

# Implementation and Enforcement of Quality and Safety in Long-Term Care

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**SUMMARY.** Long before the new coronavirus struck, nursing homes and other long-term care facilities have had declining quality care that coincides with inadequate staffing and rampant infections. These pre-pandemic conditions increased the vulnerability of these facilities to an infectious disease outbreak. As the elderly death toll rises into the tens of thousands, an overdue national discussion on how to prioritize long-term care in the US has emerged, revealing an opportunity to better link quality care metrics with sufficient reimbursement and meaningful regulatory oversight. However, the opposite approach has also surfaced, which would allow the status quo to continue and may erode the minimum standards of care that currently exist. This concerning trend is on the rise with efforts to relax the Centers for Medicare and Medicaid Services (CMS) regulatory authority over nursing homes by waiving requirements and reducing enforcement penalties. In addition, states are passing measures to limit liability exposure for nursing homes during COVID-19 and similar protections are under consideration at the federal level, even as infection rates climb and there is no evidence of frivolous lawsuits. While political will is uncertain, public outcry is ready for legislative reform that will lead to better later-in-life care. The stakes have never been higher – act now and pass laws that connect funding with regulation to support quality care in nursing homes during and after the COVID-19 pandemic – or continue to condone practices that allow infection to spread and take many lives before their time.

## Introduction

Across the country, nursing homes and long-term care facilities struggle with how to contain the coronavirus outbreak. Part of the difficulty relates to conflict between federal, state, and nursing homes that emerged as thousands of COVID-19 infections and related deaths became linked to these facilities. This Chapter identifies and reviews the major missteps in response to COVID-19 that were facilitated by laws and regulations (or lack thereof) and provides recommendations for how to better control an infectious disease outbreak through improving quality care in long-term care.

## Major Missteps

The following three areas: staffing, infectious disease controls and prevention, and emergency planning and accountability, require strengthened legislation and regulatory oversight to curb the spread of COVID-19.

**Staffing.** Pre-pandemic staffing levels fell far short of what is recommended (Harrington et al., 2020). Previous proposals to mandate minimum staffing levels have failed across the states

largely due to the nursing home industry citing cost concerns. This staffing shortage led to undue pressure for workers to continue working in potentially dangerous conditions, and low wages have made it difficult for workers to earn sufficient income without working at multiple facilities. Specifically, recent evidence finds certified nursing aides (CNAs) have unwittingly passed on the virus, as an estimated 15% to 17% work at more than one long-term facility and are commonly referred to as 'superspreaders' (Harold Van Houtven et al., 2020).

CNAs are primarily immigrants and women of color who earn low-wages, and report fear of reprisal for requesting paid sick leave and PPE. These workers represent systemic racial, gender, and economic inequalities in nursing home care that has long been relegated to the shadows, despite their essential role in caring for older Americans. In the midst of COVID-19, some states support wage increases or hazard pay to encourage CNAs to work at only one facility. Adequate PPE and paid sick leave laws with enforcement could further reduce the spread of COVID-19, along with some of the inequities facing this vulnerable population.

CNAs and other nursing home staff across the country have filed hundreds of COVID-19 related complaints with the Occupational Safety and Health Administration (OSHA) claiming their employers are putting them in danger of being exposed to the coronavirus. Workers' fears are palpable in these complaints in which they report being forced to work while symptomatic or even if tested positive for COVID-19, lacking PPE, and being kept in the dark about outbreaks in their own facilities. OSHA, the agency charged with enforcing workplace safety law, has dismissed the vast majority of the complaints received and has yet to promulgate legally binding regulations to enforce employer compliance.

**Infectious Disease Controls and Prevention.** Similar to staff shortages, rampant infections are also a pre-pandemic problem. Tens of thousands of nursing home residents annually die from infections, which commonly include urinary tract infections, diarrheal diseases, and staph infections. A Government Accountability Office report released in 2019 analyzed CMS data and found that 82% of nursing homes, over 13,000 facilities, had received citations related to poor infection control (GAO-19-433, 2019). These findings highlight how pre-pandemic conditions contributed to the spread of COVID-19 in facilities charged with caring for older adults.

The ease with which COVID-19 is transmitted makes containment more challenging, which calls for greater infection control and prevention measures. Long-term care facilities, similar to other congregate settings such as cruise ships, prisons, and shelters, group large numbers of people together for communal meals and other services. In addition, personal care needs of an older population add a layer of necessary physical contact as residents often need assistance with bathing, dressing, and toileting, further limiting the feasibility of recommended safety measures such as social distancing. CMS and the Centers for Disease Control and Prevention (CDC) saw this as an issue concerning enough to generate specific guidance for long-term care facilities (CMS, 2020). This guidance issued on April 2, 2020 outlines necessary protocols, including isolating residents with symptoms, promptly reporting cases, and implementing emergency planning. Despite this awareness, many facilities failed to implement basic health and safety protocols.

Relatedly, facilities receiving CMS funding must comply with Conditions of Participation, which establish standards for quality of care metrics, staffing, and other services, which CMS monitors and rates on a five-star system (42 C.F.R. § 483.1, 2020). In theory, such monitoring should lead to data-driven regulation, where poorly performing facilities could be identified and improved. For example, one might assume that Life Care Center of Kirkland, Washington, known for its systematic failure in response to COVID-19, would have a low CMS rating. Yet, this facility received a five-star rating right before the pandemic. A recent study found the CMS rating system was not a predictor for the COVID-19 infection outbreaks, suggesting current data collection and reporting methods should be revisited (Gebeloff et al., 2020).

Despite its potential flaws, the CMS data has been useful in showing widespread deficiencies in quality care at nursing homes. In spite

of this evidence, there are efforts to relax CMS requirements and enforcement, as well as calls to protect nursing homes from liability. For example, under the Trump administration, nursing homes are given a one-time fine for most violations rather than a fine for each day there is a deficiency, reducing average fines by one-third. Furthermore, CMS is proposing a rule to remove requirements under the Conditions of Participation deemed "obsolete or excessively burdensome," which shockingly, includes the requirement for facilities to employ an infection prevention specialist (84 Fed. Reg. 34737, 2019).

Many states have passed executive orders or legislation limiting nursing home liability exposure during COVID-19. The long-term care industry is now proposing Congress pass national immunity from liability. The rise in infections and declining role of regulatory oversight make this potential immunity all the more concerning for ensuring minimum standards of care (Sklar & Terry, 2020).

**Emergency Planning and Accountability.** Conflicting guidance from federal and state authorities has been a recurring theme during this pandemic, reflecting an overall poor approach to emergency planning. For example, many governors issued executive orders to transfer recovering COVID-19 patients to nursing homes in order to free up intensive care unit beds. However, some nursing homes lacked sufficient PPE, testing kits, adequate staffing, and ability to isolate residents, which likely contributed to the outbreaks these facilities experienced after admitting the recovering patients. Governor Cuomo issued this controversial order in New York on March 25, then reversed it on May 10, claiming the nursing homes should not have admitted these patients if they couldn't have isolated them. However, this runs counter to the orders which state, "no resident shall be denied re-admission or admission to the [nursing home] solely based on confirmed or suspected COVID-19" (Graham, 2020). If a resident was not critically ill, it was unclear how a nursing home could deny admissions, leaving staff and residents in the crosshairs of accepting COVID-19 positive residents without the resources to prevent an outbreak.

Lastly, the distribution of federal COVID-19 funding to nursing homes fails to directly address deficiencies contributing to the spread of the coronavirus. On May 22, 2020, HHS announced a \$4.9 billion nursing home allocation, with \$50,000 per facility, plus \$2,500 per bed (HHS Press Release, 2020). This funding does not earmark PPE, testing capacity, staffing, or other infection control measures, rather funds can be broadly used "to offset significant expenses or lost revenue attributable to the COVID-19."

## Assessment

This section assesses the aforementioned missteps and proposes legislative and regulatory action.

### Stronger Oversight and Tougher Enforcement

Regulatory action alone is not enough to mitigate the threat of COVID-19 in nursing homes. There are federal and state obligations already in place that need to be legally enforced for optimal effectiveness. During the pandemic, some states have addressed

staffing shortages and improved infection control through governor executive orders and legislation, saving lives in the process. These approaches highlight what could be possible were funding tied to quality metrics with effective enforcement.

The majority of states have improved facility staffing shortages and addressed other essential needs by deploying the National Guard. Maryland was one of the first states to send in the National Guard to join emergency strike teams for nursing homes, which provide emergency care, supplies, and equipment. Other states called in the Guard for disinfecting (Georgia), testing (Florida), boosting staffing levels (California), performing inspections (Connecticut), and contract tracing (Washington). Currently, the Guard deployment ends in mid-August, which could have devastating consequences if the pandemic is not under control and these services are stopped.

Workplace safety has failed on many fronts throughout the pandemic, largely due to OSHA and its state agencies' failure to execute legally binding regulations. There are current federal regulations to protect employees from hazardous conditions under the General Duty Clause, which during this pandemic could authorize the use of PPE. Under this clause, OSHA could issue a directive requiring employers to comply with CDC guidelines for PPE and other safety measures, but they have yet to do so. OSHA's enforcement is minimal, with only a handful of onsite inspections occurring in response to the hundreds of complaints from CNAs, nursing home and long-term care staff. Relatedly, wage increase or hazard pay and paid sick leave with retaliation protection could support CNAs, whom are largely immigrants and women of color, decision to work at one facility and stay home if symptomatic for a possible COVID-19 infection.

Lastly, granting nursing homes immunity from lawsuits related to COVID-19 is a concerning trend emerging across the states and proposed at the federal level. A central argument of industry groups requesting immunity is the national shortage around PPE and testing kits that limits their ability to control the spread of COVID-19 in facilities. While there are valid concerns regarding the unprecedented nature of COVID-19, these concerns do not justify granting immunity to an industry with a history of misconduct that has failed to implement basic health and safety procedures.

### Transparency and Data

The lack of timely, accurate, and reliable data about COVID-19 cases in nursing homes has hampered attempts to control the spread of infection. After pressure from the media, public, lawmakers, and resident advocacy groups, CMS released an interim final rule requiring nursing homes to submit weekly updates to CMS and CDC about confirmed and suspected COVID-19 infections and deaths at their facilities (85 Fed. Reg. 27550, 2020). The first report was due on May 8, 2020, and while the time lag is another notable misstep, this data should be useful for regulators to better track, respond to, and mitigate the spread of COVID-19. The rule also includes updates on requirements for PPE supplies, access to COVID-19 testing, and staffing shortages.

The CMS five-star rating system has not consistently identified which facilities are at higher risk for spread of infection. Perhaps with the integration of this additional weekly data, the CMS rating system can be improved. Currently, there is no published data on the race of nursing home residents by facility. As COVID-19 disproportionately impacts minorities, collecting these data points could inform a more effective response.

Additionally, more comprehensive data could lead to more targeted federal and state funding efforts. For example, the \$4.9 billion distribution of funds by HHS to nursing homes based on the number of beds could include variables such as PPE and staffing shortages, substantial violations, and staff complaints, in order to identify and optimally support high-risk facilities. Promising federal legislation does just this, linking federal funding with quality care metrics. The Quality Care for Nursing Home Residents and Workers During Covid-19 Act was introduced on May 5, 2020, in the U.S. House of Representatives (H.R. 6698, 2020). This bill proposes to increase regulatory inspections with stricter protocols around testing and reporting tied to distribution of funds for improving the level of care, rather than a general bed count. Ultimately, more funding alone will not help Americans through this process; the dollars must be linked to timely and accurate data in order to address the root causes of how the coronavirus is spreading.

There are many lessons to be learned from the response to COVID-19 in nursing homes and long-term care facilities. Regulatory action and legislation could save lives now and improve quality care for older American in the years ahead. Other efforts to further relax regulations, enforcement, and allow immunity from lawsuits could further erode a system already renowned for poor care. It is frightening to imagine a future where after this horrific event, the legislation that passes only serves to put older Americans and the general public in further harm's way should another pandemic strike. 🦠

# Recommendations for Action

## Federal government:

- CMS should mandate adequate staffing ratios in nursing homes and long-term care facilities.
- The administration should extend the National Guard deployment, continuing to fund Guard assistance to nursing homes and their residents.
- OSHA should pass legally binding regulations that makes employer compliance with PPE and other CDC safety measures compulsory under the General Duty clause.
- Congress should significantly expand OSHA's enforcement resources for effective follow-up on complaints from nursing home and long-term care staff.
- CMS should withdraw its proposed rule entitled, Requirements for Long-Term Care Facilities: Regulatory Provisions to Promote Efficiency and Transparency.
- Congress should not pass a federal law granting nursing homes immunity from liability during COVID-19.
- CMS should expand the nursing home dataset to include racial demographics of residents.
- Congress should include the proposed Quality Care for Nursing Home Residents and Workers During COVID-19 Act of 2020 in the next coronavirus relief package or similar legislation that links regulatory oversight with funding to improve quality care and health outcomes.

## State governments:

- Nursing home regulators should mandate adequate staffing ratios in nursing homes and long-term care facilities.
- Legislators should support wage increases or hazard pay for CNAs to encourage them to only work at a single facility.
- State administrations should amend or reverse any executive orders that require nursing homes to take COVID-19 positive patients if they do not have the PPE supplies and ability to adequately isolate them.
- State governors or legislators should not grant nursing homes immunity from liability during COVID-19.
- Legislators should significantly expand state OSH agency enforcement resources.

## Local governments:

- Local governments should enact paid sick leave requirements with retaliation protection.



## About the Author

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