the purposes of this report, we include Washington, D.C., when we refer to data for states.

[11]CMS's State Operations Manual provides guidance to state surveyors of nursing homes to determine compliance with federal quality standards, including those related to federal infection prevention and control program requirements. We reviewed Appendix PP of the State Operations Manual because it is the section that provides guidance to state surveyors about determining compliance with federal quality standards and their associated deficiency codes. We used the March 8, 2017, version of the Appendix PP—the most recent version during our period of review—when determining which deficiency codes to analyze for this report. CMS, *State Operations Manual, Appendix PP—Guidance to Surveyors for Long Term Care Facilities.* (March 8, 2017). We also reviewed the multiple revisions to Appendix PP in the State Operations Manual during the period of our review (January 1, 2013, through November 27, 2017). Specifically, there were eight updates to the appendix during the 5-year period. The November 26, 2014, revision to Appendix PP added new guidance and investigative criteria relating to single-use disposable equipment, single-dose medication, and insulin pens, as well as additional guidance on procedures for handling linens to prevent and control infection transmission. Otherwise, none of the other revisions significantly changed the infection prevention and control deficiency citation code used by state surveyors.

CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS deficiency data cited by surveyors from November 28, 2017, through December 31, 2017.

[12]To perform this 2018-2019 analysis, we examined nursing homes cited with the current infection prevention and control deficiency code that went into effect as part of CMS's restructured deficiency coding system on November 28, 2017. The CMS Nursing Home Compare Provider Information files were accessed on April 23, 2020, from https://data.medicare.gov/data/archives/nursing-home-compare.

address these issues, including actions announced beginning in March 2020 in light of the COVID-19 pandemic. We will examine CMS's actions in a future report.

We conducted this performance audit from April 2020 to May 2020 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Most Nursing Homes Had Infection Control Deficiencies Prior to the COVID-19 Pandemic; Half of These Homes Had Persistent Problems

Our analysis of CMS data shows that infection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with most nursing homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017 (13,299 nursing homes, or 82 percent of all surveyed homes).[13] Infection prevention and control deficiencies cited by surveyors can include situations where nursing home staff did not regularly use proper hand hygiene or failed to implement preventive measures during an infectious disease outbreak, such as isolating sick residents and using masks and other personal protective equipment to control the spread of infection.[14] Many of these practices can be critical to preventing the spread of infectious diseases, including COVID-19.

In each individual year from 2013 through 2017, the percent of surveyed nursing homes with an infection prevention and control deficiency ranged from 39 percent to 41 percent. In 2018 and 2019, we found that this continued with about 40 percent of surveyed nursing homes having an infection prevention and control deficiency cited each year.[15]

About half—6,427 of 13,299 (48 percent)—of the nursing homes with an infection prevention and control deficiency cited in one or more years of the period we reviewed had this type of deficiency cited in multiple consecutive years from 2013 through 2017. This is an indicator of persistent problems. An additional 19 percent of the nursing homes (2,563 out of 13,299) had an infection prevention and control deficiency cited in multiple nonconsecutive years. (See fig. 1.) Furthermore, of the 6,427 nursing homes with an infection prevention and control deficiency

[13]The next most common deficiencies cited in nursing homes from 2013 through 2017 were related to ensuring the environment is free from accidents (about 37 percent of surveyed nursing homes in each year) and food safety (about 36 percent of surveyed nursing homes in each year).

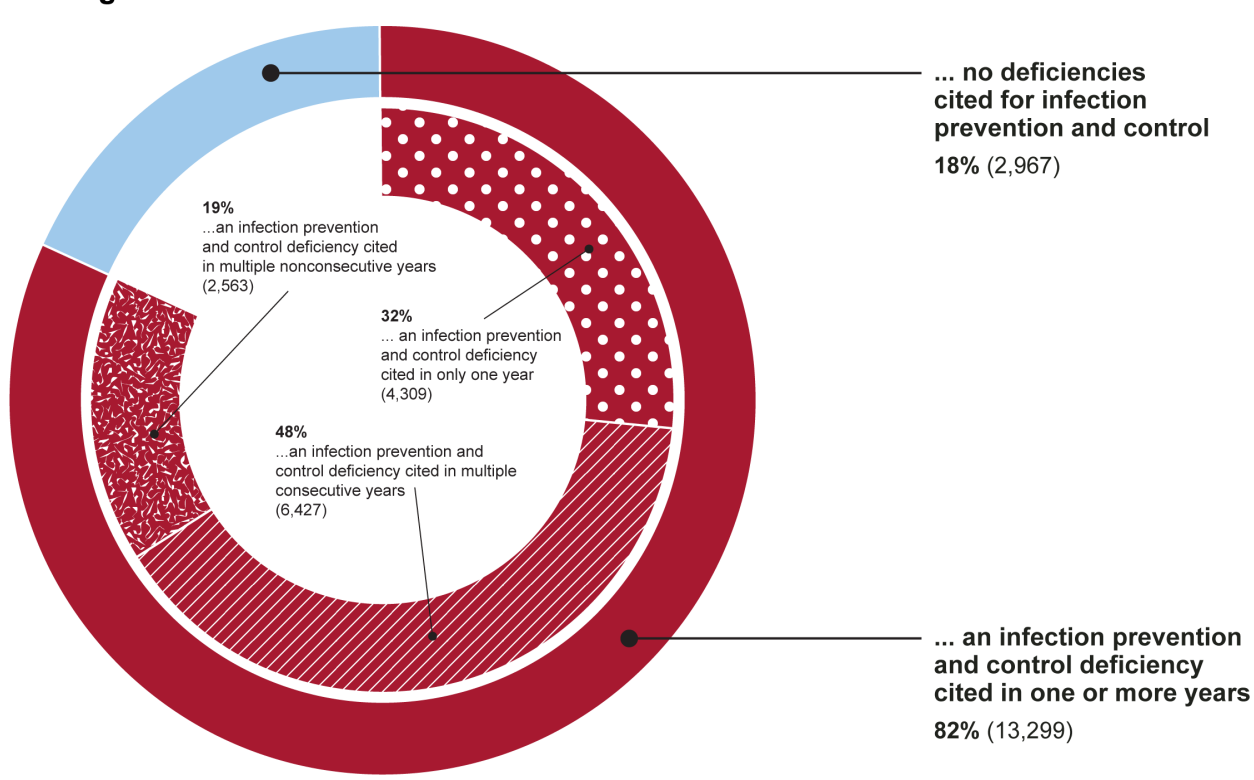
[14]Another deficiency code related to preventing the spread of infections can be cited by surveyors when a nursing home fails to develop policies and procedures to ensure that residents are offered influenza and pneumococcal vaccinations. Nursing homes must educate each resident on the benefits and potential side effects when offering each vaccine and document this interaction, as well as each resident's decision to receive or refuse each vaccine. In 2017, 4 percent of surveyed nursing homes (539 homes) had at least one influenza and pneumococcal vaccination deficiency.

[15]In our review of publicly available data from 2018 and 2019, infection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with deficiencies related to ensuring that the environment is free from accidents and deficiencies related to food safety as the next most common.

Also see: D. Cenziper, J. Jacobs, and S. Mulcahy, "Hundreds of Nursing Homes with Cases of Coronavirus Have Violated Federal Infection-Control Rules in Recent Years," *The Washington Post*, April 17, 2020; and Jordan Rau, "Coronavirus Stress Test: Many 5-Star Nursing Homes Have Infection-Control Lapses," *Kaiser Health News*, March 4, 2020.

cited in multiple consecutive years, 35 percent (2,225 nursing homes) had these deficiencies cited in 3 or 4 consecutive years, and 6 percent (411 nursing homes) had these deficiencies cited across all 5 years. At the state level, all states had nursing homes with infection prevention and control deficiencies cited in multiple consecutive years. For additional state-level information, see enclosure I.

Figure 1: Nursing Homes with Infection Prevention and Control Deficiencies Cited in Multiple Years, 2013 through 2017



Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-20-576R

Note: CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors from November 28, 2017, through December 31, 2017.

Percentages may not add to 100 due to rounding.

We also found that in each year from 2013 through 2017, nearly all infection prevention and control deficiencies (about 99 percent in each year) were classified by surveyors as not severe, meaning the surveyor determined that residents were not harmed.[16] Our review of CMS data shows that implemented enforcement actions for these deficiencies were typically rare: from 2013 through 2017, CMS implemented enforcement actions for 1 percent of these infection

[16]For the purposes of this report, a classification of "not severe" means that surveyors determined that the deficiency posed either 1) no actual harm with a potential for minimal harm or (2) no actual harm with a potential for more than minimal harm, but not immediate jeopardy. Infection prevention and control deficiencies were also categorized by scope—whether the incident was an isolated occurrence, a part of a pattern of behavior, or a widespread behavior—with about 47 percent of infection prevention and control deficiencies cited categorized as isolated, about 38 percent categorized as a pattern, and about 14 percent categorized as widespread each year from 2013 through 2017. Percentages do not add to 100 due to rounding.

prevention and control deficiencies classified as not severe. Furthermore, 67 percent of these infection prevention and control deficiencies classified as not severe did not have any enforcement actions imposed or implemented, and 31 percent had enforcement actions imposed but not implemented—meaning the nursing home likely had an opportunity to correct the deficiency before an enforcement action was imposed.[17] For examples of the types of infection prevention and control deficiencies cited in nursing homes and summaries of their resulting enforcement actions, see table 1. We plan to examine CMS guidance and oversight of infection prevention and control in a future GAO report, including the classification of infection prevention and control deficiencies.

Table 1: Illustrative Examples of Narratives from Infection Prevention and Control Deficiencies Cited in Nursing Homes

Narrative details and resulting CMS enforcement action	Classification of Scope and Severity
A certified nursing assistant in a California nursing home was observed by surveyors coughing and looking unwell. The certified nursing assistant said she had been sick for at least 2 days and had experienced fever, diarrhea, cough, and a runny nose. Surveyors also observed improper hand hygiene by a different certified nurse assistant during incontinent care, which created the potential to spread disease and infection. In addition, seven employees had not been screened for tuberculosis prior to employment. Also, surveyors observed employees who had not been vaccinated for influenza and were not wearing face masks. No enforcement actions were implemented against this nursing home.	Scope: A pattern of behavior Severity: No actual harm with a potential for more than minimal harm, but not immediate jeopardy
Surveyors observed a certified nursing assistant in an Arkansas nursing home providing incontinent care to a resident after a bowel movement and then, without removing her soiled gloves or washing her hands, the certified nursing assistant proceeded to assist the resident in repositioning in bed, adjusting the pillows, and replacing supplies in the resident's bedside table drawer. Surveyors also noted that a glucose meter was not properly disinfected before use on multiple residents. No enforcement actions were implemented against this nursing home.	Scope: A pattern of behavior Severity: No actual harm with a potential for more than minimal harm, but not immediate jeopardy
A New York nursing home experienced a respiratory infection outbreak that sickened 38 residents. The nursing home did not maintain a complete and accurate list of those who were sick, did not isolate residents with symptoms from residents who were symptom-free—nor did it isolate staff members helping sick patients—and continued to allow residents to eat in the community dining room. CMS implemented enforcement actions requiring the nursing home to provide directed, in-service training for its staff and submit a directed plan of correction to the state survey agency.	Scope: A pattern of behavior Severity: Immediate jeopardy
A New Mexico nursing home allowed two residents diagnosed with methicillin-resistant Staphylococcus aureus, a highly contagious type of infection, to share a bathroom with two other residents, therefore putting the two other residents at risk of exposure. There were also two biohazard bins in the bathroom containing contaminated wound dressings from the infected residents. CMS implemented an enforcement action by assessing a civil money penalty against the nursing home.	Scope: A pattern of behavior Severity: Immediate jeopardy

Source: GAO summary of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-20-576R

[17]Percentages do not add to 100 due to rounding. CMS may not implement imposed enforcement actions because the nursing home came into compliance prior to the implementation date of the enforcement action, among other reasons.

Notes: GAO reviewed for illustrative purposes narratives written by nursing home surveyors describing the infection prevention and control deficiencies cited. CMS categorizes deficiencies into one of three scope categories based on whether the incident was: (1) an isolated occurrence; (2) a part of a pattern of behavior; or (3) a widespread behavior. CMS categorizes deficiencies into one of four severity categories based on whether the deficiency constitutes: (1) no actual harm with a potential for minimal harm; (2) no actual harm with a potential for more than minimal harm, but not immediate jeopardy; (3) actual harm that is not immediate jeopardy; or (4) immediate jeopardy to resident health or safety.

Finally, using CMS data, we also analyzed a selection of characteristics over the 5-year period for the nursing homes that had infection prevention and control deficiencies cited in multiple years and found differences for some of the characteristics when we compared these nursing homes to (a) homes that had no infection prevention and control deficiencies cited, (b) homes with infection prevention and control deficiencies cited in a single year, or (c) all surveyed nursing homes. For example, nursing homes owned by for-profit organizations, which comprised about 68 percent of all surveyed nursing homes, accounted for about 72 percent of nursing homes that had infection prevention and control deficiencies cited in multiple years, but nursing homes owned by for-profit organizations comprised only about 61 percent of nursing homes with no infection prevention and control deficiencies cited. In contrast, nursing homes with an average overall five-star rating accounted for about 17 percent of all surveyed nursing homes but comprised about 33 percent of nursing homes with no infection prevention and control deficiencies cited and only about 10 percent of nursing homes that had infection prevention and control deficiencies cited in multiple years.[18] For additional information, see enclosure II.

Agency Comments

We provided a draft of this report to HHS for review and comment. HHS provided technical comments on the report, which we incorporated as appropriate.

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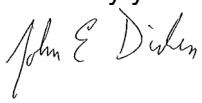
We are sending copies of this report to the appropriate congressional committees, the Secretary of HHS, and other interested parties. In addition, the report is available at no charge on the GAO Web site at http://www.gao.gov.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or at dickenj@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. Major contributors to this report were Karin Wallestad (Assistant Director), Sarah-Lynn McGrath (Analyst-in-Charge), Kathryn Richter, and Julianne Flowers. Also contributing were Isabella Guyott, Laurie Pachter, Vikki Porter, Anna Beth Smith, and Jennifer Whitworth.

Sincerely yours,



John E. Dicken
Director, Health Care
Enclosures – 2

[18]The Five-Star Quality Rating System assigns nursing homes with an overall “star” rating, ranging from one to five. Nursing homes with five stars are considered to have quality that is much above average, while nursing homes with one star are considered to have quality that is much below average. For this comparison of nursing home characteristics from 2013 through 2017, we calculated each nursing home’s average overall rating in each year during the 5-year period, and then we calculated the average overall rating across all 5 years and rounded to the nearest whole number. According to CMS, some changes to its methodology for calculating the five-star rating were made during the time period of our review.

Enclosure I: State Information on Infection Prevention and Control Deficiencies

We reviewed guidance from the Centers for Medicare & Medicaid Services (CMS) and analyzed data on nursing home deficiencies cited by surveyors in all 50 states and Washington, D.C., from 2013 through 2017 provided by CMS for a prior GAO report, with a particular focus on deficiencies related to infection prevention and control.[19] Using these data, we determined the number of nursing homes that had infection prevention and control deficiencies cited as well as the number of homes with repeated infection prevention and control deficiencies over the 5-year period from 2013 through 2017. Table 2 provides state-level data on the nursing homes that had infection prevention and control deficiencies cited in 2017. Table 3 provides state-level data on the nursing homes with infection prevention and control deficiencies cited by state surveyors from 2013 through 2017, including across multiple years.

Table 2: Infection Prevention and Control Deficiencies Cited, by State, 2017

State	Number of surveyed nursing homes	Number of surveyed nursing homes with an infection prevention and control deficiency cited	Percentage of surveyed nursing homes with an infection prevention and control deficiency cited
AK	16	5	31.3
AL	201	101	50.2
AR	217	86	39.6
AZ	131	30	22.9
CA	1,174	712	60.6
CO	187	87	46.5
CT	213	66	31.0
DC	18	6	33.3
DE	40	22	55.0
FL	646	278	43.0
GA	325	64	19.7
HI	37	17	45.9
IA	400	88	22.0
ID	61	34	55.7
IL	728	394	54.1
IN	535	187	35.0
KS	269	90	33.5
KY	264	95	36.0
LA	267	79	29.6
MA	380	111	29.2
MD	219	88	40.2
ME	100	13	13.0
MI	430	251	58.4
MN	333	138	41.4
MO	480	256	53.3
MS	191	103	53.9
MT	61	28	45.9
NC	407	64	15.7
ND	69	24	34.8
NE	193	64	33.2
NH	69	16	23.2
NJ	334	105	31.4
NM	75	27	36.0
NV	59	22	37.3

[19]GAO, *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse*, GAO-19-433, (Washington, D.C.: June 13, 2019).

State	Number of surveyed nursing homes	Number of surveyed nursing homes with an infection prevention and control deficiency cited	Percentage of surveyed nursing homes with an infection prevention and control deficiency cited
NY	533	113	21.2
OH	901	255	28.3
OK	283	90	31.8
OR	129	42	32.6
PA	680	312	45.9
RI	79	3	3.8
SC	168	40	23.8
SD	96	43	44.8
TN	296	98	33.1
TX	1,166	562	48.2
UT	80	41	51.3
VA	263	102	38.8
VT	36	4	11.1
WA	219	89	40.6
WI	351	141	40.2
WV	104	51	49.0
WY	37	18	48.6
Total	**14,550**	**5,755**	**39.6**

Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-20-576R

Note: CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors from November 28, 2017, through December 31, 2017.

Table 3: Nursing Homes with Infection Prevention and Control Deficiencies Cited, by State, 2013 through 2017

State	Total surveyed nursing homes, 2013-2017	Nursing homes with no infection prevention and control deficiencies cited	Nursing homes with infection prevention and control deficiencies cited in only 1 year	Nursing homes with infection prevention and control deficiencies cited in multiple nonconsecutive years	Nursing homes with infection prevention and control deficiencies cited in multiple consecutive years
AK	18	1	1	5	11
AL	232	10	48	46	128
AR	243	18	72	50	103
AZ	149	23	49	32	45
CA	1,258	76	176	204	802
CO	228	16	55	47	110
CT	231	45	71	38	77
DC	20	1	4	2	13
DE	47	4	10	13	20
FL	699	91	181	144	283
GA	365	169	136	30	30
HI	48	1	13	7	27
IA	460	134	158	41	127
ID	79	7	17	23	32
IL	791	50	129	127	485
IN	567	123	152	76	216
KS	369	41	100	77	151
KY	293	36	68	70	119
LA	280	60	86	47	87
MA	427	155	169	37	66
MD	234	51	75	49	59
ME	108	57	42	5	4
MI	456	24	74	78	280
MN	392	53	108	75	156
MO	531	52	116	94	269
MS	214	23	58	52	81
MT	84	2	15	17	50
NC	433	217	149	28	39
ND	82	5	24	21	32
NE	233	43	68	46	76
NH	77	32	28	6	11
NJ	374	95	133	55	91
NM	80	27	18	10	25
NV	60	4	9	9	38
NY	637	220	206	57	154
OH	995	308	357	113	217
OK	333	50	81	41	161
OR	144	43	50	26	25
PA	716	85	194	141	296
RI	84	52	25	3	4
SC	192	81	67	22	22
SD	113	2	17	17	77
TN	337	55	93	60	129
TX	1,303	161	280	205	657
UT	105	17	28	15	45
VA	298	44	89	51	114
VT	38	14	6	6	12
WA	230	32	70	37	91
WI	409	37	102	73	197

State	Total surveyed nursing homes, 2013-2017	Nursing homes with no infection prevention and control deficiencies cited	Nursing homes with infection prevention and control deficiencies cited in only 1 year	Nursing homes with infection prevention and control deficiencies cited in multiple nonconsecutive years	Nursing homes with infection prevention and control deficiencies cited in multiple consecutive years
WV	129	19	20	28	62
WY	41	1	12	7	21
Total	**16,266**	**2,967**	**4,309**	**2,563**	**6,427**

Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-20-576R

Note: CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors from November 28, 2017, through December 31, 2017.

Enclosure II: Comparison of the Percentage of Nursing Homes with and without Infection Prevention and Control Deficiencies Cited, by Characteristic, 2013 through 2017

We reviewed guidance from the Centers for Medicare & Medicaid Services (CMS) and analyzed data on nursing home deficiencies cited by surveyors in all 50 states and Washington, D.C., from 2013 through 2017 provided by CMS for a prior GAO report, with a particular focus on deficiencies related to infection prevention and control.[20] Using these data, we determined the characteristics of all surveyed nursing homes, nursing homes that had no infection prevention and control deficiencies cited, a single year of these deficiencies, or multiple years of these deficiencies from 2013 through 2017. For example, nursing homes owned by for-profit organizations, which comprised about 68 percent of all surveyed nursing homes, accounted for about 72 percent of nursing homes that had infection prevention and control deficiencies cited in multiple years, but nursing homes owned by for-profit organizations comprised only about 61 percent of nursing homes with no infection prevention and control deficiencies cited. (See table 4.)

[20]GAO, *Nursing Homes: Improved Oversight Needed to Better Protect Residents from Abuse*, GAO-19-433, (Washington, D.C.: June 13, 2019).

Table 4: Comparison of the Percentage of All Surveyed Nursing Homes and Those with No, a Single Year, or Multiple Years of Infection Prevention and Control Deficiencies Cited, by Characteristic, 2013 through 2017

Characteristic	All surveyed nursing homes, 2013-2017	Sub-groups of all surveyed nursing homes, 2013-2017: Nursing homes with no infection prevention and control deficiencies cited	Nursing homes with infection prevention and control deficiencies cited in a single year	Nursing homes with infection prevention and control deficiencies cited in multiple years
Number of nursing homes	16,266	2,967	4,309	8,990
Percentage				
Type of ownership[a]				
For-profit	67.9	60.8	63.5	72.3
Nonprofit	23.5	29.7	27.0	19.8
Government-owned	6.0	6.0	6.2	5.9
Mixed ownership[b]	1.2	1.0	1.4	1.2
Location[a]				
Urban	68.4	68.9	67.0	69.0
Rural	27.5	26.7	28.2	27.5
Transitioning area[c]	2.8	2.6	3.0	2.7
Number of Medicare and Medicaid certified beds[a, d]				
Small (Less than 50)	13.0	19.1	14.6	10.2
Medium (50 to 99)	36.5	36.2	37.4	36.2
Large (100 to 199)	43.4	37.0	40.6	46.8
Very large (200 or more)	7.1	7.7	7.4	6.8
Special Focus Facility program designation during the time period reviewed[e]				
Participated in program	2.5	1.0	1.6	3.4
Average of Five-Star System overall quality ratings over the time period reviewed[a, f]				
1 star	5.5	2.1	2.9	7.9
2 stars	21.2	9.2	15.7	27.8
3 stars	26.1	19.1	24.8	29.1
4 stars	28.1	33.2	31.6	24.8
5 stars	17.3	32.7	22.5	9.7

Source: GAO analysis of Centers for Medicare & Medicaid Services' (CMS) data. | GAO-20-576R

Notes: CMS restructured its deficiency code system beginning on November 28, 2017, and, due to these coding changes, we did not analyze CMS data cited by surveyors from November 28, 2017, through December 31, 2017.

[a]Percentages do not always add to 100 due to missing data and rounding. The percentage of nursing homes with missing data was less than 4 percent for each category.

[b]For this comparison of nursing home characteristics from 2013 through 2017, "mixed ownership" refers to nursing homes that changed their profit status at any point during the 5-year period.

[c]For this comparison of nursing home characteristics from 2013 through 2017, a "transitioning area" is where the designation changed from rural to urban or vice-versa at any point during the 5-year period.

[d]For this comparison of nursing home characteristics from 2013 through 2017, if a nursing home changed bed size categories at any point, we assigned the nursing home its largest bed size category during the 5-year period.

[e]Nursing homes with chronic noncompliance with federal standards can be selected for the Special Focus Facility program, which requires state survey agencies to conduct more frequent oversight, and the nursing homes to improve performance or risk termination from the Medicare and Medicaid programs. The table only displays percentages for those nursing homes that participated in the Special Focus Facility program during the 5-year period. The remaining nursing homes did not participate in the Special Focus Facility program during the 5-year period. For this comparison of nursing home characteristics from 2013 through 2017, we considered nursing homes to have participated in the Special Focus Facility program if they participated at any point during the 5-year period.

[f]The Five-Star Quality Rating System assigns nursing homes with an overall "star" rating, ranging from one to five. Nursing homes with five stars are considered to have quality that is much above average, while nursing homes with one star are considered to have quality that is much below average. For this comparison of nursing home characteristics from 2013 through 2017, we calculated each nursing home's average overall rating in each year during the 5-year period, and then we calculated the average overall rating across all 5 years and rounded to the nearest whole number. According to CMS, some changes to its methodology for calculating the five-star rating were made during the time period of our review.

(104261)

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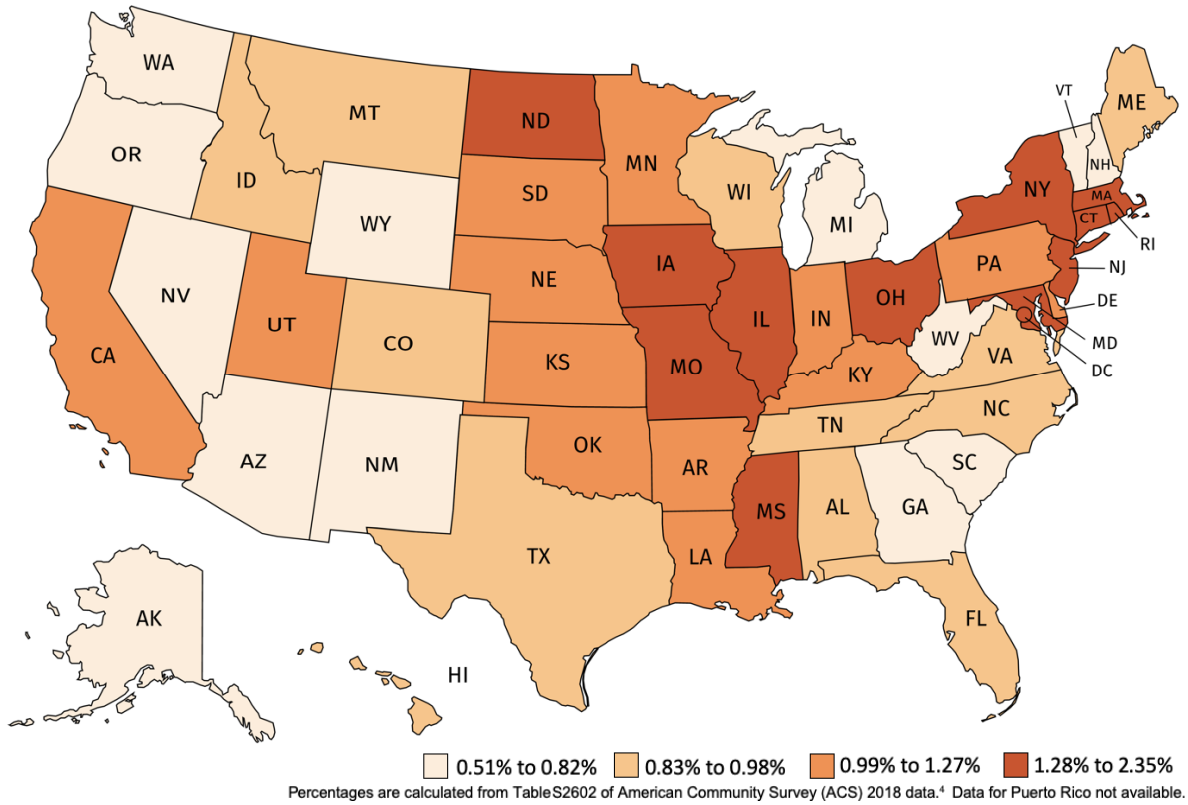
Percent of Working-Age People with Disabilities Still Living in Nursing Homes

Published July 2020

The Americans with Disabilities Act (ADA) mandates the right to live in the community with supports instead of living in a nursing home. This right was upheld by the U.S. Supreme Court in the landmark Olmstead decision in 1999.[1]

Despite this right to live in the community, some states are doing worse on overall nursing home rates, and some are doing better to support people with disabilities to live in the community. The map and table below display state percentages for working-age people with disabilities (ages 18-64) residing in nursing homes. Higher percentages (represented by a darker color) mean more people with disabilities are living in nursing homes, while lower percentages (light colors) mean more people are living in the community.

The current COVID-19 pandemic has highlighted the failure of states to meet their legal obligations for community living as long-term care residents represent 33-75% of related deaths by state despite comprising less than 2% of the population.[2,3]



Percentages are calculated from TableS2602 of American Community Survey (ACS) 2018 data.[4] Data for Puerto Rico not available.

People with Disabilities Age 18-64 Residing in Nursing Homes by State (Quartiles)

	Percent	PWD
Alaska	0.51%	343
New Mexico	0.54%	887
Vermont	0.63%	344
Washington	0.65%	3,294
Nevada	0.66%	1,352
New Hampshire	0.67%	608
South Carolina	0.67%	2,651
West Virginia	0.68%	1,355
Wyoming	0.75%	313
Oregon	0.76%	2,413
Michigan	0.77%	6,255
Georgia	0.78%	6,114
Arizona	0.82%	3,823

State	Percent	PWD
Idaho	0.83%	1,008
Maine	0.84%	1,117
Florida	0.84%	1,1365
Hawaii	0.87%	683
Tennessee	0.88%	5,225
Alabama	0.91%	4,043
Virginia	0.92%	5,036
Wisconsin	0.93%	3,544
Texas	0.93%	17,018
North Carolina	0.94%	7,194
Montana	0.96%	733
Colorado	0.98%	3,478

State	Percent	PWD
Kentucky	0.99%	4,476
Minnesota	1.01%	3,239
Arkansas	1.04%	3,069
Delaware	1.07%	696
California	1.08%	23,893
South Dakota	1.10%	584
Nebraska	1.16%	1,340
Louisiana	1.17%	4,817
Pennsylvania	1.19%	11,335
Utah	1.20%	1,935
Kansas	1.20%	2,523
Oklahoma	1.25%	4,413
Indiana	1.27%	6,636

State	Percent	PWD
Massachusetts	1.28%	5,516
Maryland	1.30%	4,657
Mississippi	1.41%	3,915
DC	1.42%	703
North Dakota	1.43%	633
Iowa	1.46%	2,715
Rhode Island	1.47%	1,183
Connecticut	1.53%	3,100
New York	1.56%	18,850
Missouri	1.57%	8,271
Ohio	1.69%	16,066
New Jersey	1.75%	7,918
Illinois	2.35%	19,069

The Americans with Disabilities Act Participation Action Research Consortium (ADA-PARC) is a collaborative national project to document participation disparities experienced by people with disabilities at the national, state and city levels.For more information on your state visit ADAPARC.ORG. For more information about your rights go to the ADA National Network ADATA.ORG

ADA PARC is funded by the National Institute for Disability, Independent Living, and Rehabilitation Research (NIDILRR) under grants 90DP0026 and 90DPAD0001

[1] Office for Civil Rights. (2018, June 28). *Serving people with disabilities in the most integrated setting: Community living and Olmstead.* U.S. Department of Health and Human Services. https://www.hhs.gov/civil-rights/for-individuals/special-topics/community-living-and-olmstead/index.html

[2] Paulin, E. (2020, June 11). *How to track COVID-19 nursing home cases and deaths in your state.* AARP. . https://www.aarp.org/caregiving/health/info-2020/coronavirus-nursing-home-casesdeaths.html

[3] Chidambaram, P. (2020, March 13). *Data note: How might Coronavirus affect residents in nursing facilities?*. Kaiser Family Foundation. https://www.kff.org/coronavirus-covid-19/issue-brief/data-note-how-might-coronavirus-affect-residents-in-nursing-facilities/

[4] U.S. Census Bureau (2020). *Characteristics of the Group Quarters Population by Group Quarters Type (3 Types), 2013-2018 American Community Survey 5-year estimates*. Retrieved from https://data.census.gov/cedsci/table?q=S2602&tid=ACSST1Y2018.S260

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COVID-19 Infection and Mortality Data for Long Term Care Facilities (Nursing Homes)

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Liam Dougherty
Policy and Project Coordinator
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COVID-19 Infection and Mortality Data for Long Term Care Facilities

As a Center for Independent Living, Liberty Resources, Inc. has worked tirelessly over 40 years to end the institutional bias in Long Term Care (LTC) in Pennsylvania and across the United States. Beginning in 2004 Pennsylvania has made great progress for People with Disabilities and Seniors by rebalancing the LTC system in Pennsylvania towards more desired and cost-efficient community-based services instead of unnecessary, segregated institutional care. In 2017 LTC Medicaid funding in Pennsylvania was paying more for providing Home and Community-Based Services than Nursing Home care in Long Term Care Facilities (LTCFs). The data in this report clearly demonstrates the increased risk to people living in congregate LTCFs where COVID-19 spreads much faster than in community-based settings.

Data collected for this analysis comes from the Pennsylvania National Electronic Disease Surveillance System[1] (PA-NEDSS) and self-reporting of long-term care facilities. While the individual facility report published on May 26, 2020 showed initial data from 587 Nursing Homes in Pennsylvania total, obtained through the PA-NEDSS data source, more recent data is increasingly derived from facilities "Self-Reporting" their own COVID-19 infections and deaths incidents. The most recent individual facility report (released on July 7, 2020) was based entirely on Department of Health (DOH) facility data, which may be self-reported. Of the 694 Nursing Homes included in the individual report, 211 facilities across Pennsylvania did not release any data on COVID-19 infections and deaths at all, answering "No Data" in every data column. The number of non-reporting facilities has doubled (106) since the last data release on June 30, 2020.

This is even more striking when analyzing Nursing Homes in Philadelphia itself. Although the individual report includes all 47 Nursing Homes operating in Philadelphia County, 22 (almost half) answer "No Data" for questions about infections or death from COVID-19. Without more complete data reporting on Nursing Homes from DOH and/or DHS, the public is unable to assess the total impact of the COVID-19 Pandemic on Seniors and People with disabilities. By analyzing COVID-19 data from the facilities that are releasing details and comparing data across counties, we can see only a partially complete data set for both LTCFs staff and residents. An omission worthy of further investigation is how the DOH/DHS is only reporting data on individual Nursing Home staff COVID-19 infections, but not the number of staff deaths from COVID-19.

This data is based on reports from the Department of Health (DOH) and the Department of Human Services (DHS). The released data is coded with some facilities reporting "*" for some responses. This indicates that less than 5 people are in a certain category, and for the purposes of this report are substituted by the average "2". Also the State's "individual" facility reports separate Nursing Homes and Personal Care Homes. In this report the two categories are consolidated into Long Term Care Facilities unless otherwise noted.

[1] https://www.health.pa.gov/topics/Reporting-Registries/Pages/PA-NEDSS.aspx

County Aggregate LTCF Data

DHS releases aggregated data[2] that does not go into detail about individual facilities but gives a clearer picture of what is going on in Nursing Homes and Personal Care Homes in each county. Total county data is derived from the Pennsylvania COVID-19 Dashboard.[3]

Reported data is separated by LTCF Staff and LTCF Residents. For the purposes of this report they have been combined to show the total "# of LTCF Infections" associated with LTCF.

This analysis shows the shocking fact that in most of the Five County Area, the vast majority of COVID-19-related deaths are coming from LTCFs. Montgomery county has the highest rate, with over 93.3%, meaning that just 6.7% of deaths came from all non-institutionalized people living in the community.

Table 1- LTCF COVID-19 Rates vs Total County COVID-19 Rates by County

Facility County	# LTCF Infections	# LTCF Deaths	# Total County Infections	# Total County Deaths
Bucks	2,036	453	5,484	572
Chester	1,059	276	3,743	333
Delaware	2,462	574	7,268	667
Montgomery	3,067	771	8,775	826
Philadelphia	1,961	531	22,727	1,635

Table 2- Percent of COVID-19 Rates Associated with LTCF by County

Facility County	% Infections Associated with LTCF	% Deaths Associated with LTCF
Bucks	37.1%	79.2%
Chester	28.3%	82.9%
Delaware	33.9%	86.1%
Montgomery	35.0%	93.3%
Philadelphia	8.6%	32.5%

[2] https://www.health.pa.gov/topics/disease/coronavirus/Pages/LTCF-Data.aspx on 7/10/2020
[3] https://www.health.pa.gov/topics/disease/coronavirus/Pages/Cases.aspx on 7/10/2020

County Aggregate LTCF Charts

Chart 1- COVID-19 Infections in LTCFs vs Community by Total County

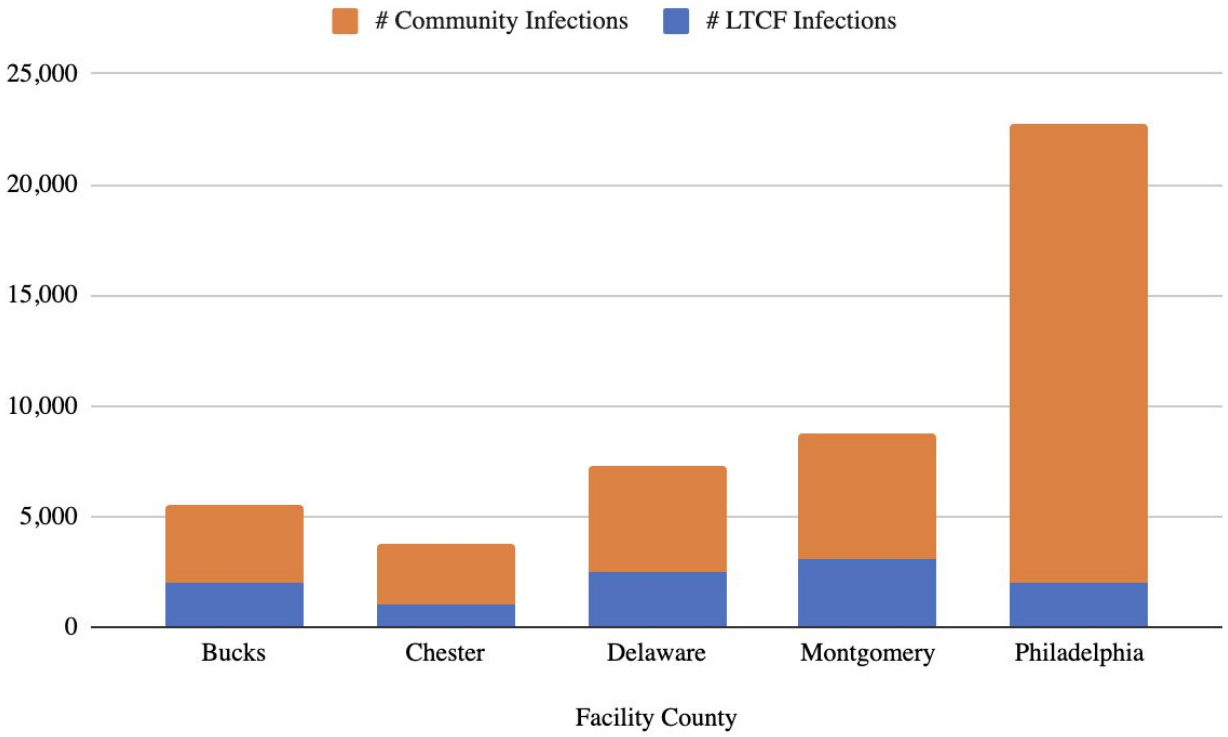
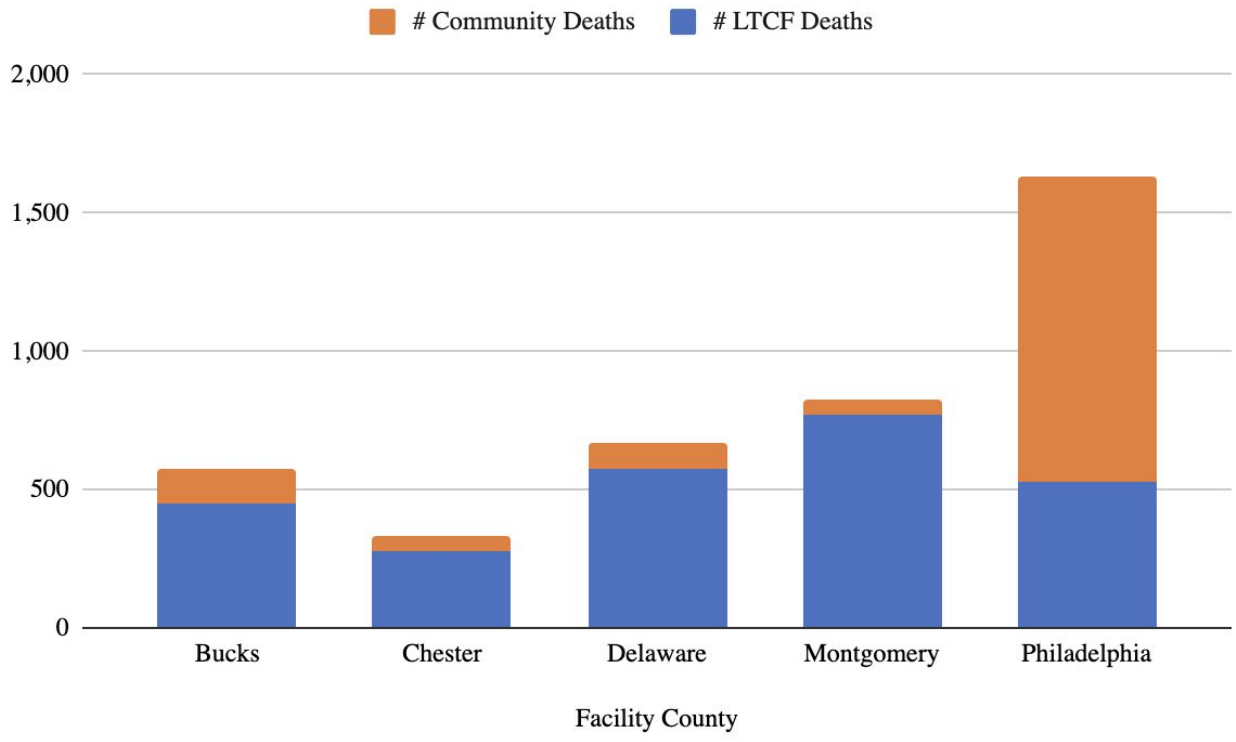


Chart 2- COVID-19 Deaths in LTCFs vs Community by Total County



Significantly Worse LTCF Death Rate than People Living in the Community

It is central to LRI's efforts to encourage and support life in the community instead of living in institutions. Bureaucratic, political, and big business forces and interests have combined to form an "institutional bias" that often keeps people with disabilities trapped away in dangerous institutions. The current pandemic has made it clear that life in these Long Term Care Facilities can lead to negative health outcomes, such as infection or death from COVID-19.

So far data in this report shows how Nursing Home residents are disproportionately infected by COVID. But the data below provides a very rough estimate how the virus is much more deadly to residents of LTCFs.

If LTCF resident data per county is taken out of data for the entirety of a county, "Community" data is left. Multiple factors, including the lag time between infection and death and the fact that data are taken from different sources make this far from a reliable death rate. It is fair to say however that residents of LTCFs are many times more likely to die from an infection of COVID-19 than people living in community settings.

Table 3- LTCF COVID-19 Rates vs Community COVID-19 Rates by County

Facility County	# LTCF Infections	# Community Infections	# LTCF Deaths	# Community Deaths	# Total County Infections	# Total County Deaths
Bucks	2,036	3,448	453	119	5,484	572
Chester	1,059	2,684	276	57	3,743	333
Delaware	2,462	4,806	574	93	7,268	667
Montgomery	3,067	5,708	771	55	8,775	826
Philadelphia	1,961	20,766	531	1,104	22,727	1635

Table 4- Percent of COVID-19 Rates Associated with LTCFs vs Community by County

Facility County	LTCF Death per Infection	Community Death per Infection
Bucks	22.2%	3.5%
Chester	26.1%	2.1%
Delaware	23.3%	1.9%
Montgomery	25.1%	1.0%
Philadelphia	27.1%	5.3%

Top 20 LTCFs in Five County Area- COVID-19 Data

Five County data represents the greater Philadelphia metro area, comprised of Bucks, Chester. Delaware, Montgomery, and Philadelphia Counties. Of the 190 LTCF detailed in the individual facility report, 77 did not report any COVID-19 data about infections and deaths in facilities, which accounts for 40% of the total. The number of Nursing Homes that have not released data has increased from 50 in the previous data released on June 30, 2020

Table 5- Top 20 LTCFs in the Five County Area- Number of Resident Infections

Name	County	# Beds	# Resident Infections
Neshaminy Manor Home	Bucks	360	157
Manorcare Health Services-Yeadon	Delaware	198	140
Chapel Manor	Philadelphia	238	133
Philadelphia Nursing Home	Philadelphia	402	123
Hillcrest Center	Montgomery	180	121
Valley Manor Rehabilitation And Healthcare Center	Bucks	180	120
Brandywine Hall	Chester	180	115
Crestview Center	Bucks	180	114
St. John Neumann Center For Rehabilitation & Healthcare	Philadelphia	226	110
St. Francis Center For Rehabilitation & Healthcare	Delaware	273	108
Parkhouse Rehabilitation And Nursing Center	Montgomery	467	108
Saunders House	Montgomery	180	108
Manorcare Health Services-Oxford Valley	Bucks	170	105
Southeastern Pennsylvania Veterans' Center	Chester	238	105
Manorcare Health Services-Montgomeryville	Montgomery	155	102
Abramson Residence	Montgomery	324	99
Briarleaf Nsg And Conv Center	Bucks	178	93
Oakwood Healthcare & Rehabilitation Center	Philadelphia	148	93
Fairview Nursing And Rehabilitation Center	Philadelphia	176	92
Powerback Rehabilitation 1526 Lombard Street	Philadelphia	150	79
Ivy Hill Rehab Center	Montgomery	145	77

Table 6- Top 20 LTCFs in the Five County Area- Number of Resident Deaths

Name	County	# Beds	# Resident Deaths
Parkhouse Rehabilitation And Nursing Center	Montgomery	467	52
Neshaminy Manor Home	Bucks	360	48
Southeastern Pennsylvania Veterans' Center	Chester	238	42
Saunders House	Montgomery	180	38
St. John Neumann Center For Rehabilitation & Healthcare	Philadelphia	226	36
Green Meadows Nursing & Rehabilitation Center	Chester	184	36
Chapel Manor	Philadelphia	238	34
Abramson Residence	Montgomery	324	34
Brandywine Hall	Chester	180	31
Wesley Enhanced Living At Stapeley	Philadelphia	120	31
Manorcare Health Services-Oxford Valley	Bucks	170	28
Ivy Hill Rehab Center	Montgomery	145	27
Valley Manor Rehabilitation And Healthcare Center	Bucks	180	26
Oakwood Healthcare & Rehabilitation Center	Philadelphia	148	26
Manorcare Health Services-Montgomeryville	Montgomery	155	25
Cheltenham Nursing And Rehabilitation Center	Philadelphia	255	25
Manorcare Health Services-Yeadon	Delaware	198	24
Lafayette-Redeemer, The (A D/B/A Entity Of Hrhs)	Philadelphia	120	24
Crestview Center	Bucks	180	23
Willowbrooke Court At Spring House Estates	Montgomery	96	23
St. Francis Center For Rehabilitation & Healthcare	Delaware	273	22

Table 7- Top 20 LTCFs in the Five County Area- Number of Staff Infections[4]

Name	County	# Beds	# Staff Infections
Neshaminy Manor Home	Bucks	360	68
Lafayette-Redeemer, The (A D/B/A Entity Of Hrhs)	Philadelphia	120	67
Cheltenham Nursing And Rehabilitation Center	Philadelphia	255	62
Chapel Manor	Philadelphia	238	55
Meadowview Rehabilitation And Nursing Center	Montgomery	244	52
Southeastern Pennsylvania Veterans' Center	Chester	238	47
Manorcare Health Services-Oxford Valley	Bucks	170	47
Paul'S Run	Philadelphia	120	44
Parkhouse Rehabilitation And Nursing Center	Montgomery	467	43
Saunders House	Montgomery	180	42
St. John Neumann Center For Rehabilitation & Healthcare	Philadelphia	226	41
Manorcare Health Services-Montgomeryville	Montgomery	155	40
Powerback Rehabilitation Exton	Chester	120	40
Providence Rehab And Healthcare Center At Mercy Fitzgera	Delaware	129	37
Philadelphia Nursing Home	Philadelphia	402	34
Crestview Center	Bucks	180	30
Manorcare Health Services-Yeadon	Delaware	198	29
Caring Heart Rehabilitation And Nursing Center	Philadelphia	249	29
St. Francis Center For Rehabilitation & Healthcare	Delaware	273	28
River'S Edge Rehabilitation & Healthcare Center	Philadelphia	120	28
Attleboro Nsg And Rehab Ctr	Bucks	179	28

[4] An omission worthy of further investigation is how the DOH/DHS is only reporting data on individual Nursing Home staff COVID-19 infections, but not the number of staff deaths from COVID-19.

Other Facility Comparison Metrics

The table below shows various data taken from the individual LTCF report for the Five County Area, as well as two new metrics: Resident Infections per Bed and Resident Death per Infection. In addition to allowing us to analyze and compare LTCF individual performance, these measures hint at the data not yet made public and the wide variability of different facility's COVID-19 preparedness.

Table 8- LTCFs in the Five County Area- Number of Resident Infection per Bed

Name	County	# Beds	# Current Residents	# Resident Infections	# Resident Deaths	Resident Infection per Bed	Resident Death per Infection
Richboro Rehabilitation & Nursing Center	Bucks	82	70	63	12	76.83%	19.05%
Laurel Square Healthcare And Rehabilitation Center	Philadelphia	87	50	63	21	72.41%	33.33%
Edgehill Nursing And Rehabilitation Center	Montgomery	60	35	43	15	71.67%	34.88%
Manorcare Health Services-Yeadon	Delaware	198	141	140	24	70.71%	17.14%
Juniper Village At Bucks County Rehabilitation And Skilled (	Bucks	17	7	12	5	70.59%	41.67%
Dock Terrace	Montgomery	72	41	49	19	68.06%	38.78%
Hillcrest Center	Montgomery	180	139	121	21	67.22%	17.36%
Valley Manor Rehabilitation And Healthcare Center	Bucks	180	116	120	26	66.67%	21.67%
Manorcare Health Services-Montgomeryville	Montgomery	155	118	102	25	65.81%	24.51%
Lafayette-Redeemer, The (A D/B/A Entity Of Hrhs)	Philadelphia	120	54	77	24	64.17%	31.17%
Brandywine Hall	Chester	180	119	115	31	63.89%	26.96%
Crestview Center	Bucks	180	126	114	23	63.33%	20.18%
Oakwood Healthcare & Rehabilitation Center	Philadelphia	148	84	93	26	62.84%	27.96%
Manorcare Health Services-Oxford Valley	Bucks	170	125	105	28	61.76%	26.67%
River'S Edge Rehabilitation & Healthcare Center	Philadelphia	120	103	73	14	60.83%	19.18%
Saunders House	Montgomery	180	116	108	38	60.00%	35.19%
Wesley Enhanced Living - Doylestown	Bucks	60	42	35	13	58.33%	37.14%
Wayne Center	Delaware	112	70	65	17	58.04%	26.15%
Harston Hall	Montgomery	120	72	68	17	56.67%	25.00%
Suburban Woods Health & Rehabilitation Center	Montgomery	120	73	68	6	56.67%	8.82%
Quadrangle, The	Delaware	78	39	44	22	56.41%	50.00%

Resident Infections per Bed is obtained by dividing the "# Beds" value by "# Resident Infections". This number gives us a window into the severity of the number of infections relative to the size of the facility. It is important to note here that "# Beds" is only an approximation, since not all beds at a given facility are filled and the actual census at a facility (shown in the "# Current Residents" column) is in a constant state of flux.

Resident Deaths per Infection captures how well a facility treats an infection. This data is gotten by dividing "# Resident Deaths" by "# Resident Infections". This figure varies greatly between facilities, coming in as well over a third of infections in some cases. This should also be taken as an approximation because there are some residents who are infected and will die but have not at the time of this data collecting, As mentioned previously this data is all self-reported and may be inaccurate.

Philadelphia County

Table 9- Top 20 LTCFs in Philadelphia County- Number of Resident Infections

Name	County	# Beds	# Resident Infections
Chapel Manor	Philadelphia	238	133
Philadelphia Nursing Home	Philadelphia	402	123
St. John Neumann Center For Rehabilitation & Healthcare	Philadelphia	226	110
Oakwood Healthcare & Rehabilitation Center	Philadelphia	148	93
Fairview Nursing And Rehabilitation Center	Philadelphia	176	92
Powerback Rehabilitation 1526 Lombard Street	Philadelphia	150	79
Lafayette-Redeemer, The (A D/B/A Entity Of Hrhs)	Philadelphia	120	77
Roosevelt Rehabilitation And Healthcare Center	Philadelphia	240	77
River'S Edge Rehabilitation & Healthcare Center	Philadelphia	120	73
Cheltenham Nursing And Rehabilitation Center	Philadelphia	255	72
Centennial Healthcare And Rehabilitation Center	Philadelphia	180	69
Laurel Square Healthcare And Rehabilitation Center	Philadelphia	87	63
Caring Heart Rehabilitation And Nursing Center	Philadelphia	249	58
Willow Terrace	Philadelphia	173	45
Wesley Enhanced Living Pennypack Park	Philadelphia	120	36
St. Monica Center For Rehabilitation & Healthcare	Philadelphia	180	33
The Pines At Philadelphia Rehabilitationandhealthcare Cente	Philadelphia	49	25
Kearsley Rehabilitation And Nursing Center	Philadelphia	84	24
Cathedral Village	Philadelphia	119	12
Pennypack Nursing And Rehabilitation Center	Philadelphia	54	2
Tulip Special Care, Llc	Philadelphia	64	2

Table 10- Top 20 LTCFs in Philadelphia County- Number of Resident Deaths

Name	County	# Beds	# Resident Deaths
St. John Neumann Center For Rehabilitation & Healthcare	Philadelphia	226	36
Chapel Manor	Philadelphia	238	34
Wesley Enhanced Living At Stapeley	Philadelphia	120	31
Oakwood Healthcare & Rehabilitation Center	Philadelphia	148	26
Cheltenham Nursing And Rehabilitation Center	Philadelphia	255	25
Lafayette-Redeemer, The (A D/B/A Entity Of Hrhs)	Philadelphia	120	24
Caring Heart Rehabilitation And Nursing Center	Philadelphia	249	22
Laurel Square Healthcare And Rehabilitation Center	Philadelphia	87	21
Centennial Healthcare And Rehabilitation Center	Philadelphia	180	18
River'S Edge Rehabilitation & Healthcare Center	Philadelphia	120	14
Fairview Nursing And Rehabilitation Center	Philadelphia	176	12
Roosevelt Rehabilitation And Healthcare Center	Philadelphia	240	12
Willow Terrace	Philadelphia	173	10
Wesley Enhanced Living Pennypack Park	Philadelphia	120	9
Philadelphia Nursing Home	Philadelphia	402	8
Powerback Rehabilitation 1526 Lombard Street	Philadelphia	150	8
St. Monica Center For Rehabilitation & Healthcare	Philadelphia	180	7
The Pines At Philadelphia Rehabilitationandhealthcare Center	Philadelphia	49	2
Kearsley Rehabilitation And Nursing Center	Philadelphia	84	2
Cathedral Village	Philadelphia	119	2
Tulip Special Care, Llc	Philadelphia	64	2

Table 11- Top 20 LTCF in the Philadelphia County- Number of Staff Infections

Name	County	# Beds	# Staff Infections
Lafayette-Redeemer, The (A D/B/A Entity Of Hrhs)	Philadelphia	120	67
Cheltenham Nursing And Rehabilitation Center	Philadelphia	255	62
Chapel Manor	Philadelphia	238	55
Paul'S Run	Philadelphia	120	44
St. John Neumann Center For Rehabilitation & Healthcare	Philadelphia	226	41
Philadelphia Nursing Home	Philadelphia	402	34
Caring Heart Rehabilitation And Nursing Center	Philadelphia	249	29
River'S Edge Rehabilitation & Healthcare Center	Philadelphia	120	28
Oakwood Healthcare & Rehabilitation Center	Philadelphia	148	23
Fairview Nursing And Rehabilitation Center	Philadelphia	176	20
Laurel Square Healthcare And Rehabilitation Center	Philadelphia	87	16
Kearsley Rehabilitation And Nursing Center	Philadelphia	84	13
Willow Terrace	Philadelphia	173	9
Roosevelt Rehabilitation And Healthcare Center	Philadelphia	240	8
Cathedral Village	Philadelphia	119	8
The Pines At Philadelphia Rehabilitationandhealthcare Center	Philadelphia	49	7
Tulip Special Care, Llc	Philadelphia	64	2
Pennypack Nursing And Rehabilitation Center	Philadelphia	54	2
Wesley Enhanced Living At Stapeley	Philadelphia	120	0
Centennial Healthcare And Rehabilitation Center	Philadelphia	180	0
Wesley Enhanced Living Pennypack Park	Philadelphia	120	0

Next Steps/ Recommendations

Liberty Resources, Inc. has always fought for the choice of Medicaid Consumers to remain living in the Community with transportation and attendant services paid for by Home and Community Based Services as a civil rights issue. For decades, the State has violated the civil rights of People with Disabilities by forcing them to live away from their friends and families in isolated and segregated Long Term Care Facilities such as Nursing Homes.

However this current pandemic has shined a light on the health-related disparities which have proven deadly to thousands of residents of institutions. LRI believes that now is the time to leverage this focus on the damages done by institutionalization to encourage the further shift of long term care into community settings. There is no doubt that such a shift would save the lives of tens of thousands of Seniors and People with Disabilities throughout our country

Pennsylvania Coalition of Affiliated Healthcare & Living Communities

An affiliate of the County Commissioners Association of Pennsylvania

July 16, 2020

The Honorable Mike Sturla
Chair
House Democratic Policy Committee
G-50 Irvis Office Building
Harrisburg, PA 17120

Dear Chairman Sturla:

Thank you for your attention to long-term care and its residents of Pennsylvania during the COVID-19 outbreak. The continued attention that the House Democratic Policy Committee (HDPC) has provided to Pennsylvania Coalition of Affiliated Healthcare & Living Communities (PACAH) members, and their residents, has been paramount during this difficult time.

PACAH members care for one of the most vulnerable populations - a population extremely vulnerable to COVID-19. Before and during the COVID-19 outbreak, PACAH members have been the safety net for many counties in Pennsylvania, delivering a level of access to care that other facilities may not provide. This is even more true in the current environment. As many non-PACAH facilities struggle to provide care, PACAH's county facility members have risen to the occasion, providing the same level of support and care that Pennsylvania residents have come to expect. This is especially true for our Medicaid residents who lack the resources for care that others may have.

We are grateful for the opportunity to share our thoughts regarding COVID-19 and issues that long-term care facilities face during this time. As we have confronted this pandemic, PACAH members encountered an unprecedented number of hurdles in our fight to provide the highest level of care. Yet, we continue to face challenges that place uncertainty and undue burdens on this care.

The most pressing issue that we would like to bring to HDPC's attention is DOH's current reporting system. The current reporting platform is causing uncertainty and confusion for facilities that are diligently working to play their part in overcoming this pandemic.

As many of HDPC's members may know, Secretary Levine issued an order on May 14, 2020, which requires all skilled nursing facilities (SNFs) to report several sets of data to the Department of Health (DOH). While initial reporting processes presented their own challenges, we continued to work through them as we faced this deadly disease. Reporting continues, but the last couple of weeks have been the most challenging to date.

On July 3rd, the vendor who operates the reporting platform ran an update to their systems, which resulted in many facilities being unable to report and some even unable to login. This continued through the July 4th weekend, and, as of July 6th, many facilities had not been able to report their data as they had in the past. Instead, many facilities used a DOH email account where they emailed their data and supporting documentation, as they understand that reporting this information is crucial for Pennsylvania's continued response to the COVID-19 crisis.

Unfortunately, the week of July 6th was the same time that many facilities started to receive enforcement letters from DOH for failing to report. This enforcement letter (attached) claimed that the DOH had not received the required data from the facilities, encouraged them to report their data, and failure to report their data would result in a $300 per day fine for non-compliance.

To date, the "bugs" in the reporting system are still being worked on, and several facilities are still having issues with reporting. We have been assured that the DOH will work with facilities regarding the enforcement letter, but no guidance or clarification has been issued. In addition, many facilities have emailed the Resources Account email for the DOH regarding the DOH's preferred way of reporting while the reporting platform is inoperable, but the only response facilities have received is a form response.

We ask that the HDPC look into this issue and encourage the DOH to make available guidance of clarification on this matter. If the DOH would issue guidance on how they are dealing with these enforcement letters, we believe this would resolve this matter without further confusion.

While we continue to fight for our residents and staff, PACAH thanks the HDPC for their attention to long-term care during this time. We hope the Committee will consider our comments as they work to support our long-term care facilities, their staff and their residents.

Sincerely,

Chase Cannon

Chase Cannon
Executive Director
Pennsylvania Coalition of Affiliated Health Care & Living Communities