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Written Testimony to the New York State Legislature

Before the Joint Legislative Committees on Health, Aging, and
Investigations and Government Operations

Topic: Residential Health Care Facilities and COVID-19
August 10, 2020

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Thank you for the invitation to provide testimony on COVID-19's impact on residential healthcare facilities and other long-term care settings as well as the opportunity to provide recommendations for improving New York's long-term care system.

The Center for Elder Law & Justice (CELJ) is a civil legal services agency with offices in Buffalo, Dunkirk, and Lockport, New York and serves nine Western New York (WNY) counties. Since 1978, we have provided free comprehensive legal services to the community's older adults, people with disabilities, and the lower income community. Our services help people maintain the essentials of life and our mission is to use the legal system to help our clients live independently and with dignity. We are partnered with the local regional Long Term Care Ombudsman Program (LTCOP), and as that program's legal liaison, advocate for the rights of people living in nursing homes and adult care facilities.

Before the COVID-19 pandemic we saw the challenges our clients faced living in long-term care settings (nursing homes and adult care facilities): short-staffing, abuse, neglect, indignities, lax infection control practices, insufficient enforcement actions, and enabling substandard care to continue through the Certificate of Need Process. The pandemic has exacerbated these issues and long-term care residents and their families are sick of excuses. It is time for New York State (NYS) to stop being complicit in substandard care that occurs in our long-term care facilities.

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I. Need for Transparency and Accountability

A. Facility Level COVID-19 Information

Data drives policy, is important for population health, and enables for targeted pandemic support.[1] Decisions must not be made behind closed doors. Data must be publically available. The NYS Department of Health (DOH), up to the date of this written testimony, only releases the numbers of residents who have died from COVID-19. This is woefully inadequate and undermines the health of long-term care residents and staff, and the surrounding community. Absent transparency there is no accountability and there is no public trust.

DOH only provides to the public the number of residents who died while in their nursing home or adult care facility. DOH does not publically account for residents who were transferred to a hospital or other location where they later died of COVID-19. The damage done to residents in long-term care settings extends past those who died in these settings. Long-term care residents who have died as a result of COVID-19 deserve to be counted and the public needs to know. Contrary to the testimony of DOH Commissioner Dr. Howard Zucker, DOH can incorporate hospital deaths and not double count the nursing home deaths. The nursing home death count is from those who died in the nursing home and not elsewhere.

DOH must also publish the COVID-19 infections and rates by facility for residents and staff. DOH has this information, and long-term care facilities, specifically nursing homes, are required to report this information to the CDC.[2] It is not a major burden to publicly provide this data.

Disclosing this information is vital to the public for many reasons: facilitation of local support to the facility, many have loved ones who reside in long-term care facilities, visitation depends on this data, and hospitalized patients in need of long-term care facility placement deserve to know this information prior to agreeing to live there. Throughout the course of the pandemic, DOH has hid behind the ‘veil of privacy’ stating it would not release such data because resident privacy

[1] Bonner, David G. Stevenson Alice. “The Importance of Nursing Home Transparency and Oversight, Even in the Midst of a Pandemic.” *Health Affairs*, May 12, 2020, https://www.healthaffairs.org/do/10.1377/hblog20200511.431267/full/

[2] 42 C.F.R. § 483.80(g), see also CMS COVID-19 Nursing Home data, available at https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/

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rights would be violated.[3] We disagree. CMS publishes facility based data and there is no excuse for DOH to not do the same.

The quality of care and the lives of long-term care residents is something we as a society must prioritize and transparency is key to doing this. Decisions that impact resident health are not something that should be done behind closed doors. However, **DOH is making such decisions behind closed doors.** For example:

- Staff Testing

Originally mandated under E.O 202.30, that required all nursing home and adult care facility staff be tested twice per week, was amended to once per week by E.O 202.40 for facilities located in phase two regions. As explained by DOH Commissioner Dr. Howard Zucker on June 10, 2020, the reasoning for this was the weekly positive test rate declined from 3% to less than 1%, and facilities in Phase 2 regions had 0.76% positive test results.[4] We agree that it makes sense to reduce the testing to once per week based on community spread of infection and the staff rate of infection, however how does the public know this to be true? DOH has the data and it is in the interest of the public's health to have access to it.

- Reopening Visitation

Visitation to long-term care facilities was banned March 13, 2020. On July 10, DOH Commissioner Dr. Howard Zucker announced the reopening of long-term care facilities for limited visitations.[5] While we discuss the visitation issues on page 14, visitation under the DOH current guidance is partly dependent on the community or facility spread of infection. However, the parameters of community and facility spread of infection are not clearly stated. What constitutes community? The region? The county? What is the infection rate? How can residents and family trust when a facility 'pauses' visitation when a staff or resident tests positive?

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[3] *See,* Michel, Lou. "Covid-19 deaths at New York's nursing homes more than double in 5 days," *The Buffalo News*, April 11, 2020, https://buffalonews.com/business/local/covid-19-deaths-at-new-yorks-nursing-homes-more-than-double-in-5-days/article_faef987b-bf1d-5f28-b5d9-68fa4dfbdc13.html.

[4] Statement from New York State Health Commissioner Dr. Howard Zucker on Successful Nursing Home Testing Program." *New York State Department of Health,* June 10, 2020. https://www.health.ny.gov/press/releases/2020/2020-06-10_nursing_home_testing_program.htm. Press release.

[5] "New York State Department of Health Announces Resumption of Limited Visitation to Nursing Homes." *New York State Department of Health*, July 10, 2020. https://www.health.ny.gov/press/releases/2020/2020-07-10_resumption_of_limited_nh_visitation.htm. Press release.

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B. Transparency Needed Outside of COVID-19 Data

1. Demographic Data

Initial research shows that nursing homes caring predominately for Medicaid or racial and ethnic minority residents tend to have more confirmed cases of COVID-19.[6] This is not surprising as there have been multiple reports on the health care disparities in racial and ethnic minorities, and that alone is a public health crisis. Data drives policy and is key to overall population health.[7]

The public health crisis is impacting low-income communities, communities of color, and older adults disproportionally. This should not be unexpected, as these are the populations with long-standing disparities in health and health care. The impact on low income and African American communities in Buffalo specifically, is evident.[8] COVID-19 has impacted our entire region of WNY, but as shown in the data, certain areas have been hit harder than others.

Within Buffalo, the zip codes with the highest number of positive cases also have populations that are majority people of color; zip codes 14209, 14208, 14215, 14207, and 14211.[9] There are four nursing homes in these zip codes. One is owned by the county and is currently CMS overall rated 4-star (above average quality). The other three are for-profit owned, and are all CMS overall rated 1-star (much below average quality).[10] Of these three, two received Immediate Jeopardy deficiencies for violations of infection control and prevention standards.[11] Residents should not be subjected to poor care simply because of their zip code and historic disparities.

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[6] *See* Li, Yue, Temkin-Greener, Helen, Shaun, Gao, Cau, Xueya. "COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates. "*Journal of the American Geriatrics Society*, July 2020. Accessed at https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.16689 ;*see also* "The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes." *New York Times*, May 21, 2020, https://www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html ; Shapiro et al. "In New York Nursing Homes, Death Comes To Facilities With More People Of Color." *National Public Radio*, April 22, 2020, https://www.npr.org/2020/04/22/841463120/in-new-york-nursing-homes-death-comes-to-facilities-with-more-people-of-color.

[7] *See* Artiga, Samantha, Orgera, Kendal, and Pham,Olivia. "Disparities in Health and Health Care: Five Key Questions and Answers," *Kaiser Family* Foundation, March 4, 2020 https://www.kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/ .

[8] PPG: Mapping COVID-19 Cases and Other Local Data, May 19, 2020 https://ppgbuffalo.org/news-and-events/news/article:05-19-2020-12-00am-diving-into-the-data-covid-19-cases-and-other-local-data/.

[9] *Id.*

[10] CMS Nursing Home Compare Provider Dataset, https://data.medicare.gov/Nursing-Home-Compare/Provider-Info/4pq5-n9py/data , accessed August 6, 2020.

[11] Buffalo Center for Rehabilitation and Nursing, survey completed April 30, 2020, accessible at https://profiles.health.ny.gov/nursing_home/view/150794#inspections ; Humboldt House Rehabilitation and Nursing Center, survey completed April 26, 2020, accessible at https://profiles.health.ny.gov/nursing_home/view/150361#inspections.

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DOH currently does not require nursing homes (or adult care facilities) to report demographic data, such as race, ethnicity, or disability. **DOH needs to collect demographic data to drive public policy in the right direction.**

2. *Staffing*

As detailed on page 12, the problem of insufficient staffing is not new. Nursing homes are required by federal regulation to post on a daily basis, at the beginning of each shift, the total number and actual hours worked by Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Certified Nurse Assistants (CNAs) and the resident census. The posting of this information must also be "in a prominent place readily accessible to residents and visitors."[12] While it is true the facility must make this data available to the public upon request, why should residents, families and their representatives be forced to be ask?

Nursing homes (and adult care facilities) are required to post their formal visitation plan to their public website.[13] Nursing homes are also required to post a copy of their admissions agreement on their public website.[14] Long-term care facilities should also be required to post their daily staffing numbers on their public websites by shift. While CMS does publish daily staffing information through the Payroll Based Journal database, this is reported quarterly, and does not break down the information by shift.[15] Residents and families deserve to know the numbers of nurse staffing by shift in a proactive manner. When a resident or family entrusts their care in a facility, they should not be forced to find out that the facility was short-staffed when, or in some cases, months after, an incident occurs.

Lastly, visitation is dependent on staffing availability.[16] While limited visitation is dependent on other factors, the short-staffing of a facility must not be one of them. Public information on staffing by shift is important. **Require long-term care facilities post their nurse staffing information by shift on their public websites.**

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[12] 42 C.F.R. § 483.35(g).
[13] NYS DOH, *Health Advisory: Skilled Nursing Facility Visitation*, July 10, 2020, https://coronavirus.health.ny.gov/system/files/documents/2020/07/health-advisory_nursing-home-visitation_final-7.pdf.
[14] NY Pub Health § 2803-y.
[15] *See* Staffing Data Submission Payroll Based Journal (PBJ), for more information https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.
[16] NYS DOH, *Health Advisory: Skilled Nursing Facility Visitation*, July 10, 2020, https://coronavirus.health.ny.gov/system/files/documents/2020/07/health-advisory_nursing-home-visitation_final-7.pdf.

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3. *Medical Loss Ratio*

Research has shown that overall quality of care is lower in for-profit nursing homes compared to not-for profit nursing homes. In comparing care in for-profit to non-profit, a study found that residents in for-profit nursing homes were almost twice as likely to experience adverse health problems as a result of substandard care. Part of the problem, the study found, was that administrators in for-profit homes were paid more compared to non-profit nursing homes.[17] During the pandemic, a preliminary analysis of found a higher incidence of COVID-19 cases in for-profit nursing homes compared with non-profit.[18] A case study released August 2020 further supports the preliminary analysis, and found that residents at private equity nursing homes had higher COVID-19 infection and fatality rates.[19]

While residing in a non-profit home does not automatically mean a resident will receive quality care and support services, non-profit nursing homes are required to account for how the funds are spent and fulfill their obligations under their missions. For-profit nursing homes are not required to publically account for their finances and how the monies are spent. In addition, as detailed in The New York Times, related-party transactions are common, and enable nursing homes to outsource goods and services to other companies in which they have ownership interest.[20]

During the pandemic, the U.S. Department of Health & Human Services distributed $4.9 billion in COVID-19 relief funds directly to skilled nursing facilities, with each nursing home receiving a payment of $50,000 plus an additional $2,500 per bed.[21] Nursing homes in Erie and Niagara

[17] Friedman L, Avila S, Friedman D, Meltzer W. Association between type of residence and clinical signs of neglect in older adults. [published online October 9, 2018]. *Gerontology*. doi: 10.1159/000492029.
[18]Amirkhanyan, Anna, McCrea, Austin, Meier, Kenneth. “Why some nursing homes are better than others at protecting residents and staff from COVID-19.” *The Conversation*, June 10 ,2020, https://theconversation.com/why-some-nursing-homes-are-better-than-others-at-protecting-residents-and-staff-from-covid-19-138703.
[19] Americans for Financial Reform Education Fund. “The Deadly Combination of Private Equity and Nurisng Homes During a Pandemic: New Jersey Case Study of Coronavirus at Private Equity Nursing Homes.”, August 2020 https://ourfinancialsecurity.org/wp-content/uploads/2020/08/AFREF-NJ-Private-Equity-Nursing-Homes-Covid.pdf.
[20] Rau, Jordan. “Care Suffers as More Nursing Homes Feed Money Into Corporate Webs.” *The New York Times*, Jan. 2, 2018https://www.nytimes.com/2018/01/02/business/nursing-homes-care-corporate.html.
[21] Spanko, Alex. “HHS Releases $4.9B in COVID-19 Relief for Skilled Nursing Facilities.” *Skilled Nursing News*, May 22, 2020, https://skillednursingnews.com/2020/05/hhs-releases-4-9b-in-covid-19-relief-for-skilled-nursing-facilities/.

counties received $19.6 million of these fund.[22] $175 billion through the Provider Relief Fund which directed federal stimulus payments to nursing homes, hospitals and other health care providers went to facilities previously accused of misusing federal funds.[23]

A Medical Loss Ratio (MLR) is one way to ensure there is accountability on how private and taxpayer supported funds like Medicaid, are spent.[24] The federal government, under the Affordable Care Act, adopted an MLR that required health insurance companies spend a percentage of premiums on health care services. While this was done at the federal level and for health insurance companies, the NYS Legislature should consider passing similar legislation at the state level that would place accountability on nursing home operators to ensure public Medicaid dollars are not wasted on administrative costs, profits, and other expenses that do not support the recruitment, retention, and training of staff.

Nursing homes are paid by Medicaid (and Medicare) to provide care and services to meet the needs of the residents. However, there is little accountability. This needs to change. The NYS Legislature does not need to wait for Congress, and can act by passing legislation that ensures accountability of how funds are spent by nursing homes in NYS.

4. *Inspection Reports*

Nursing home and adult care facility operators are required to make the most recent results of DOH inspections (statement of deficiencies), publically available onsite at the facility, and by request. In addition, for nursing homes, both CMS and DOH publish the inspection results on their websites, Nursing Home Compare and Nursing Home Profiles, respectively.[25] While these requirements do afford for some transparency as to the quality of care and services at the facility, the requirements do not go far enough for the following reasons:

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[22] Pasciak, Mary. "Nursing homes in Erie, Niagara get emergency federal funding." *The Buffalo News,* May 27, 2020, updated June 23, 2020 https://buffalonews.com/business/local/nursing-homes-in-erie-niagara-get-emergency-federal-funding/article_cd9669b3-6eaa-5bb8-bc64-5ee5849f473b.html.

[23] Cenziper, Debbie, Jacobs, Joel, Mulcahy, Shawn. "Nursing home companies accused of misusing federal money received hundreds of millions of dollars in pandemic relief." *The Washington Post*, Aug. 4, 2020, https://www.washingtonpost.com/business/2020/08/04/nursing-home-companies-accused-misusing-federal-money-received-hundreds-millions-dollars-pandemic-relief/.

[24] Harrington, Charlene, Ross, Leslie, Mukamel, Dana, Rosenau, Pauline. "Improving the Financial Accountability of Nursing Facilities." *The Kaiser Commission on Medicaid and the Uninsured*, June 2013. https://www.kff.org/wp-content/uploads/2013/06/8455-improving-the-financial-accountability-of-nursing-facilities.pdf.

[25] https://www.medicare.gov/nursinghomecompare/search.html ; https://profiles.health.ny.gov/nursing_home/index

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- Residents, their families, and representatives do not always know when DOH has conducted an inspection. How can they know to ask for recent inspection results if they do not know it happened?

- During the pandemic, families and other visitors have been physically banned from entering the facility and cannot view the posted statements of deficiencies.

- It takes months for inspections to be published on the CMS and DOH websites.

Timely information is essential to resident well-being. For example, a nursing home in the City of Buffalo was cited at the Immediate Jeopardy level on April 26, 2020, when DOH surveyors observed facility staff entering and exiting resident rooms diagnosed with COVID-19 and then entering the rooms of residents without a COVID-19 diagnosis; CNAs did not remove their gowns or gloves and did not complete appropriate hand hygiene; and CNAs were unable to identify residents who were on Contact and Droplet Precautions for COVID-19. The administrator of the facility was informed of the IJ status on April 23, 2020.[26] Unless a family member or representative knew the survey occurred, how could they have known their loved one was in a facility that was in Immediate Jeopardy status? The statement of deficiencies was not available on the DOH nursing home profiles website until the June data update.

Adult care facility residents, their families, and representatives face an additional barrier. While DOH has an Adult Care Facility Profiles website, unlike nursing homes, DOH does not publish the written statements of deficiencies. Instead, DOH publishes the regulatory citation of the deficiency.[27] This is not useful and does nothing to inform the public.

Nursing homes and adult care facilities should be required to inform every resident and family member about the results of the inspections and publically post the written statement of deficiencies on the facility's public website. If deficiencies were found, facilities should fully explain to residents and families the measures that are being taken to rectify the deficiencies, regardless whether the facility is disputing the deficiency with DOH. If any residents were directly impacted by the violations, facilities must be required to contact family of those residents, explain themselves, and what is being done to protect their loved ones. The NYS Legislature can pass legislation that requires public posting of statements of deficiencies and other communications/notifications.

[26] Humboldt House Rehabilitation and Nursing Center, survey completed April 26, 2020, accessible at https://profiles.health.ny.gov/nursing_home/view/150361#inspections.
[27] https://profiles.health.ny.gov/acf

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5. *Certificate of Need*

Hospital and related services including health-related service of the highest quality, efficiently provided and properly utilized at a reasonable cost, are of vital concern to the public health.[28] In NYS, no nursing home "shall be established except with the written approval of the DOH Public Health and Health Planning Council (PHHPC)."[29] The PHHPC consists of the DOH commissioner and 24 members appointed by the governor with the advice and consent of the senate.[30] In carrying out its powers and duties, PHHPC takes into account the impact of its actions and recommendations on the quality, accessibility, efficiency and cost-effectiveness of health care throughout the state.[31]

When considering an application to operate a nursing home, PHHPC must be satisfied as to: (a) the public need for the existence of the nursing home at the time and place and under the circumstances proposed; (b) the character, competence and standing in the community of the proposed operators; (c) the financial resources of the proposed institution and its sources of future revenues; and (d) such other matters as it shall deem pertinent.[32] In reviewing a proposed nursing home operator, PHHPC reviews the applicant's ten year history for other facilities owned by the applicant. After that review, the PHHPC cannot recommend approval for the new operation unless it can affirmatively find by substantial evidence as to each facility owned by the operator that a substantially consistent high level of care is being or was being rendered in each facility.[33]

It is our opinion that DOH/PHHPC fails to perform its mandated duty in its process of reviewing and approving changes, through the Certificate of Need (CON) process, in approving nursing home operators. DOH/PHHPC have made certain approvals that ignore serious quality of care violations by operators.[34] Too often, struggling nursing homes are purchased by operators (owners) who already run other subpar facilities.

[28] NY Pub Health § 2800.
[29] NY Pub Health § 2801 defines an Art. 28 "hospital" as a "facility or institution" and specifically includes a "nursing home." PHL § 2801-A sets the operator approval requirements.
[30] NY Pub Health § 220.
[31] NY Pub Health § 224-b.
[32] NY Pub Health § 2801-a(3).
[33] *Id*
[34] For example, see our Profile on Emerald South, available at: https://elderjusticeny.org/emerald-south-profile-of-a-nursing-home/.

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It appears there is an unwritten rule that it is better for a struggling nursing home to be kept open and operated by a different operator with a poor history, than to close it.[35] While the closure of nursing homes should not be done without thought, people must not be subjected to abuse and neglect because no other operator will take on the challenge. In addition, prospective buyers are allowed by DOH to enter into management contracts with the current operator, often in advance of when the prospective buyer submits its CON application for approval.

Furthermore, while PHHPC does make its meetings public, and affords the public opportunity to submit comment, it is meaningless. For example, there is no notice sent to current residents and their families about an upcoming meeting that will decide who will formally take over operations, and it is through meeting materials, that the public is informed what CON applications are being discussed. These meeting materials are not publically posted until a week or less before the meeting. How can interested parties, residents, family, and representatives, meaningfully participate if they are not afforded the opportunity to do so?

We recommend the following legislative actions to increase transparency, which in turn allow for the public to meaningfully participate in the process:

- When an operator is seeking to sell, require that operator to send written notice to all residents, their families, and representatives, and the NYS LTCOP.

- Require public notice of an ownership change application within one month of DOH receipt of the application. Notice shall be sent to residents, their families and representatives, and the NYS LTCOP. Such notice shall provide clear instructions on how to submit public comment.

- Require prior to any CON approval that:
  - o All residents are afforded the opportunity of a discharge plan to the community or other location of their choice.
  - o The proposed operator must develop a written plan of action, in consult with residents, their families, and representatives, and LTCOP, on what will be done to improve the quality of care and life for the residents. If, the CON is approved, require the written plan

[35] For example, when Emerald South was closed, approximately 35 of the facility's 64 residents of the residents were moved to Emerald North, without regards to their rights and were not provided the opportunity to return to the community, a lower level of care, or a better quality nursing home. *See,* Michel, Lou. "Emerald South nursing home officially closed." *The Buffalo News*, January 4, 2020, https://buffalonews.com/news/local/emerald-south-nursing-home-officially-closed/article_9c0b18cd-b1c8-502f-bfba-cbd75290bf93.html *See also,* CON Project # 182272-E document: the receiver turned buyer of the former Emerald North, the majority of their facilities were one-star health rated and they rely on contract staff.

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of action be published on the nursing home's website, and ensure compliance with the written plan of action by an independent quality monitor.

- Require, when a current operator contracts with an outside entity (who is usually the prospective buyer) to manage and operate the nursing home under the current operator's license, that the current operator and contracted entity issue written notification about the contract and where to address concerns, to residents, their family and representatives, and the NYS LTCOP.

II. Harmful Impact on Resident Rights and Care: COVID-19 Era Policies and Longstanding Challenges

In making any decision or implementing policy to protect the public's health, the benefits and risks of that decision or policy must be weighed. However, as stated in the above section, transparency is lacking and NYS, in part through the actions (inactions) of DOH, has lost its trust in ensuring residents in long-term care settings are protected not only from COVID-19, but from indignities, abuse, neglect, and other harms.

Throughout the pandemic, guidance has been issued by multiple sources: CMS, CDC, NYS Governor Andrew M. Cuomo, and DOH. However, there was no one place for residents, their families, and others to view the guidance. CELJ has endeavored to create a comprehensive guide of the federal and state regulations and guidance released on the topic of long-term care facilities during the pandemic. The goal of this guide was to create a useful tool for advocacy efforts directly related to issues in long-term care facilities on the topic of COVID-19 as well as to create a more complete overall picture of the ways that federal and state guidance have impacted resident's lives. The guide contains a timeline listing all executive orders, regulations, legislation, and other Federal and State guidance issued to long-term care facilities on the topic of COVID as well as an exploration of that guidance by subject matter. The guide is attached to this testimony as an addendum and can be found online at: https://elderjusticeny.org/wp-content/uploads/2020/06/SNF-and-ACF-Guidance-Timeline-Aug-6-V-1.04.pdf.

A. Staffing

The problem of insufficient staffing and the harm that results to nursing home residents is nothing new.[36] As stated in our public testimony before members of DOH on September 20, 2019,

[36] For example, see: NYS Office of the Attorney General Medicaid Fraud Control Unit. *Staffing Levels in New York Nursing Homes: Important Information for Making Choices*," January 2006. https://ag.ny.gov/sites/default/files/press-releases/archived/final.pdf

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and detailed in our written comment for the DOH Safe Staffing Study, low staffing and substandard care are a problem, accountability of nursing home providers is lacking and current enforcement efforts are not effective.[37] For example, Safire Rehabilitation and Nursing of the Southtowns, the facility highlighted on our September 20, 2019 testimony, has continually reported it is short on nursing staff to CMS.[38] How are the residents' needs being met? What are DOH and the operator doing to address this?

Numerous studies show higher nurse staffing improves the quality of care and life of nursing home residents. For example, higher Registered Nurse (RN) staffing levels are associated with fewer pressure ulcers, decreased infections, improved activities of daily living, less dehydration, and weight loss, and less inappropriate use of antipsychotics. In addition, higher nurse staffing levels reduce emergency room use and re-hospitalizations.[39] **Safe staffing matters and initial research into COVID-19 and its impact on nursing homes shows that nursing homes with higher RN staffing had lower deaths from COVID-19.**[40]

<u>NYS does not have minimum staffing levels in nursing homes.</u> Instead, NYS follows the federal requirement that nursing homes have "sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment."[41]

The "sufficient" standard is rarely fully enforced by NYS nor is it followed by nursing homes. NYS, based on the most recently available public data, averages 3.40 total care staff hours per resident

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[37] *See* https://elderjusticeny.org/ny-state-nursing-homes-staffing-study/; and https://elderjusticeny.org/celj-staffing-study-written-comments/.

[38] CMS. COVID-19 Nursing Home Data, https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg/ last accessed Aug. 1, 2020.

[39] *See* Dellefield ME, Castle NG, McGilton KS, Spilsbury K. The relationship between registered nurses and nursing home quality: an integrative review (2008-2014).*Nurs Econ*. 2015;33:95-108, 116; Castle NG, Anderson RA. Caregiver staffing in nursing homes and their influence on quality of care. *Med Care*. 2011;49:545-552.; Horn SD, Buerhaus P, Bergstrom N, Smout RJ. RN staffing time and outcomes of long-stay nursing home residents: pressure ulcers and other adverse outcomes are less likely as RNs spend; Simmons SF, Schnelle JF. Individualized feeding assistance care for nursing home residents: staffing requirements to implement two interventions. *J Gerontol A Biol Sci Med Sci*. 2004;59:M966-M973.

[40] Li, Yue, Temkin-Greener, Helen, Shaun, Gao, Cau, Xueya.. "COVID-19 Infections and Deaths among Connecticut Nursing Home Residents: Facility Correlates. "*Journal of the American Geriatrics Society*, July 2020. Accessed at https://onlinelibrary.wiley.com/doi/full/10.1111/jgs.16689.

[41] 42 C.F.R. § 483.35.

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per day, placing NYS 26 out of 50 states plus DC. NYS' averages 0.46 RN care hours per resident per day, placing NYS 31 out of 50 states plus DC.[42] **How many lives could have been saved in NYS nursing homes if they met 4.1 total care staff hours per resident per day, and 0.75 RN care hours per resident per day recommended by the 2001 federal study?**

The Safe Staffing for Quality Care Act has existed in various forms since the late 1990s.[43] On June 22, 2018, NYS Governor Andrew M. Cuomo stated he would "introduce legislation allowing DOH to set safe staffing levels by regulation as legislative solutions have not been forthcoming."[44] Instead however, the Governor pushed for a workgroup, and in 2019 the legislature passed legislation requiring DOH conduct a staffing study. This study was supposed to be issued at the end of 2019 and it is our understanding DOH is going to address it August 14, 2020.

It is our hope that this report supports the implementation of safe minimum staffing levels in nursing homes, as stated under the Safe Staffing for Quality Care Act, and does not bow to industry pressure who falsely claim the workforce does not exist or it is too costly. We disagree with the nursing home industry's assertion. Nursing homes make a legal and moral promise to each resident they chose to admit to provide safe and quality care. While the state can implement policy that helps boost the workforce, the responsibility to recruit, retain, and properly train staff rests with the nursing home.

B. Visitors

NYS Governor Andrew M. Cuomo announced a ban on visitors to nursing homes, on March 12, 2020, which was put into effect March 13, 2020.[45] While restricted visitation at the time was to protect residents from COVID-19, the implementation of the visitation ban by the DOH, and the differences between COVID-19 guidance released at the state and federal levels, has caused confusion and eroded resident rights in long-term care facilities.

The impact of the visitation ban for residents was immediate and severe. It cut off residents from the outside world and oftentimes from vital sources of support and services. Without in-person access, families, loved ones, and advocates lost insight into the daily condition of those residents. Even worse, residents without family supports lost access to advocates who sometimes fill that

[42] CMS. PBJ Daily Nurse Staffing CY 2019Q4, accessed at https://data.cms.gov/Special-Programs-Initiatives-Long-Term-Care-Facili/PBJ-Daily-Non-Nurse-Staffing-CY-2019Q4/aif9-utfe.
[43] A2954(Gottfried)/S1032(Rivera) Safe Staffing For Quality Care Act.
[44] Statement from New York State Governor Andrew M. Cuomo, June 22, 2018, https://www.governor.ny.gov/news/statement-governor-andrew-m-cuomo-190.
[45] New York State. Department of Health, *Health Advisory: COVID-19 Cases in Nursing Homes and Adult Care Facilities*, March 13, 2020, https://coronavirus.health.ny.gov/system/files/documents/2020/03/acfguidance.pdf.

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role such as LTCOP. During this time, we were notified by family members who were not contacted by their loved ones nursing home, and had a family member who was not notified of their mother's death by her facility until calling the facility ten days after she had passed.[46]

DOH did little to alleviate the challenges caused by lack of communication. DOH did not issue explicit guidance to long-term care facilities to follow that ensured family and advocate communications during the pandemic. Instead, DOH issued "best practices," that encouraged but did not require detailed communication with families and advocates.[47] We have fielded numerous calls from concerned loved ones simply wanting to know the condition of their family member. In one such tragic case locally, family were left to file a complaint to allow the DOH to determine if their loved one had received adequate assistance during meals prior being admitted to a local hospital at a weight of 110 pounds. The resident passed away shortly after being admitted to the hospital, and after having lost as much as 45 pounds within as little as 46 days at her nursing home.[48]

In its reopening requirements, DOH has left long-term care facilities to decide themselves if they want to reopen to visitation after meeting the requirements to do so.[49] Further complicating the implementation of the visitation ban, DOH has not consistently echoed federal guidance for reopening. For example, in the guidance to reopening nursing homes for visitation, DOH matched the CMS and CDC guidance that a facility first be free from COVID-19 for at least 28 days. It fails however, to pass along a broader understanding of exceptions to the visitation ban for, "compassionate care situations," outlined in the same guidance from CMS that requires those 28 days.[50]

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[46] Spina, Matthew. "Son finally learns where nursing home sent mother's body." *Buffalo News*, 22 Apr 2020. https://buffalonews.com/news/local/son-finally-learns-where-nursing-home-sent-mothers-body/article_2fa00f84-cc5e-557a-9965-875c256080c6.html.

[47] New York State. Department of Health. *Guidance for Resident and Family Communication in Adult Care Facilities and Nursing homes*. Department of Health. 19 Apr 2020. https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh-_covid_acf-nh_communicationpractices_041920.pdf.

[48] Michel, Lou. "5,000 nursing home investigations delayed, thanks to Covid-19." *The Buffalo News*, 17 Jul 2020. https://buffalonews.com/news/state-and-regional/5-000-nursing-home-investigations-delayed-thanks-to-covid-19/article_abaa7896-c205-11ea-8c7b-4f2c25860c00.html.

[49] New York State. Department of Health. *Health Advisory: Skilled Nursing Facility Visitation*. Department of Health. 10 Jul 2020. https://coronavirus.health.ny.gov/system/files/documents/2020/07/health-advisory_nursing-home-visitation_final-7.pdf.

[50] United States. Centers for Medicare and Medicaid Services. *Frequently Asked Questions (FAQs) on Nursing Home Visitation*. Centers for Medicare and Medicaid Services. 23 Jun 2020. https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf.

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DOH states it is following federal guidance to establish a COVID-19 free environment for at least 28 days. Why is it not following that same guidance that explicitly allows compassionate exceptions to the visitation ban? The aforementioned guidance from CMS states that compassionate care situations do not exclusively refer to end-of-life situations, and provides as an example a resident who recently was admitted to a nursing home who is dealing with a sudden lack of family and encourages facilities to consult with state leadership, families, and ombudsman, to help decide if a compassionate care visit is warranted. **Not only has DOH failed to explicitly endorse broader interpretations of compassionate care, it has failed to enforce even the strictest interpretation consistently.** This has led to unthinkable scenarios.[51]

Limitations on nursing home and adult care visitation may be necessary to protect resident wellbeing during the ongoing COVID-19 outbreak, however, DOH has not thus far implemented these limitations while taking into account the needs of stakeholders like residents and family members. (Although, DOH is in communications with the industry trade associations.)

In <u>making any decision or implementing policy to protect the health of the public, for example, long-term care residents, the benefits and the risks of that policy/decision must be weighed.</u> In this case, taking into account the benefits visitors provide: such as combating social isolation and providing the necessary care services understaffed nursing homes are unable to provide. Actions made by DOH have caused irreparable harm to many residents in long-term care who have suffered and died without access to vital supports, advocates, and family. DOH's approach does not consider the physical and psychological needs of residents, is untenable going forward and will undoubtedly give way to more unforeseen and unnecessary violations of resident rights. We encourage NYS to review and adopt the Long Term Care Community Coalition's Blue Print for visitation as guidance in protecting the health and safety of residents in long-term care settings.[52]

C. Involuntary Discharge/Transfer

Involuntary discharges and transfers (discharges) from nursing homes have been a problem prior to the pandemic. For example, we represented a client who was issued a discharge notice to a shelter in the City of Buffalo. During representation, our client informed us she was from NYC area and was in Buffalo because her former nursing home in NYC put her into a cab and sent her

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[51] For example, see Michel, Lou. "Cuomo administration won't say when nursing home visits will resume." *Buffalo News*, 1 Jun 2020. https://buffalonews.com/business/local/cuomo-administration-wont-say-when-nursing-home-visits-will-resume/article_9018d3f0-99fe-5f88-8fd1-6f0ed01b5f56.html.

[52] Long Term Care Community Coalition. *Let Our People In: A Blueprint for Restoring Residents' Rights to Visitation and Care.* https://nursinghome411.org/wp-content/uploads/2020/06/LTCCC-Statement-Let-Our-People-In.pdf.

to their sister nursing home in Buffalo. The Buffalo nursing home then proceeded to try to discharge her to a shelter in Buffalo.

At the start of the pandemic, we and other advocates were seeing an increase in involuntary discharges to shelters and office buildings like the Local Department of Social Services. On March 20, 2020, we and other organizations wrote to DOH Commissioner Dr. Howard Zucker, requesting DOH place a moratorium on involuntary discharges in the interest of public safety.

As stated in the letter, a significant portion of involuntary discharges were to homeless shelters, which pose high public health risk due to close living quarters. Moreover, we questioned how individuals' medical needs would be met in that environment. In addition, with the suspension of visitation, LTCOP could not access residents who have received discharge notices to advise them of their right to appeal the discharge and provide assistance with the process. Reaching residents by telephone is difficult to impossible. **We never received a response from DOH during the pandemic. Due to DOH's inaction, many residents were stripped of their right to appeal their discharge and suffered harm.**[53]

Examples out of WNY during the pandemic:

- Client was given a 30 day notice of discharge for non-payment with proposed discharge location to the City Mission or the Department of Social Services Homeless Unit. This notice was not sent to LTCOP as required by federal law.[54] This client was already a client of CELJ prior to the notice being issued. Thankfully client called our office as the facility was threatening to discharge him prior to the 30 days. With the involvement of LTCOP and DOH we were able to prevent the involuntary discharge.
    - Since this case, we have been made aware of other residents being involuntary discharged to shelters, without opportunity for LTCOP or other advocate involvement.
- CELJ was contacted by client's guardian. Client was in facility A, fell, was sent to hospital, then sent to facility B (same operator group as facility A). Facility B issued notice of discharge for client to be transferred to facility A. Guardian appealed the discharge, but Facility B transferred client to Facility A illegally after the appeal was filed.[55] Due to transfer trauma

[53] Silver-Greenberg, Jessica, and Harris, Amy Julia. 'They Just Dumped Him Like Trash': Nursing Homes Evict Vulnerable Residents." *The New York Times,* June 21, 2020, https://www.nytimes.com/2020/06/21/business/nursing-homes-evictions-discharges-coronavirus.html.
[54] 42 C.F.R. § 483.15(c)(3)(i).
[55] It is against federal regulation to transfer a resident once an appeal has been filed. 42 C.F.R. § 483.15(c)(1)(ii) states: "The facility may not transfer or discharge the resident while the appeal is pending, pursuant to §

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and other concerns, the Guardian did not want to appeal for a return to Facility B. CELJ filed a complaint with DOH that to date has not been resolved.

In addition to ignoring the concerns of advocates, on May 11, 2020, DOH issued guidance to hospital administrators which in part stated "no hospital shall discharge a patient to a NH or ACF unless the facility administrator has first certified that they are able to provide that patient with adequate care."[56] While that directive made sense, and it was always the case that nursing homes or adult care facilities should only admit patients they can provide 'adequate care' to, we were concerned that nursing homes would use this as an opportunity to 'dump' residents who were considered 'difficult' or 'challenging' at hospitals. Shortly after that directive, a nursing home in Niagara County refused to readmit a resident, who they frequently sent to hospitals and refused to readmit. In refusing to readmit the resident, the facility cited the May 11, 2020 guidance. We represented this resident through his Guardian at a hearing, and the Administrative Law Judge (ALJ) held in our client's favor.

While we know DOH is responding to nursing home involuntary discharge appeals and hearings are being scheduled, DOH must take a proactive stance and actively investigate this issue. Responding retroactively is not working. When patterns are raised, DOH must investigate the entire facility and operator chain. In addition, DOH must consider all nursing home involuntary discharge appeals as complaints, and issue deficiencies for violations of the federal and state discharge regulations. It currently does not and as a result, residents' rights are being trampled.

D. Infection Control

Infection control is an issue in NYS nursing homes and nation-wide.[57] For example, more than 46 nursing homes in Erie and Niagara counties were cited by DOH for violating infection control standards over the past four years.[58] Right before the pandemic, a nursing home in Rome, NY

431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose."

[56] New York State Department of Health. *Directive: Hospital Discharges and Admissions to Nursing Homes and Adult Care Facilities.* May 11, 2020. https://www.health.ny.gov/professionals/hospital_administrator/letters/2020/docs/dal_20-14_covid_required_testing.pdf

[57] U.S. Government accountability Office, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic¸* May 20, 2020 https://www.gao.gov/assets/710/707069.pdf.

[58] Pasciak, Mary, Michel, Lou. "Even before COVID-19, infection control was an issue at area nursing homes." *The Buffalo News*, May 24, 2020, https://buffalonews.com/news/local/even-before-covid-19-infection-control-was-an-issue-at-area-nursing-homes/article_90ec5d4c-43ff-5a5d-ab1b-f440492a7001.html .

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was cited because a member of the staff, who did not receive the influenza vaccine, was observed wearing a flu mask incorrectly in a resident care area.[59] If staff cannot follow the basic influenza protocol and wear a mask correctly, what hope was there for residents if COVID-19 entered the facility? This same nursing home was cited for an infection prevention and control deficiency a year prior for not performing proper hand hygiene.

In addition, three nursing homes in WNY, were cited at Immediate Jeopardy during the federally mandated Focused Infection Control survey. All three nursing homes, among other issues, were cited for staff entering and exiting the rooms of residents wearing the same PPE.[60]

Infection control in our nursing homes was an issue prior to the pandemic, and it continues to be during the pandemic. The time is now for NYS to do something about it and rise to the task in passing legislation that codifies new federal requirements.[61]

The federal nursing home regulations were updated for the first time in almost 25 years in October 2016. The reason behind the major updates was to reflect the advances in the practice of service delivery and safety, and implement sections of the Affordable Care Act. Specifically to infection control, the new regulations required every nursing home have an infection prevention and control program that includes a system to prevent, identify, report, investigate, and control both infections and communicable diseases for residents and all those working and visiting the nursing home.[62]

Efforts of the nursing home lobby to rollback resident rights protections began in December 2016 when they submitted a letter to then President-Elect Donald Trump to repeal and replace the regulations that became effective in November 2016. In March 2017, the nursing home lobby requested CMS revise the survey and certification process, specifically to Civil Monetary Penalties.[63] On infection control, in response to the nursing home lobby's outcries, CMS issued

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[59]The Grand Rehabilitation and Nursing at Rome, survey completed January 23, 2020, accessible at https://profiles.health.ny.gov/nursing_home/view/150478#inspections .

[60] Buffalo Center for Rehabilitation and Nursing, survey completed April 30, 2020, accessible at https://profiles.health.ny.gov/nursing_home/view/150794#inspections ; Humboldt House Rehabilitation and Nursing Center, survey completed April 26, 2020, accessible at https://profiles.health.ny.gov/nursing_home/view/150361#inspections l The Villages of Orleans Health & Rehabilitation Centers Olean Campus, survey completed May 9, 2020, accessible through CMS Nursing Home Compare downloadable surveys post. As of Aug 9, 2020 is no on NYS nursing home profiles.

[61] It is our understanding DOH is proceeding with updating the NYS nursing home regulations to match the federal nursing home regulations. However we have yet to see any proposed rulemaking.

[62] 42 C.F.R. § 483.80

[63] Justice in Aging. "Fighting the Rollback of Nursing Home Protections., last accessed Aug 6, 2020 *https://www.justiceinaging.org/fighting-rollback-nursing-home-protections/*.

proposed rules on July 18, 2019 to eliminate/revise regulations it "identified as unnecessary, obsolete, or excessively burdensome."[64] As of August 1, 2020, CMS has not published its final rulemaking, nor have they indicated whether they will rescind the proposed rule that if published, would harm residents.

The original CMS rule (that was supposed to be in effect on November 28, 2019) required nursing homes have at least one staff member be designated as the infection preventionist (IP) who must be responsible for the facility's infection prevention and control program. CMS proposed to change the 'part time' requirement to 'sufficient' time and that the IP did not have to be a designated member of current staff. In its proposed rule, CMS acknowledged infection is the leading cause of morbidity and mortality among nursing home residents, yet sided with the nursing home lobby that these requirements were 'burdensome'.

We strongly disagreed with CMS' proposed reversal and urged CMS to strengthen the infection prevention and control requirements. Having a fully developed and implemented infection prevention and control program is essential to ensuring the safety of residents in the nursing home. The infection preventionist is central to this. As evidenced by countless examples during the pandemic, a fully functioning infection prevention and control program is key to ensuring the health and safety of long-term care residents and staff. **We urge the NYS Legislature to pass legislation that would require nursing homes have a full-time IP on staff**. Do not wait for Congress or CMS to act.

E. NYS Long Term Care Ombudsman Program

One longstanding challenge to resident rights that has been exacerbated by the pandemic is funding for the LTCOP. LTCOP is an advocate and resource for both older adults and persons with disabilities who live in long-term care facilities, such as nursing homes, assisted living, and board and care homes. The NYSLTCOP is administratively housed within the NYS Office for the Aging (NYSOFA) and is comprised of a small number of paid staff and a large corps of trained volunteers who visit the approximately 1,500 LTC facilities in the state.[65] LTCOP's primary function is to identify, investigate, and resolve complaints made by or on behalf of residents in those facilities. **LTCOP is often the only advocate for residents who have no family or other loved one to provide support.** For those who do have family or other advocates, the program connects them to resources and services they would not have otherwise known. LTCOP acts as an extra set of

[64] *Id.*

[65] New York City Comptroller, Scott M. Stringer, "Ombudsman Program amid COVID-19 Pandemic." June 17, 2020. https://comptroller.nyc.gov/newsroom/comptroller-stringer-investigation-reveals-chronic-underfunding-of-long-term-care-ombudsman-program-amid-covid-19-pandemic/. Press release.

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eyes and ears in our long-term care facilities; providing a voice for the voiceless and is an invaluable tool for ensuring that residents rights are upheld.

Despite playing a vital role in solidifying residents' rights, LTCOP has been chronically underfunded. In 2017 NYS spent below $7.34 per resident bed on funding for its LTCOP while all other states spent $14.70.[66] The institute of Medicine recommends one full-time paid Ombudsman Coordinator for every 2,000 long-term care facility beds.[67] Yet, only 37.6 FTEs, about half the recommended, were employed at the regional programs during FFY ending September 30, 2018. NYS ranked 39th when compared to other states on paid staff per 2,000 beds.[68]

The understaffing of FTEs complicates efforts to recruit and train volunteers. As of January 2019, about 600 of the approximately 1,500 long-term care facilities in the state, about 40 percent, had an assigned volunteer ombudsman.[69] About 28 percent of facilities covered were not visited at least once by an ombudsman during the FFY ending September 30, 2018, and only 36 percent of facilities were visited at least quarterly.[70] This routine lack of adequate funding plays out directly in the lives of NYS's most vulnerable long-term care residents. As stated by the NYS Comptroller, "without...access to these important services, the most vulnerable residents may be reluctant to, or unable to, bring their concerns to someone who can advocate on their behalf."[71]

Funding to the NYS LTCOP needs to be increased to ensure LTCOP has the resources needed to fortify the free exercise of resident rights.

III. Survey and Enforcement

A. Survey and Enforcement Tools Must be Reviewed for Efficacy

The federal and state governments share responsibility for ensuring Medicare and Medicaid certified nursing homes are meeting the minimum conditions of participation in the Medicare

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[66] *Id.*
[67] Office of the New York State Comptroller. *Office for the Aging Long-Term Care Ombudsman Program.* No. 2018-S-48, 2018, https://www.osc.state.ny.us/sites/default/files/state-audits/documents/pdf/2019-10/sga-2020-18s48.pdf. Accessed 31 Jul. 2020.
[68] *Id.*
[69] *Id.*
[70] *Id.*
[71] *Id.*

and Medicaid programs set forth by federal regulation.[72] Under agreement with the U.S. Department of Health and Human Services, DOH is required to conduct surveys (inspections) to determine whether nursing homes are in compliance with federal regulations.[73] DOH is also required to review all nursing home complaint allegations and conduct a standard or abbreviated survey to investigate complaints of violations of the federal regulations.[74] If DOH identifies a deficiency, which is noncompliance with a federal regulation, DOH is responsible to determine the deficiency rating using scope and severity components outlined in regulation and CMS guidance.[75]

For nursing homes that DOH cite with Immediate Jeopardy and/or Substandard Quality of Care, or repeat deficiencies at the GG or harm levels, DOH recommends Federal remedies:

- Civil Money Penalty (CMP): State recommends the fine to CMS.
- State Monitoring (MON): State survey staff is onsite in the facility to monitor and oversee correction.
- Directed Plan of Correction (DPOC): A corrective action plan that is developed by the State or CMS, and requires a facility to take action within specified timeframes. In NYS, the facility is directed to determine the root cause of the deficiency, identify and implement steps to correct the problem, and evaluate whether corrective measures are successful.
- Directed In-Service (DI): State directs in-service training for staff, which must be provided by a consultant who is not affiliated with the facility.
- Denial of Payment for New Admissions (DoPNA): Facility is not paid for new Medicaid or Medicare residents until correction of deficiencies is achieved.[76]

Whether or not a facility is subject to CMPs, DoPNAs, or other actions, depends on DOH's ability to fully investigate, identify, and determine the scope and severity components of the deficiency. While the NYS Office of the State Comptroller, in February 2016 found that DOH met CMS's quality measures for conducting surveys in accordance with federal regulations, including the

[72] Social Security Act §§ 1864 and 1902
[73] 42 C.F.R. § 488 subpart E.
[74] 42 C.FR. § 488.08.
[75] 42 CFR § 488.404, and CMS State Operations Manual, Chapter 7-Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities. https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07pdf.pdf.
[76] *See* New York State Department of Health. Recommended Federal Remedies 9-1-2016 through 01/31/2020 https://health.ny.gov/facilities/nursing/federal_remedies_and_section_12_fines/.

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accurate assessment of the scope and severity of citations, we remain skeptical of DOH's ability to do so presently.[77]

For example, a nursing home in Cattaraugus County, was cited at "D", for a quality of care deficiency for critical errors in the care for one resident including: failure to monitor and correct fluid intake, transcription errors that led to incorrect medication dosage, and failure to monitor labs that were critically important for the resident. The resident experienced kidney failure and died.[78] We fail to see how a resident who died of kidney failure that was arguably related to the poor care practices at the nursing home to be "no harm with the potential for more than minimum harm."

Routine audits of DOH's ability to correctly identify deficiencies, and the scope and severities of those deficiencies must occur. Resident lives depend on it.

In 2018, the NYS Office of the State Comptroller issued a follow-up to the 2016 report, whereby DOH informed the NYS Office of the State Comptroller DOH implemented a Performance Monitoring Program (PMP) that is used by DOH to conduct greater oversight with the goal to:

- Increase program oversight over nursing homes with performance concerns throughout the State and across the Division;
- Improve the likelihood of successful and sustained nursing home corrective action implementation, thereby reducing the volume and frequency of repeat deficiencies; and
- Identify and share regional office best practice models across the regions.

According to the comptroller's report, at that time, 16 nursing homes were placed in the PMP, and 10 were removed because they implemented corrective actions.[79] The 2018 report leaves more questions than answers: what is the PMP, what nursing homes were in the PMP, does the PMP still exist and if so what nursing homes are on it? **CMS publishes a complete list of its Special Focus Facilities and facilities that are candidates. DOH must do the same with facilities in the PMP.**

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[77] New York State Office of the State Comptroller. Thomas P. DiNapoli. "Nursing Home Surveillance Department of Health." Report 2015-S-26, February 2016, https://www.osc.state.ny.us/sites/default/files/audits/2017-12/sga-2016-15s26.pdf.
[78] Salamanca Rehabilitation & Nursing Center, survey completed Aug. 2, 2019, accessible at https://profiles.health.ny.gov/nursing_home/view/150319#inspections.
[79] New York State Office of the State Comptroller. Thomas P. DiNapoli. Letter to Department of Health Commissioner, "Re: Nursing Home Surveillance" "Report 2017-F-12 March 8, 2018. https://www.osc.state.ny.us/sites/default/files/state-audits/documents/pdf/2019-01/sga-2018-17f12.pdf .

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Another review of DOH, this time by the U.S. Health and Human Services Office of Inspector General (OIG), found that DOH did not ensure nursing homes complied with CMS requirements for life safety and emergency preparedness and that DOH needs to improve its oversight of nursing homes' compliance.[80] OIG conducted on-site visits of 20 nursing homes and all 20 nursing homes had deficiencies related to life safety and emergency preparedness, with 219 areas of noncompliance. OIG attributed noncompliance to several contributing factors, specifically inadequate management oversight and staff turnover at the nursing homes.[81] OIG also found DOH did not check to see whether carbon monoxide detectors were installed in accordance with state law.[82] With respect to compliance with the requirement to have an emergency plan in place that must be updated at least annually, of the 20 nursing homes visited by OIG, 13 had 1 or more deficiencies related to their emergency plan. While it is difficult to predict a pandemic, the OIG report is concerning on a variety of levels, and shows nursing homes, prior to the pandemic, were not prepared to handle even environmental disasters.

During the pandemic, Governor Andrew M. Cuomo and DOH have stated that noncompliance with all DOH and CDC laws, regulations, directives and guidance could lead to $10,000 fines per violation, or operators to lose their license.[83] Have any nursing homes (or adult care facilities) been fined or had action taken to revoke (temporarily or permanently) their operating license? DOH has always had the ability to suspend or revoke the operating certificate of any nursing home or adult care facility. However, rarely does it proceed with such actions.

While it is best practice for residents and families to try to resolve complaints on their own, and utilize advocacy programs like LTCOP, when advocacy fails, it falls on DOH to ensure federal and NYS resident rights and protections are upheld. LTCOP is not the regulatory enforcement agency. That is the role of DOH and it is essential DOH does its job completely and accurately. The surveys are a central part of regulating nursing homes and the quality of care they provide to residents.

CMS, under the Trump Administration, has reduced accountability of nursing homes to residents and taxpayers by implementing policies that reduce the number of fines against a nursing home for serious health violations. For example, CMS shifted its fines from daily for every day of

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[80] Department of Health and Human Services Office of Inspector General. Joanne M. Chiedi."New York Should Improve Its Oversight of Selected Nursing Homes' Compliance with Federal Requirements for Life Safety and Emergency Preparedness." Aug 2019, https://oig.hhs.gov/oas/reports/region2/21701027.pdf.
[81] *Id.*
[82] N.Y. Exec. Law § 378.
[83] New York State Governor Andrew M. Cuomo. *Amid Ongoing COVID-19 Pandemic, Governor Cuomo Announces State Health Department Will Partner with Attorney General James to Investigate Nursing Home Violations*. April 23, 2020 https://www.governor.ny.gov/news/amid-ongoing-covid-19-pandemic-governor-cuomo-announces-state-health-department-will-partner; NYS E.O 202.18, and NYS E.O 202.19.

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noncompliance, to just one fine, no matter how long that violation exists.[84] The average fine dropped to $28,405 under the current administration, down from $31,260 in 2016.[85]

NYS Public Health Law, provides for fines (civil penalties) of up to two thousand dollars for every such violation, up to five thousand dollars for a subsequent violation of the same violation, and up to ten thousand dollars if the violation directly results in serious physical harm to any patient or patients.[86] **The paltry fines available under NYS Public Health Law are nothing more than a cost of doing business for nursing homes. The Legislature has the ability to pass legislation that increases fines under Public Health Law, and we urge the legislature to do so.**

B. NYS DOH Must Resume all Inspections

On March 4, 2020 CMS suspended all non-emergency inspections in health care facilities across the country and set priorities for inspections that included Immediate Jeopardy complaints, infection control complaints, and recertification surveys as high priority.[87] CMS took that further on March 20, 2020, when it halted all state inspections except for the focused infection control survey and complaints that are triaged at the immediate jeopardy level.[88] On June 1, 2020, CMS began allowing states to expand beyond current restricted survey prioritization once entering Phase 3 of CMS' nursing home re-opening guidance, issued on May 18, 2020, or earlier at the state's discretion.[89] CMS is allowing for states to perform the following surveys, in addition to the Focused Infection Control and Immediate Jeopardy complaints:

- Complaint investigations that are triaged as non-immediate jeopardy-high;
- Revisit surveys of any facility with removed IJ (but still out of compliance);

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[84] Center for Medicare Advocacy. "Enforcement Weakens as Civil Money Penalties Shift From Per Day to Per Instance," October 11, 2018, https://medicareadvocacy.org/enforcement-weakens-as-civil-money-penalties-shift-from-per-day-to-per-instance/.

[85] Rau, Jordan, "Nursing Home Fines Drop as Trump Administration Heeds Industry Complaints," The New York Times, March 12, 2019, accessed at https://khn.org/news/nursing-home-fines-drop-as-trump-administration-heeds-industry-complaints/.

[86] NY Pub Health § Art.12

[87] CMS, Memorandum to State Survey Agency Directors. *Suspension of Survey* Activities. Ref QSC-20-12-All. March 4, 2020, https://www.cms.gov/files/document/qso-20-12-all.pdf .

[88] CMS, Memorandum to State Survey Agency Directors. Prioritization of Survey Activities. Ref: QSO-20-20-All, https://www.cms.gov/files/document/qso-20-20-allpdf.pdf

[89] CMS, Memorandum to State Survey Agency Directors. *COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes*. Ref QSO-20-31-ALL. June 1, 2020, https://www.cms.gov/files/document/qso-20-31-all.pdf

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- Special Focus Facility and Special Focus Facility Candidate recertification surveys; and
- Facilities that have not had a recertification surveys in over 15 months.

CMS further explains that when States are determining the order of which to schedule more routine surveys, States should prioritize facilities based on those with a history of noncompliance, or allegations of noncompliance with:

- Abuse or neglect;
- Infection control;
- Violations of transfer or discharge requirements;
- Insufficient staffing or competency; or
- Other quality of care issues (i.e. falls, pressure ulcers, etc.)

In other words, CMS has allowed for, at NYS' discretion, expansion beyond Focused Infection Control and Immediate Jeopardy survey prioritizations since June 1, 2020. In WNY, we are seeing some complaint investigations, (as referenced in our oral testimony), but as of August 1, are unaware of any recertification surveys for any of WNY's Special Focus Facilities or Special Focus Facility Candidates.[90]

Approximately 5,000 nursing home complaint investigations have been delayed.[91] This is extremely concerning, since DOH is supposed to be the enforcement entity of the federal and state nursing home regulations. **DOH must do more to timely respond to all complaints and must resume full certification inspections**.

C. Disparities Between DOH Regional Offices and Inspections

Administratively, DOH divides NYS into nursing home regions.[92] The Metropolitan Area Regional Office is the largest, responsible for overseeing 339 nursing homes where an average of over

[90] Currently WNY does not have any nursing homes designated as a CMS Special Focus Facility. WNY has 2 nursing homes on the CMS Special Focus Facility Candidate list: Buffalo Community Healthcare Center (on list 37 months-note there was an operator change ~November 2018 and The Pines Healthcare & Rehab Centers Olean Campus (on list 15 months). *See* https://www.cms.gov/files/document/sff-posting-candidate-list-july-2020.pdf.
[91] Michel, Lou. "5,000 nursing home investigations delayed, thanks to COVID-19." *The Buffalo News*, July17, 2020, https://buffalonews.com/news/state-and-regional/5-000-nursing-home-investigations-delayed-thanks-to-covid-19/article_abaa7896-c205-11ea-8c7b-4f2c25860c00.html.
[92] See, New York State Department of Health, *Nursing Homes in New York State-Regional Offices,* https://www.health.ny.gov/facilities/nursing/regional_offices.htm.

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67,500 individuals reside.[93] The Capital District, Central New York and Western Regional Offices oversee the remaining 279 nursing homes, with about 36,500 residents.

We have noticed significant variation in the DOH survey results between the facilities assessed by the DOH in one of these regions, the Metropolitan Area Regional Offices and those in the rest of the state. The data posted on the CMS Nursing Home Compare website confirms the disparity.[94]

Where DOH surveyors find that federal minimum standards are not met by a nursing home, they should cite the facility for a deficiency and assess how serious that violation is, from the viewpoint of a resident. CMS summarizes the survey findings by a score reflecting the scope and severity of deficiencies cited and evaluated by DOH. More serious, widespread deficiencies receive more points. For example, any deficiency that DOH evaluates as "Immediate Jeopardy to resident health or safety" counts 50 points if isolated, or as much as 175 points if widespread. On the other end of the scale, any deficiency with a severity evaluated by DOH as "No actual harm with potential for minimal harm" counts as 0 points.[95]

The CMS 5-star rating system starts with a weighted average survey score of the last 3 cycles (roughly the last three years). On this important measure, the Metropolitan surveyors score its nursing homes too leniently. The table below compares the Metro Area survey scores with those of the rest of the state:

	Cycle 1 average	Cycle 2 average	Cycle 3 average	Weighted 3 cycle average
Metro	21.9	16.9	22.2	20.3
Rest of NYS	35.3	36.7	57.5	39.4

CMS and survey scores: CMS has delegated to DOH the responsibility to conduct periodic inspections of nursing homes. These health inspections are a primary device to determine

[93] The Metro office is responsible for the DOH surveys done in the 5 NYC counties (Bronx, Kings, New York, Queens and Richmond), Long Island (Nassau and Suffolk) and the lower Hudson Valley (Dutchess, Orange, Putnam, Rockland, Sullivan, Ulster and Westchester). *See,* https://www.health.ny.gov/facilities/cons/more_information/regional_offices.htm

[94] CMS Nursing Home Compare, Provider Dataset, https://data.medicare.gov/Nursing-Home-Compare/Provider-Info/4pq5-n9py Data updated as of April 1, 2020, visited May 28, 2020.

[95] CMS. Design for Nursing Home Compare, Five-Star Quality Rating System: Technical Users' Guide. July 2020, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf.

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whether the nursing homes are meeting federal Conditions of Participation, the minimum levels that nursing homes must maintain to qualify for Medicare and Medicaid payments. The surveys are a central part of regulating nursing homes and the quality of care they provide to residents.

CMS also relies on these surveys as the starting point for its 5-star rating system of nursing homes. The system is designed to help potential residents choose higher performing facilities over those that provide a lower quality of care. The rating system reviews three criteria to separate nursing homes into tiers, from 5-star, much above average, to 1-star, much below average. Ratings on staffing and quality measures may impact the overall rating, but the DOH survey scores have the biggest impact of these three elements. Nursing homes that are not held strictly accountable in the survey process may appear to be providing better quality care than they in fact are providing, and this may mislead the consumer.

CMS totals the points from all surveys, but only uses the last three survey cycles (essentially the scores over the most recent 3 years) in its rating system. These scores are weighted to place more emphasis on the more recent inspections. The result is a weighted average survey score over the last 3 cycles. A nursing home's initial star rating is then assigned using the following criteria:

- The top 10% of nursing homes with the lowest health inspection scores in each state get a health inspection rating of 5 stars.
- The middle 70% of nursing homes get a rating of 2, 3, or 4 stars, with an almost equal number of nursing homes in each rating category.
- The bottom 20% get a 1-star rating.

CMS then adjusts the overall rating in limited ranges based on staffing and quality measure factors.[96] CMS also relies on the 3-cycle weighted survey score to identify Special Focus Facilities, those nursing homes with a history of serious quality issues that has persisted over a long period of time.[97]

DOH, surveys and scoring: CMS posts the survey reports conducted by DOH surveyors and calculates the health inspection scores for each nursing home. The more lenient Metro survey scoring defeats the purpose of the 5-star rating system in identifying the lowest performing

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[96] CMS. Design for Nursing Home Compare, Five-Star Quality Rating System: Technical Users' Guide. July 2020, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/usersguide.pdf.

[97] See, CMS Special Focus Facility Program List, https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/CertificationandComplianc/downloads/sfflist.pdf.

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nursing homes; almost every Metro area nursing is rated average or better (271 out of 339). Rather than the target of 20%, only 27 Metro facilities (8%) have a 1-star health inspection rating. This distorts the overall rating so that only 20 (6%) have an overall 1-star rating. Only two Metro facilities (out of 339, 0.6%) have weighted survey scores over 100 points while the rest of the

state has 18 (out of 279, 6.3%).[98] The discrepancy in survey scores is more surprising given the Metro facilities rate lower in average staffing, a key measure of quality of care.

The uneven survey scoring also greatly reduces the possibility that a Metro area facility would be designated as a Special Focus Facility, and thus get the focused regulatory attention they may need to improve. CMS currently identifies three NYS facilities as Special Focus Facilities, none are in the Metro territory.[99]

DOH must do more to ensure there is consistency between the Metropolitan Regional Office and the rest of the state Regional offices.

IV. Reforming the System

The current system of long-term care is broken, unconscionable, and unconstitutionally forces older adults and people with disabilities into institutionalized settings. NYS must act now to reimagine how long-term care services and supports are provided so that every NYS resident can receive quality long-term care services and supports in the least restrictive setting possible. This will mean purposefully implementing resources to home care services and supports, access to safe and affordable housing, and forcing nursing homes operators to change the way they do business.

Prior to the pandemic, occupancy levels in nursing homes were declining. During the pandemic, occupancy levels have been further reduced because residents are choosing to leave, families are taking residents out, and for a time, elective surgery was prohibited in hospitals, and therefore closed off the hospital to nursing home pipeline. While time will tell whether nursing home occupancy levels increase with the resumption of elective surgery, one thing is clear: NYS residents do not want go to a nursing home for short-term rehabilitation or long-term care.

[98] See, CMS Nursing Home Compare, Provider Dataset, https://data.medicare.gov/Nursing-Home-Compare/Provider-Info/4pq5-n9py (Data updated as of April 1, 2020, visited May 28, 2020).
[99] CMS Special Focus Facility Program List, https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/CertificationandComplianc/downloads/sfflist.pdf

We recommend the following:

A. Explore Alternate Nursing Home Models

The current institutionalization nursing home model is outdated. NYS should implement policies that explore alternative models and nursing home designs for long-term care facilities including utilizing principles found in the Green House Model.

The Green House Model promotes the values of real home, meaningful life, and empowered staff through small, residential style houses located in community neighborhoods also reflect similar goals. The Green House Model has houses containing 10–12 residents within the building. The residents all have a private room, attached bath and shared communal spaces such as the kitchen, dining, and living areas with access to outdoor space. Universal caregivers are also responsible for a range of activities and are assigned to specific resident's care with a nurse available 24 hours a day, further promoting a resident focused form of care.[100]

The Green House Model prior to the pandemic has been found to reduce spending and residents have benefited from the small size and consistent staff assignment in the homes. A new study, that reviewed COVID-19 data from over 3,200 older adults living in 300 Green House homes between February 1 and May 31, 2020, found that COVID-19 cases remained low for both residents and staff, and fewer residents died from COVID-19 compared to other nursing homes.[101] The New York Times also reports that as of May 21 2020, in 245 Green House homes with 2,653 residents, only nine have had Covid-19 cases, resulting in 6 deaths.[102]

A more modern design of nursing homes is necessary for the safety of both residents and staff. Single-bed rooms are more conducive for infection control and patient care, as it reduced stress

[100] Cohen, Lauren W., et al. "The Green House Model of Nursing Home Care in Design and Implementation." *Health Services Research*, vol. 51, 2015, pp. 352–377., doi:10.1111/1475-6773.12418.
[101]Novotney, Amy. "Approximately 95% of Green House homes have reported zero cases COVID-19 among resident or staff: study." *McKnights Senior Living*, Aug. 3, 2020, https://www.mcknightsseniorliving.com/home/news/business-daily-news/approximately-95-of-green-house-homes-have-reported-zero-cases-covid-19-among-residents-or-staff-study/?mpweb=1326-10823-240311&fbclid=IwAR0Zcn1D4B89xC0KrsqV9anA9xZK1EltBxvxpF4dgLsFPkcRvrpXXyyIsHw ; https://www.thegreenhouseproject.org/application/files/2415/9526/8890/GHP_COVID-19_Study_Report_Two_Pager_Jul_1.pdf ; http://eziegler.com/Files/SL_ZNEWS_072720.pdf
[102] Pan, Paula. "The New Old Age: How to Improve and Protect Nursing Homes from Outbreaks.", *The New York Times*, May 22, 2020 https://www.nytimes.com/2020/05/22/health/coronavirus-nursing-homes.html.

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and improved outcomes for patients while increasing privacy and accessibility for patients and families.[103] In addition, private rooms provide cost savings.[104]

NYS can implement policies that support the redesign of the standard institutionalization model that currently dehumanizes older adults and people with disabilities. One such policy would require all new nursing home construction and redesigns to focus on private rooms, instead of redesigning lobbies.

B. Take actions That Support Long-Term Care Services and Supports in the Community

The intent of the Medicaid program is to provide coverage and access to low-income people and people with disabilities. Medicaid is the primary payer of long-term care services and supports in nursing homes and the community. Until NYS takes action to make long-term care insurance affordable, or passes legislation like the State of Washington's Long Term Care Trust Act,[105] or A5248-A/S3577-A Provides for establishment of the New York Health Plan,[106] Medicaid will remain the primary payer.

A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.[107] Medicaid is a lifeline to many and ensures that our older adults and people with disabilities are able to live in the least restrictive setting and have access to needed services and supports; all which support them in their daily lives and right to autonomy. For anyone who qualifies for home care services through Medicaid, the most integrated setting would be their community residence. However, through the 2020-2021 NYS Fiscal Year Budget, passed on April 3, 2020, NYS imposed new barriers to access of necessary home health care services for the older adult and disabled populations. In effect, these changes will cause unnecessary delays to eligibility determinations and limit the eligibility criteria for home care programs available through Medicaid. The result? An increased likelihood that people will be forced into nursing home institutionalization.

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[103] Rosenberg, Karen; Todd, Betsy "The Effects of Private Rooms on Hospital-Associated Infections.", AJN, American Journal of Nursing: November 2019 - Volume 119 - Issue 11 - p 53 doi:0.1097/01.NAJ.0000605376.45065.6b

[104] *See* Grabowski, David C et al. "The Impact of Green House Adoption on Medicare Spending and Utilization." *Health services research* vol. 51 Suppl 1,Suppl 1 (2016): 433-53. doi:10.1111/1475-6773.12438, and Calkins, Margaret & Cassella, Christine. (2007). Exploring the Cost and Value of Private Versus Shared Bedrooms in Nursing Homes. The Gerontologist. 47. 169-83. 10.1093/geront/47.2.169.

[105] *See* Washington State Long Term Care Trust Act. https://www.ltc-associates.com/education-center/who-pays-for-long-term-care/public-programs/washington-state-long-term-care-trust-act/#gs.c8ey1v

[106] https://www.nysenate.gov/legislation/bills/2019/s3577/amendment/a

[107] 28 C.F.R. § 35.130(d), *see also* Olmstead v. L. C. by Zimring, - 527 U.S. 581, 119 S. Ct. 2176 (1999).

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Beginning October 1, 2020, the new Medicaid rules will require a full review of an individual's finances, going back two and a half years, if that person is seeking Medicaid coverage of long-term care services in a community setting. A community look-back is overly burdensome and creates a delay in access to necessary health care services, especially for older adults and disabled individuals who seldom have assets to gift or transfer in the first place. Generally, a nursing home Medicaid application is submitted when the individual is already living in the facility or has already received the needed care from the nursing home. **Applicants in the community, however, must wait for approval before services can begin, leaving them without the care or assistance that is often crucial to maintaining their health and well-being in the community.**

Further, eligibility criteria for enrollment in Medicaid's Consumer Directed Personal Assistance Program (CDPAP) and Personal Care Services (PCS) is heightened as of October 1, 2020, requiring that individuals need assistance with more than two activities of daily living, with limited exceptions. The way in which applicants are assessed for their need is also changing, will require coverage determinations to be made by medical professionals who do not regularly treat or interact with the individuals needing the care.

NYS should revise the eligibility criteria for long-term community-based Medicaid programs. With the shortage of staffing in nursing homes and the burden that the global pandemic has placed on health care facilities in general, NYS should be looking to home and community-based care models as a solution. NYS instead, amid the pandemic, has restricted eligibility and access to community-based long-term care services and supports. NYS should reconsider the imposition of a community look-back period, as it may lead to unnecessary hospitalizations and nursing home institutionalizations when applicants are unable to timely access the community-based care needed to prevent such institutionalizations from happening.

Every NYS resident has the constitutional right to health care and to receive services in the least restrictive setting of their choosing. NYS and society cannot turn our backs on our older adults and people with disabilities. The DOH meets with industry representatives, but it does not meet with consumers or advocates for those who live in long-term care settings. CELJ is available and willing to meet with DOH, the NYS Legislature, and others to improve the quality of care in long-term care settings and in the community.