STATE WIDE
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Testimony

Before the
Joint Legislative Committees on
Aging, Health and Investigations

COVID-19'S IMPACT ON RESIDENTIAL HEALTHCARE FACILITIES AND OTHER LONG-TERM CARE SETTINGS, AND RECOMMENDATIONS FOR IMPROVING SYSTEMS, PROTOCOLS AND PRACTICES TO REDUCE TRANSMISSION AND MORTALITY RATES OF CONTAGIOUS DISEASES.

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Thank you for the opportunity to testify today. I am Gail Myers, Deputy Director of New York StateWide Senior Action Council. ("*StateWide*.") We are a grassroots organization with chapters throughout the state. In addition to the input of our members, we learn about problems in the aging and health care delivery systems from the two helplines that we operate through contracts from the NYS Office for the Aging as a result of state budget appropriations, the **Managed Care Consumer Assistance Program** and our **Patients' Rights Hotline and Advocacy Project.** These cases inform us on how the aging and healthcare systems' policies and practices are affecting residents; we then can inform policymakers to see if system corrections can be made. These cases also informed our work with Senator May as we co-hosted a June 1st forum with her on the crisis in nursing homes.

There has been a growing crisis, prior to the pandemic, in the quality of care and the oversight by the state in adult care facilities. This includes a backlog of complaints needing investigation, fines that are merely a cost of doing business and do not create a disincentive to poor practices, inadequate staff to resident ratios and less than optimal visitation to facilities by the long term care ombudsman program.

There is also a crisis in home care that is marked by inadequate funding/availability of COVID testing, personal protective equipment (PPE) and for staff recruitment/retention which was further reduced during the SFY2020-21 Budget. The Legislature is acutely aware of the ongoing shortage of home care workers for all clients needing care regardless of payer source. The home care crisis prevents older New Yorkers from aging in their community homes which is where they prefer to be, rather than in institutional settings.

The disproportionate impact of the pandemic on residents of long-term care facilities combined with the disproportionate impact on residents of color heightens the need for immediate action. We fully support the statements of many legislators that have decried the conditions in nursing homes prior to the pandemic including understaffing and poor enforcement. The state must take immediate action to protect the rights of those who need long term care services. *StateWide* has been seeking changes for decades, including minimum staffing standards, more timely response to complaints, investigations of poor outcomes or practices where corrective actions truly result in improved care, and fines that are meaningful. We wonder, if the public outrage over the current disaster in care doesn't spark action, what will?

We have identified five major areas of concern as they relate to long term care services delivered in residential facilities. These are:

1. **The rights of residents and families** that have been negatively impacted due to a) inadequate staffing and the shortage of PPE which we believe led to the high rate of COVID 19 infection, and b) the ban on visitation which led to isolation and physical and mental deterioration of residents, c) the elimination of visitation by the long term care ombudsmen, as well as a lack of innovation by the state's Long Term Care Ombudsman which is compounded by the under-funding of salaried positions for the regional providers and inadequate tools to work remotely for the volunteers in the program in spite of special funding designated for this purpose in the CARES Act. There needs to be a strong consumer education component to ensure that residents, caregivers, and families understand their rights and can hold the nursing homes and facilities accountable when their rights are

not being met or violated. It is disturbing that consumer education material about nursing home resident rights is not widely distributed and is only available in English and Spanish.

2. **Pre-existing high risk of infection** and lack of enforced infection control and staff training preceded the epidemic and is a predictor of the spread of the disease. This has been compounded by insufficient surveillance, a dearth of unanswered formal complaints, and minimal penalties for poor performance that do not function as a disincentive to poor practice. Currently the DOH complaint line mostly takes calls to gather information that will advise a future surveillance team, but does not see its function to assist consumers and their families if they have a complaint in real time - that has to change.

3. **The failure to articulate disaster/pandemic plans** that for years had been a federal regulatory standard, the lack of enforcement of state and federal regulations; the inconsistency of the star rating system that fails to assure consumers of the right to quality, dignified care; and the lack of public information regarding COVID+ cases in facilities, not just rate of death - which in itself does not tell the full picture since transfers to hospitals that resulted in death are not uniformly disclosed.

4.**The corporate structure of facilities and lack of accountability** has contributed to reduced quality of care and poor infection control. Corporations should be held accountable for meeting their responsibilities and the liability waiver granted in the budget should be repealed in a retroactive manner. What started as an executive order to facilitate the recruitment of health care professionals should never have provided liability relief for corporate providers. A medical loss ratio should be established for for-profit nursing homes with a moratorium on conversion from non-profit or public to for-profit during this time along with a prohibition on purchases by both venture capitalists and LLCs that do not disclose ownership.

5. **The inability to discharge appropriately to the community due to lack of housing and community supports which includes the shortage of home care workers**, the unsafe "dumping" discharges to shelters, and the appearance that preference on admission was given to those with higher reimbursement, including the “COVID bonus.”

For detailed recommendations on these topics we endorse the testimony of the Elder Justice Committee of Metro Justice, Neighbors to Save Rivington House, the Center for Elder Law and Justice and Cynthia Rudder, PhD who have prepared testimony in detail on these issues.

We are testifying today on behalf of the many callers to *StateWide's* Patients Rights Helpline who asked us to share the challenges those needing care and families have experienced during the COVID crisis. Overwhelmingly, callers complain about short staffing. The crisis in care in residential long-term care facilities due to inadequacy of staffing pre-dates and has been exacerbated by the COVID19 pandemic. For decades, studies about safe levels of staffing have found a direct relationship between a minimum number of both RN and total hours of care per resident hour per day [**Attachment I.**] And yet, there has been no action that could have saved lives. Some states have required a full-time infection control staff person in each nursing home with good results.

Can you imagine being in a nursing home during the pandemic and being a prisoner in your own room? Now add to that picture the only personal interaction you have is with staff and that is less than 4.1 hours of patient care per day in 85% of nursing homes as reported in the last quarter of 2019 when there was no

pandemic! New Yorkers in nursing home facilities deserve a minimum of 4.1 hours of patient care per day. If not now, when?

This testimony will focus on nursing home family visitation and communication during the pandemic highlighting the impact on residents and family members, as told by their own stories. *StateWide* will also provide you with recommendations, including some that have been implemented in other states related to visitation, communication and upholding residents' rights.

I refer you to selected **case studies in Attachment II**, but will highlight frequent concerns:

- Many wanted care in the community and could not find a home care agency able to take on new clients because of staff shortages.
- Some wanted to discharge loved ones from a nursing home and were persuaded by facilities not to do so because they would not be guaranteed they could return after the pandemic.
- Most complained that nursing home residents were declining, and family members attributed this to social isolation, inadequate staffing and lack of visitors who often supplement paid staff care.
- Some were frantic because of the lack of communication and unknown status of their loved one.
- Often we heard about unanswered calls to the Department of Health complaint lines and a backlog of complaints being investigated.
- Many noted that they feared reprisals against residents if they raised concerns about inadequate care and not enough bedside staff.
- Observations were shared about call bells not being answered that were attributed to staff being assigned too many residents to care for.
- Residents have been confined to their rooms and totally isolated. Some were not receiving assistance in getting out of bed or toileting with resulting bed sores and mobility issues.
- Residents and family members did not know that every adult care facility resident should have access to a long-term care ombudsman.
- Frequent visitors did not getting information on window or drive by visitation, or if the facility has been approved to open for family visits, or how to find the visitation plan for a facility.
- Compassionate care visitation was not being offered at or near to end of life.

StateWide's Recommendations:

On the Long Term Care Ombudsman Program (LTCOP) during Pandemic.

- Innovative practices should be developed. (Please see Attachment III). Here are a few examples:
    - In other states the Long Term Care Ombudsman has collected the names and contact information for residents and their families and outreach calls were being made and letters have been sent by the local ombudsman to

residents and families so they knew there was an advocate still available to them.

- Several states are holding virtual family council meetings.

- Some state ombudsman programs have printed and placed posters/flyers outside of the main entrance to facilities so that families who drive by can have ombudsman program contact information.

- Many states have already distributed CARES Act funding that was designed to allow for remote work and enhance Ombudsman presence in facilities while they cannot physically visit due to the pandemic, expanding their virtual presence to residents and their families, and continuing to promote the health, safety, welfare, and rights of residents in the context of COVID-19. This funding gives Ombudsman programs the flexibility to hire additional staff and purchase additional technology, associated hardware, and personal protective equipment. Ombudsmen should have tablets to contact residents as well as staff (for meetings and consultations) and the facilities should make tablets available for the residents to communicate with their families and the ombudsman. NYS received almost $1.2m for the LTCOP program and reports from the field are that funding has not been released. According to a guidance memo, "effective use of CARES Act funds requires that the state Ombudsman coordinate closely with the State Unit on Aging and local Ombudsman entities, where applicable, to determine distribution and use of funds."

On the Long Term Care Ombudsman Program Pre-pandemic:

- The state must ensure sufficient staffing to meet the current standard that an ombudsman **visits every facility at least once every 90 days**. This can be achieved through a combination of increased paid and volunteer ombudsmen. The State Comptroller's December 2019 audit found that as of January 2019, only about 600 of the approximately 1,500 LTC facilities in the State – about 40 percent – had an assigned volunteer ombudsman and that about 28 percent of facilities covered by the Office **were not visited at least once** by an ombudsman during the FFY ending September 30, 2018.

- New methods of volunteer recruitment are essential since many of the current volunteers are self-isolating because they are older and are themselves at high risk for COVID-19 infection. They will not return to visiting the facilities to which they are assigned until after the risk of infection is no longer a threat to their own health.

- Provide outreach to families and redouble efforts to establish family councils in each facility.

On Visitation

- Federal government guidance on compassionate care visits indicates that at the end of life is an example of compassionate care visit. We recommend that compassionate care visits due to evidence of decline -either physical or mental – should be immediately implemented. When the resident's psycho-social health is deteriorating, or a physical decline such as a significant unplanned weight loss, the concerned family/friend who has been a frequent visitor pre-pandemic should be able to seek a compassionate care exemption (consistent with guidance in CMS memorandum QSO-20-14-NH – Revised.)

- Every resident should have a designated visitor, if one is available. The state should immediately authorize all facilities to allow one "essential support person" to be named for every nursing home or assisted living resident, not just those who are dying. This person should have the right to go into the facility as long as he or she wears personal protective equipment, follows infection control protocols and interacts only with the resident he or she cares for.

- Opening for visitation should not be at the option of the facility. All facilities that meet the criteria must allow residents to have visitors with appropriate social distancing and PPE. Facilities should provide PPE for such purposes.

- Criteria for visitation should not be based on excessive caution as we now see with the requirement that no infection of staff or residents has been reported within 28 days. Clear communication plans need to be in place to inform the community when facilities no longer meet the criteria for opening, as they likely will go in and out of open for visitor status as new cases emerge.

Additional Recommendations

Nursing home residents should receive the attention, care, and respect that such an extremely vulnerable population requires. To assure that quality care is provided, there is supposed to be a system of checks and balances. It includes visitation by family and friends, active ombudsmen programs, residents' councils, and optional family councils. We should expect the state to ensure a vigorous surveillance and corrective action program. Yet during the pandemic state and federal directives eliminated most of these. Getting "eyes on" the status of residents, especially those with dementia who may not be able to self-advocate, is critical. We need to improve.

Communication with Families by both facilities and the Department of Health was inadequate

To counterbalance the prohibition on visitors, and after dramatic and devastating family stories were reported in the media, both federal and state government came up with guidelines for communicating with families and hotlines to report complaints. Unfortunately, the public was unaware of these guidelines for many days. When these new

rules began to emerge in early April, *StateWide* anxiously waited for the state to provide consumers with guidance, but none emerged. Through *StateWide's* Patients Rights Helpline and Advocacy Project, we posted the state and CMS guidelines to our own website and started to advise callers of their rights.

> Before we posted the information to our website, we emailed and called the Department of Health, identifying ourselves as the state funded Patients' Rights Helpline, to make sure everything we had was accurate. We also sought additional guidance and clarification on how we could work with the Department to assist families. We never received a response. This needs to change; lack of responsiveness to residents and families are one reason why there have been so many problems.
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> State Ombudsman Claudette Royal was responsive. She reviewed the information and gave us some comments so that we could post a clear alert for families and distribute the information to ombudsmen and other community-based organizations. The information was widely shared and heavily utilized.

Regional DoH Office Contacts

During a pandemic each regional office should identify a trained point person to follow up on inquiries on the status of residents by family members and a coordinator for pandemic planning. In our experience, phones at some regional offices just rang, with no messages for worried families or voice mail or systems to take inquiries. Complaints to helplines that were made were logged in but no feedback or advice to families was provided. This is unacceptable. Every family member who wishes to know, should be able to determine if their loved one is alive, dead, has the infectious disease, is being treated, where they are located, and how they can find out about their condition on a regular basis. Human rights cannot be suspended during a pandemic. The state should immediately establish and rigorously promote a special 24/7 number for families to call if they are not getting the cooperation of the nursing home and post the rights for families, including how to reach the ombudsman for assistance, on a website that is easy to access and understandable. Public service announcements and media releases should be produced to inform the public. During a pandemic, regional offices of DoH also should host regular calls to share information and guidance with all regional residential long-term care facilities - nursing homes, assisted living centers and adult homes and include Ombudsmen in these calls.

Temporary Emergency Ombudsmen

If Ombudsmen are not allowed into facilities or an insufficient number of volunteer ombudsmen are available, temporary ombudsman training should be provided to our National Guard, or volunteer medical and social services personnel to fulfill this important role. A corps must be ready to go on site to see if conditions are acceptable and that residents' needs are being met. They can help fulfill the ombudsman function to protect the rights of residents and their families and to enable families to connect with residents via technology.

Beefing up the Ombudsman Program with Legal Liaisons

StateWide makes many referrals to the ombudsman program. We often find that families

struggle not only with questions about quality or how to complain, but they also desperately need legal guidance. A model already exists for this in Western NY where People Inc., the regional ombudsman program contractor, formed a legal liaison partnership with the Center for Elder Law and Justice. This has given the program increased capacity to assist with many important rights issues that volunteer ombudsman may not be able to address without support, including Visitation Rights, HIPPA barriers, Quality of Care Complaints, Nursing Home (and Adult Care Facility) Discharge/Transfers, Medicare and Medicaid Appeals , Financial Exploitation Preventative and Corrective Assistance, Consumer Protection, Advance Directives, and Private Bar Referrals. The state should provide resources so that each regional Ombudsman Program can establish a Legal Liaison component.

Help Residents Who Wish to Move Back Into the Community

During a pandemic, nursing home transition-to-community programs need to be given the resources and training to continue to assist residents who wish to move back into the community. Testimony from the Center for Independence of the Disabled, New York documented the number of cases that requested assistance with discharge to the community and the need to ensure the adequacy of community-based supports including home care, housing and supportive services. The fundamental infrastructure to support community-based care for the current population must be secured, and these programs must grow to meet the need of an increasingly aging population.

Empower Resident and Family Councils

New York requires each nursing home and assisted living facility to have an active resident council that operates free of facility influence. Family councils are permissible but not mandated. Facilities should engage the residents' council, and the family council wherever one is in place, in the development of the facility disaster and pandemic plans annually as well as other policies. The ombudsman should be expected to be in regular communication with these Councils and help with training to recruit members and develop leadership skills when needed. Certainly, a sufficient number of ombudsmen must be engaged to be so deployed. Regional Department of Health staff should be available to discuss concerns and keep the Councils updated in the planning for, prevention of, and management of epidemics. The Councils are the frontline of advocacy to ensure residents rights; they can help identify problems, provide feedback, and join in developing solutions. Surveyors should also be expected to meet with councils and to seek input from family visitors.

The state of New Hampshire has developed a program called Seniors Aid (more information is available at: https://sanh.nhhca.org). This approach could be used as a model for New York that could be implemented by the Ombudsman program on a regional basis. This would provide a platform to encourage residents in adult care facilities to communicate with key state leaders and policy makers on issues that affect them and assure that policy changes aren't considered without consulting with the residents who are impacted.

Provide Socialization to Residents

Facilities need to be required to develop pandemic plans that include safe methods that prevent social isolation. The state also needs to develop the parameters for increasing safe family visits.

Provide Technology to Connect Families and Residents
Technology has made virtual visitation simpler than ever, but many older residents and those with limited abilities will need help to understand and use the smart phones and tablets that are available. Why not deploy non-direct care staff to assist residents to use technology to communicate with virtual visitors.

Next Steps

Data Analysis needs to be ongoing to guide next steps

We should expect the Department of Health to share data they collected from complaint calls to the special state COVID hotline, analyze their own data and that derived from complaints received by the Attorney General's office, determine what patterns emerged, and meet with stakeholders to determine proactive actions that should be taken to address them and help residents and families. What we hear is that we are in the middle of a pandemic, implying that this is not the time for reviewing what has occurred. In fact, nursing home residents are still vulnerable and visitors in most facilities at this moment are still locked out. If indeed a re-emergence of a high number of cases occurs before a viral treatment and preventive vaccine are available, and if the steady and ongoing decline of non-COVID residents continues, we will regret waiting to review, analyze and implement corrective measures.

Ensure communications across the entire continuum of care

During the height of the pandemic, special coordination was established across hospital systems. Long term care – both facility based and home care – were not part of the dialog. As a result, while conditions improved in hospital settings to make sure the systems were not overwhelmed with patients, the same was not considered for the long-term care sector. Nor were supplies of PPE procured and allocated across the continuum of care to ensure that all essential personnel were protected. This must change. Additionally, not for profits that deliver social determinants of care were not included in the disaster response plans early on. This, too, must change.

Cease approving hospital closures, mergers and bed reductions
The need to discharge COVID+ hospital patients to nursing homes beds was caused by the perception that there was insufficient hospital capacity to care for these patients. A lack of hospital beds and the accompanying staff required was occurring for decades with the approval of the state.. Prior to the pandemic, Community Voices for Health Systems Accountability and other groups were calling for a cessation of hospital closures and mergers. Even during the pandemic the state moved ahead approving more bed closures. The state needs to cease such actions and reassess every request in light of the needed pandemic capacity especially in high risk and underserved neighborhoods.

Place a moratorium on for-profit ownership of nursing homes. Nursing home quality and staffing levels have declined with the increasing ownership by for-profit corporations and private equity firms. Lack of adequate reimbursement systems and local governments' desire to stay within the property tax cap have placed untoward pressure to convert public

facilities to private models. The outcome of these policy decisions have been an unacceptable acceptance of deteriorated staffing hours per resident which has led to a diminishment of quality of care.

Create A Better Vision for Long Term Care

New York State needs to reimagine long term care and take steps within the next fiscal year to implement positive changes. No doubt, there will always be the need for nursing homes and assisted living facilities, but we don't need to continue warehousing vulnerable populations in big box institutional settings. The Greenhouse concept and Pioneer movement should be the framework to restructure adult care facilities so that few residents are in each building section, so that staff can get to know their residents, and so that when a pandemic hits staff and resident infection rates can be minimized. Implementation of the Olmstead Decision is long overdue, as is providing support to the community-based systems that will ensure that New Yorkers receive care in the least restrictive, most integrated, and culturally competent setting.

StateWide looks forward to working with you. If not now, when.

Attachment I

Safe Staffing Saves Lives

Year	Entity	Finding
1999	The HHS Office of Inspector General issued a report	Reviewed six studies that it had recently conducted on nursing home care in ten states including New York. Detailed extensive evidence of serious care deficiencies – including inadequate prevention and treatment of conditions such as pressure sores, lack of nutrition, and incontinence. The report concluded that nursing home staffing levels should be higher, "since this directly impacts on the care residents receive."
2001	The Institute of Medicine issued a report	There is abundant research evidence that both nursing-to-resident staffing levels and the ratio of professional nurses to other nursing personnel are important predictors of high quality of care in nursing homes. The 2001 report was not the first assessment by the IOM; it built on prior studies including a 1986 report on ways to improve the quality of care. The report presented research associating greater numbers of nurses with improved resident outcomes. It concluded that on the whole there were inadequate numbers of nurses to provide the care needed.
2002	The Government Accountability Office report: "Nursing Homes: Quality of Care More Related to Staffing than Spending," GAO-02-431R on Nursing Home Expenditures and Quality	It studied deficiency statistics and staffing data for nursing homes in three states. The overall analysis showed that "nursing hours per resident day – especially nurses' aide hours – were related to quality of care deficiencies in homes providing more nursing hours being less likely to have identified quality problems than homes providing fewer nursing hours."

2002	Centers for Medicare and Medicaid Services (CMS) at the direction of Congress) Comprehensive federal study	Identified three staffing thresholds below which the quality of care was found to suffer: • a threshold of 0.75 hours per resident day (45 minutes) for RNs; • a threshold of 1.3 hprd (1 hour, 18 minutes) for total licensed nursing services (RNs plus LPNs); • and a threshold of 2.8 hprd (2 hours, 48 minutes) for CNAs. Any nursing home that meets these standards would provide at least 4.1 hprd (4 hours, 6 minutes) of total nursing care.
2004	Assemblymember Gottfried introduces bill, now: Gunther A2954 Rivera S1032	Would require 4.1 minimum hours of care per resident day in nursing homes.
2006	NYS Attorney General issues report: "Staffing Levels in New York Nursing Homes"	"Numerous studies have shown a strong relationship between the hours of care a resident receives and the quality of care a resident receives." [According to NYS self-reported figures] "about 98% of New York's nursing homes fall in the range at which, in the comprehensive federal study quality of care for long-stay residents was shown to suffer." Found 2% (10 out of 629) NYS nursing homes met the CMS study standard in 2006.
2020	Researchers Harrington (California) & Li (Connecticut) separately examining staffing and COVID infections	http://theconsumervoice.org/uploads/files/issues/Staffing_COVID_webinar.pptx Study Aim: Identify Factors that Impacted Whether Nursing Homes Had Residents with COVID-19 Infections. Harrington Finding: California Nursing homes with low RN and total staffing were associated with more: Total deficiencies Infection control deficiencies For-profit ownership Large size facilities Facilities with COVID-19 residents Li Finding: Connecticut study Higher RN staffing help reduce virus transmission and resulting deaths Among NHs with >1 confirmed case, every 20 minutes (per resident day) increase in RN staffing was associated with 22% fewer confirmed cases ($p<0.001$). Among NHs with >1 death, every 20 minutes (per resident day) increase in RN staffing was associated with 26% fewer COVID-19 deaths ($p=0.047$).

Case Studies

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From Rensselaer County: *A daughter, who had for years regularly visited her 91 year old mother in a nursing home, was denied any information about her once COVID began. Despite massive efforts to make contact with her mother or get basic health care updates on her status, she was never were able to do so. Tragically her mother died and she only found out about her death by reading a posted death notice. Her mother's death certificate listed her as "died of natural causes" and no autopsy was done. The daughter wonders if this is an example of how many COVID related deaths were under reported. Also, the daughter felt that facilities hide behind HIPPA and health care proxy designations to deny information to family members who have been regular visitors. She believes that if a family member had visitation rights then they should be afforded updates and efforts should be made to connect with their loved ones.*

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From Brooklyn: *A son heard from his sister that his 78 year old mother was going to be intubated although no reason was given. He could not get information about his mother's care but he had the wherewithal to appear at the nursing home to demand that they produce his mother or he would call the police. When he saw her poor condition that he attributed to obvious neglect, he took her to a hospital where she was treated for severe dehydration and poor nutrition, blood clots in her legs, and bed sores. She recovered and was placed in a different nursing home. He shared his outrage that there was no reason for such neglect to have occurred and without his intervention his mother may have died.*

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From the Adirondacks*: My mother is in a nursing home that is chronically short staffed. On the evening shift, weekends and many weekdays there is only one certified nursing assistant for 15 residents. My mother has advanced dementia and is on a unit with other dementia residents who have behavioral problems and need a lot of emotional support. It is virtually impossible for one certified nursing assistant to meet the needs of 15 residents. There is a high turnover of staff. You can have the best policies and procedures, the best practices which have been proven and verified but without enough quality certified nursing assistants, residents do not get the care that they need to thrive in their environment. Limited staffing is the perfect soil for infection. Schedules are frequently changed and certified nursing assistants and nurses are pulled to other units because of call outs and limited staffing on other units. There is no guarantee that if they are working with very sick and highly infectious residents that they won't be required to work on another unit the next day with different residents because of staffing issues. When staff are overworked they take short cuts and they are forced to prioritize. They do not have the time to pay attention to the signs and changes that residents present. That lack of attention leads to missing critical cues about a resident's condition. Missing those critical cues can be very dangerous. There is also a high turnover for RNs' and LPNs. What I have observed is that they leave because it just becomes too much. They work overtime. They are asked to help out on their days off because of staffing shortages, their workload is excessive. What one RN told me before she left was that since she took this position she never sees her family. An LPN who also left shared with me that she was constantly being asked to work overtime and it just became too much.*

Activity Aides are a great support to residents and staff. There is a high turnover of activity aides. I have seen some of the best and most qualified activity aides leave because of low pay and better opportunity. One activity aide that I call to mind was a mature woman who was skilled and compassionate. She did so much more than was in her job description. She loved working with the residents and did a great job. The reason she left was because, as she described it, she wasn't earning a living wage at $11.40/hr. I would appreciate it if you would protect my anonymity. I need to protect my mother.

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From Tompkins County: *I was a retired RN that returned to work in a nursing home where my 96 year old mother was a resident. It was the only way I could see her. We have had no cases either in residents or staff!*

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From Westchester*: My husband is a resident of NYSVH-Montrose and it has been almost 5 months that I have been unable to hug my husband, hold his hand, feed him lunch, etc., I visited him every other day until COVID hit. From the perspective of family visitors, whether these challenges are on the local administrative level or at the state/DOH level is not certain, but the fallout sure is: The home closed to Visitors on March 9th. We did not give our loved ones COVID.*

- *Illness started to spread rapidly on/about the first-second week of April. There were serious staffing shortages and most residents were confined to bed or to their rooms to compensate for staff reductions. The CFO of the home died of COVID.*
- *During March & April there was limited (if any) information coming out of the home to families.*
- *NYSVH-Montrose did not start ZOOM calls with families until May 20th (months after other facilities). Families are on 'mute' and unable to speak. Questions posed in a 'chat box' are cherry picked as to which will be addressed.*
- *'Window Visits' started June 23rd (months after other facilities) and appointments were rationed out to families.*
- *To our disbelief, Ombudsmen and Boards of Visitors were not present in facilities since the closures.*
- *Outdoor Visits were to start in early August and we were 22 days into a 28 day waiting period under the Reopen NY protocol when 3 Staff members tested COVID+ and the clock was reset to Day 1. This is wholly unacceptable.*

Nursing Homes in New Jersey allow in person visits. Hospitals in New York allow a family member to accompany a loved one to the Emergency Room and be present in the inpatient room if they are admitted. How can the protocols be so arbitrary? We families will be happy to undergo screening. Nursing Homes have to be held accountable not only for the medical aspects of care but as importantly, for the humane aspects.

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From Western NY: *How is the state protecting residents through surveillance and findings, particularly regarding deficiencies in infection control – which is a predictor of COVID19 infection spread. An assisted living facility was surveyed, but immediately after they got a clean bill of health on surface infection control from the NYSDOH there was a facility-wide outbreak of shingles. At the Residents Council meeting, a primary topic of discussion, (besides the recurring unpalatable food and clothing lost by the laundry staff issues) was infection control. Residents complained that aides changing soiled linens throw them onto the floor (without it being cleaned afterward) and the aide track it into their bathrooms, touching the handles on the bathroom doors and the sink spigots with soiled gloves. As a result of NYSDOH COVID-19 inspections for infection control, the facility was placed in immediate jeopardy. This situation was preventable.*

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From Nassau County*: My mother has been living in an assisted living facility for 5 years. Up until mid May she was fine even with macular degeneration, and hearing loss, but she was still able to make her own breakfast, clean up her room, go for a walk in the hallway, watch the news and other tv shows and was very sharp. She was able to talk on any topic. A week after Mother's Day - after being locked in her room without seeing her loved ones or access to other residents to talk to for such a long period of time and seeing only people with masks - she started to become depressed, anxious, delusional. She now believes she's in a prison, and being locked in. There was a day she said she was kidnapped and being held hostage and she did not believe I was her daughter. I bring food to her weekly, but she believes that she is not allowed to eat the food I bring, and barely eats the food that is brought to her by the staff from the kitchen. While the staff do take care of her, she is now paranoid and believes they are not taking care of her.*

Last week, visitation finally started - 30 minutes outdoors. I finally got to see her and she is nowhere near the person she was. She talks about being fed old food or not allowed to eat what I bring. She does not recognize the staff members that she's known for 5 years. I think locking people in their rooms all day - 24/7 was the worst thing that could have been done to them. We are always told to check on the elderly and be kind to them and talk to them and here they were being locked away. It would've been possible to allow them to have distanced visits with family, and distance sitting with other residents at different times of day. There could have been scheduled times to walk and sit with others - again distanced. Their dining rooms were closed. So why not have the residents visit in the dining rooms (no meals) but able to sit distanced with one another? They would've seen other people, and not been locked in their own heads. I know of other residents in her place that have are in the same shape as my mother and they were all sharp, feisty people. While my mother did not test positive for COVID, I believe it will be COVID that will kill her.

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From Monroe County*: My mom was in a for profit nursing home since 2015. On April 26, I was alarmed about a text I received: This is an anonymous person. This facility has an outstanding amount of COVID cases. They are not in the news and I feel they're keeping it a secret. Can you please*

contact the State and let them know what's going on for the sake of the innocent residents and staff. That was how I found out that there was an infection in the facility where my mom was being cared for! My mother was hospitalized in early May and died three weeks later. I continued to receive a daily Robo call telling me to check the facility website for updates. This just highlights the incompetence of the corporate office. I am very tired of feeling angry. It infuses my personality and makes me a person I do not want to be. I hope venting by sharing my story about this situation helps me.

From Albany County: *I had visited a dear friend, aged 92, at her own home many times every week for years. I was her health care proxy. At the end of February, I found her on the floor and called 911. She was taken to the hospital and had surgery for a broken hip. I visited her daily. She was sent to a nursing home for rehab in mid-March. When she left the hospital she was expecting to recover and looking forward to returning home where she lived independently, with no assistance. I visited her frequently at the nursing home and she was making good progress with physical therapy. When the home was closed to visitors, I called daily. By July, I found her less responsive, and less coherent. She told me she had lost a lot of weight and was a prisoner in her room. She had not been out of bed and had no physical therapy. I couldn't get my calls to the facility social worker returned. I was frantic, and did not know how to get information about my friend. I found out about StateWide and was referred to the ombudsman. N spite of my many visits to the nursing home before the pandemic closure I never noticed any signage and never knew there was an ombudsman program to help. I was able to get some information, but sadly my friend died in the nursing home in July. She never got to return to her home. I'll never know if COVID was the cause of death, but her rapid decline in the nursing home during the pandemic when I could not see her will always be a concern.*

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From Essex County*: A family member of a resident in a Lake Placid facility that converted ownership from a not for profit to a large private company expressed concern that the facility wants to expand but it already is short staffed.*

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From Western NY*: Many, if not all Ombudsman volunteers, are retirees aged 60+. That is one of the first risk factors for COVID-19 mortality. How can I be expected to put my life and health on the line when adult care facilities re-open for ombudsman visitation?*

Innovative Practices During the Pandemic

A sampling of good practices from CMS July 2020 Toolkit on State Actions to Mitigate COVID-19 Prevalence in Nursing Homes

Source: https://www.cms.gov/files/document/covid-toolkit-states-mitigate-covid-19-nursing-homes.pdf?eType=EmailBlastContent&eId=ae6acf77-6efa-4a7e-9681-b487eb05908a

Arkansas:
Greenhurst Nursing Center opens visiting station

California:
The California Association of Long Term Care Medicine developed recommendations that include:
1) stellar infection control, including a full-time infection preventionist in every nursing home;
2) access to sufficient personal protective equipment (PPE);
3) readily available testing for symptomatic and asymptomatic staff and residents;

Delaware:
Delaware Health Care Facilities Association (DHCFA facilities provide one-on-one electronic communication with facility ombudsman to ensure families are connected to staff on important information

Georgia:
Successful COVID-19 containment strategies at a nursing home in southeast part of the state. The facility has had no COVID-19 cases since March 2020.
o Infection control practices started early to include temperatures of staff and residents
o Isolation plans were implemented for residents coming from the hospital, dialysis, or other external sources
o The facility conducted frequent staff education and requested that staff only work in its facility and not others to contain travel and reduce public exposure for the protection of the residents and staff
o Open windows allow fresh air in the building and residents have outdoor time with social distancing
o The National Guard has assisted with cleaning
o The facility continually communicates with families on pandemic activities, including testing as required by the state of Georgia
o Leadership is committed to keeping all lines of communication open with staff, residents, and families

On June 11, 2020, Governor Kemp issued an Executive Order stating that controlled outdoor visitations may occur as part of a compassionate plan of care, so long as state guidelines are followed.

Indiana:
May 2020, State Department of Health communication guidelines for long term care facilities were released
Developed communication guidelines for reporting facility COVID-19 status
Developed strategy guidelines for COVID-19 in memory care units
Created an outreach email for those families having difficulty receiving COVID-19 communication on loved ones from long term care facilities
Allows visitation (including family) for end of life situations

Essential Family Caregivers in Long Term Care Facilities - Released update on June 5, 2020 recognizing the critical role family members and other outside caregivers (e.g., friends,volunteers and private personal caregivers) often have in the care and support of residents.
Recommended that long term care facilities consider designating as Essential Family Caregivers those family members and other outside caregivers who, prior to visitor restrictions, were regularly engaged with the resident at least two or more times per week to provide companionship and/or assist with activities requiring one-on-one direction
The goal is to help high risk residents who are missing care previously provided by a loved one or outside caregiver

Long Term Care Facility Outdoor Visitation guidance released on June 3, 2020.

Department of Health created a Long Term Care COVID-19 website dedicated specifically to LTC questions and guidance for COVID-19 The website contains links for guidance on long term care facilities, visitation, personal services, essential family caregivers, and outdoor family visitation.

Department of Health updated Visitation Guidance requiring all NHs to offer outdoor visitation, and permitting indoor visitation effective July 4, 2020, unless there has been a new facility-onset COVID-19 casein the past fourteen (14) days

Kansas:
Leading Age Guide to outdoor time for residents during COVID-19

Maine
The Lincoln Home's porch in Newcastle has been transformed to serve as a safe place for family visitation. The home divided the screened porch in half with Plexiglass to allow family to enter their part of the porch from the outside and residents enter from the inside.

Maryland:
FutureCare Nursing Homes rolled out a robust new telecommunication system,

enabling each patient to have remote face to face communications with their loved one.

Massachusetts:
Senior Care secured donations of 750 tablets from companies including Amazon, Walmart, TeelTechnologies, and Acer, as well as a financial contribution from Personable, Inc., which were distributed to nursing home residents across the state to facilitate face-to-face communication with their loved ones.

Minnesota:
Department of Health offers public reporting of congregate facilities with COVID-19 cases updated daily, waits 48 hours to list the congregate facilities to allow the facility to notify residents and families
Issued guidance for window visits and outdoor visitation at long term care facilities
Developed a framework that long term care providers can use to designate people to be essential caregivers, striking a balance between meeting residents' needs and limiting n risks

Missouri:
Long-Term Care Ombudsman Program provides guidance and links to the national Long Term Care Ombudsman Resource Center, factsheets, Q&As, newsletters, and Centers for Medicare & Medicaid Services communications regarding COVID-19 for long term care facilities, residents, and their families

New Jersey:
Long Term Care Ombudsman is working to implement a Centers for Medicare & Medicaid Services draft memorandum to State SurveyAgency Directors that provides notification requirements for facilities to inform family members when transferring residents to an acute care facility on an emergent basis. The notice is to include the reason for transfer, date of transfer and location to which the resident is transferred, AND contact information for the ombudsman.

New Mexico:
Long-Term Care Ombudsman Program communicates directly with residents and families of those who have died from or contracted COVID-19. Town Halls are used to answer questions from the public and family members and educate on resident rights, family councils and their importance and impact, technology innovations, and the ombudsman program. The ombudsman is setting up a process to track and analyze the use of tablets in long term carefacilities. A tiered approach to volunteering creates a fast track to increase volunteer capacity.

New York:
Long Term Care Ombudsman Program has done outreach to inform the public of its continued services.

North Dakota:
Established Reuniting Families & Residents Task Force/Committee, led by a nursing home resident. The Task force consists of North Dakota nursing home

residents, staff, leadership, and family members working towards opening of visitation and social support for nursing home residents.

Pennsylvania:
Long-Term Care Ombudsman Program helps with a new statewide resource called the Virtual Family Council. The program offers weekly online meetings with a local ombudsman and a team of 10 local experts. Anyone can participate and ask questions, share concerns, or just listen to learn and gather information. The meetings provide an opportunity for dialogue and networking and updates on resources and policies.

South Dakota:
Avera Prince of Peace Retirement Community created a visitation booth that separates residents from their visitors by a piece of plexiglass. Family members can contact the nursing home to reserve a time for the booth.

Vermont:
The Department is proactively contacting all long term care facilities, nursing homes, assisted living facilities, and senior housing facilities to review strategies to prevent COVID-19 infection and to develop plans to respond immediately if an infection is identified. If a case of COVID-19 is associated with a long term care facility, an epidemiology team is quickly activated. The team contacts the facility to provide recommendations and infection control support and begins contact tracing to determine the source of the infection and how it may be spreading.