Center for Medicare Advocacy

Advancing Access to Medicare and Health Care

ENFORCEMENT

Recent Developments in Nursing Homes

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CENTERS FOR MEDICARE & MEDICAID SERVICES

Editor's Note: The Centers for Medicare & Medicaid Services's information and guidance about the coronavirus pandemic change on a daily basis. For more up-to-date information, please go to the Center for Medicare Advocacy's coronavirus website, https://www.medicareadvocacy.org/medicare-info/covid-19-coronavirus-and-medicare/, which is updated promptly as CMS guidance changes. The Center has also produced and regularly updates "COVID-19: An Advocates Guide to Medicare Changes," https://www.medicareadvocacy.org/covid-19-an-advocates-guide-to-medicare-changes/.

1.CMS REINSTATES REQUIREMENT THAT NURSING FACILITIES SUBMIT PAYROLL-BASED STAFFING DATA; ANNOUNCES CHANGES TO *NURSING HOME COMPARE*

On June 24, 2020, the Centers for Medicare & Medicaid Services (CMS) reinstated the requirement that nursing facilities submit staffing data through the Payroll-Based Journal (PBJ) System; facilities must submit data for the second quarter of calendar year 2020 (April-June 2020) by August 14, 2020, but not for the first quarter (January-March 2020). CMS, "Changes to Staffing Information and Quality Measures Posted on the Nursing Home Compare Website and Five Star Quality Rating System due to the COVID-19 Public Health Emergency," QSO-20-34-NH (June 25, 2020) (Memorandum from David Wright, Director, Quality Safety and Oversight Group, to State Officials, State Survey Agency Directors, and Nursing Home Stakeholders). CMS indicated that approximately 60% of facilities submitted PBJ staffing data for Calendar Quarter 1, despite CMS's waiver of the requirement, but that CMS will not use those first quarter data to calculate staffing measures or ratings.

Editor's Note: *McKnight's Long Term Care News* reports that Steven Littlehale, a gerontological clinical nurse specialist and chief innovation officer at Zimmet Healthcare Services Group, recommends that that facilities not submit the 2020 first quarter MDS data to CMS because although it will not be used by CMS in the five-star quality rating system, "'it will be publicly accessible and be possibly used by others.'" He said, "'I would be careful in sharing data externally that isn't required, but keep meticulous documentation on your staffing and all your attempts to provide appropriate staff to your residents.'" James M. Berklan, "Providers cautioned against submitting too much staffing data, despite new federal demands," *McKnight's Long-Term Care News* (June 26, 2020), https://www.mcknights.com/news/providers-cautioned-against-submitting-too-much-staffing-data-despite-new-federal-demands/.

CMS also announced that that, on July 29, 2020, it will hold constant on *Nursing Home Compare* staffing data based on the submissions from the fourth quarter of 2019 (October-December 2019). However, because CMS is lifting the waiver, effective with the second quarter of calendar year 2020, "staffing measures and ratings will be updated in October 2020 based on data submitted by August 14, 2020."

CMS also waived federal requirements that facilities submit resident assessment data. Describing resident data after January 1, 2020 as affected by the waiver and the public health emergency,

CMS says, "quality measures based on [the] data collection period ending December 31, 2019 will be held constant." Quality measures "will continue to be updated until the underlying data reaches December 31, 2019." CMS is not holding quality measure ratings constant, however, "as a facility's quality measure rating can still be updated by a quality measure with underlying data that is earlier than December 31, 2019."

> **Editor's Note:** What this language seems to mean is that the quality measure rating will be updated, but only to the extent that it reflects resident assessment data prior to December 31, 2019.

"Changes to Staffing Information and Quality Measures Posted on the Nursing Home Compare Website and Five Star Quality Rating System due to the COVID-19 Public Health Emergency" is available at https://www.cms.gov/files/document/qso-20-34-nh.pdf and from the Center for Medicare Advocacy, on request.

2. In Frequently Asked Questions, CMS Revises Guidance on Visitation to Nursing Facilities

On June 23, 2020, in seven Frequently Asked Questions, the Centers for Medicare & Medicaid Services (CMS) revises its guidance on visitation to nursing facilities during the COVID-19 pandemic. CMS, "Frequently Asked Questions (FAQs) on Nursing Home Visitation" (Jun. 23, 2020). Recognizing "the toll of separation from family and other loved ones while at the same time recognizing the need to balance the safety of residents and staff" (Question 3, below), CMS provides additional, more flexible guidance on visitation.

Question 1 reiterates steps that facilities should take before reopening, referring to guidance from CMS and the Centers for Disease Control and Prevention (CDC). CMS continues to say that facilities should not be reopened until Phase three.

Question 2 clarifies that the definition of "compassionate care situation" means more than end-of-life situations. CMS provides additional examples of compassionate care situations:

- A resident recently moved into a facility; "the change in their environment and sudden lack of family can be a traumatic experience. Allowing a visit from a family member in this situation would be consistent with the intent of the term 'compassionate care situation.'"

- "Similarly, allowing someone to visit a resident whose friend or family member recently passed away, would also be consistent with the intent of these situations."

While CMS cannot define all situations where visits should be permitted, it "encourages facilities to consult with state leadership, families, and ombudsman, to help determine if a visit should be conducted for compassionate care." Nevertheless, it cautions that visits "should not be routine."

In addition, visitors must take appropriate actions during visits to prevent the transmission of COVID-19 – screening, social distancing, hand hygiene, and face coverings.

Facilities may also want to create "safe spaces," such as see-through separation walls or other such areas;" "setting up appointment times to ensure control of the number of visitors at any time;" and limiting the number of visitors (such as two) for a resident.

Question 3 confirms that facilities can use "creative means" and flexibility for allowing visitation before phase three. Examples include outside visits, outdoor visitation sessions "in courtyards, on patios, or even in parking lots."

CMS concludes this analysis with the statement, "As more information becomes available at the national, state, and local levels, facilities are encouraged to work with their state officials to determine the appropriate level of visitation restrictions within available guidelines from the CDC."

Question 4 confirms that residents can "participate in communal activities" before phase three of the reopening plan. As explained in CMS's May 18 reopening recommendations, residents may eat in the same dining room and participate in group activities, while maintaining social distancing, hand hygiene, and using face coverings or masks.

"Facilities may be able to offer a variety of activities while also taking the necessary precautions." Examples include "book clubs, crafts, movies, and Bingo."

Question 5 identifies factors that facilities should consider, in coordination with state and local officials after a careful review of facility-level, community, and state factors/orders" "when making decisions about visitation." CMS confirms, "As facilities explore these options, they are still responsible for preventing the transmission of COVID-19."

Question 6 says that residents and staff who have tested positive for COVID-19 should not participate in in-person visits. Residents who cannot have in-person visits should still have "ways to connect with loved ones." CMS reminds facilities that civil money penalty reinvestment funds may be used to buy adaptive communicative technologies that enable "virtual visits." In addition, "facilities can have staff assist residents with sending or reading texts or emails with family."

Question 7 confirms the regulatory requirement (42 C.F.R. §483.10(f)(4)(i)(C)) that facilities must provide ombudsman with immediate access to residents, even if ombudsmen cannot visit in-person due to COVID-19. CMS also confirms, "Since ombudsmen are critical resources for residents and their families, nursing homes should facilitate their in-person access as soon as is practicable."

CMS also confirms that facilities must comply with all discharge requirements, except for discharges for purposes of cohorting. Existing requirements include the requirement to send a copy of discharge notices to the state ombudsman.

Frequently Asked Questions is available at https://www.cms.gov/files/document/covid-visitation-nursing-home-residents.pdf and from the Center for Medicare Advocacy, on request.

3. CMS Announces Members of Coronavirus Commission on Safety and Quality in Nursing Homes

On June 19, 2020, the Centers for Medicare & Medicaid Services (CMS) announced that its contractor, the Mitre Corporation, has selected the 25 members of the Coronavirus Commission on Safety and Quality in Nursing Homes from the more than 800 people who applied. CMS, "CMS Announces Membership of Independent Coronavirus Commission on Safety and Quality in Nursing Homes" (Press Release, June 19, 2020).

The press release describes three areas of focus for the Commission:

- Ensuring nursing home residents are protected from COVID-19 and improving the responsiveness of care delivery to maximize the quality of life for residents;
- Strengthening efforts to enable rapid and effective identification and mitigation of COVID-19 transmission (and other infectious disease) in nursing homes; and
- Enhancing strategies to improve compliance with infection control policies in response to COVID-19.

The Commission will meet during the summer 2020. A final report is expected in the fall of 2020.

Commission members are:

- **Roya Agahi,** RN, MS HCM, WCC; Chief Nursing Officer, formerly of NYC Health + Hospitals, soon to be of CareRite, New York
- **Lisa M. Brown**, PhD, ABPP; Professor of Psychology, Palo Alto University, California
- **Mark Burket,** CEO, Platte Health Center Avera, South Dakota
- **Eric M. Carlson,** JD; Directing Attorney, Justice in Aging, California
- **Michelle Dionne-Vahalik**, DNP, RN; Associate Commissioner, State Health and Human Services Commission, Texas
- **Debra Fournier**, MSB, BSN, ANCC RN-BC, LNHA, CHD, CPHQ; COO, Veterans' Homes, Maine
- **Terry T. Fulmer**, PhD, RN, FAAN; President, The John A. Hartford Foundation, New York
- **Candace S. Goehring**, MN, RN; Director, State Department of Social and Health Services, Aging and Long-Term Support Administration, Washington
- **David C. Grabowski**, PhD; Professor of Healthcare Policy, Harvard University, Massachusetts
- **Camille Rochelle Jordan**, RN, BSN, MSN, APRN, FNP-C, CDP; Senior Vice President of Clinical Operations & Innovations, Signature Healthcare, Kentucky
- **Jessica Kalender-Rich**, MD, CMD, AGSF, FAAHPM, FACP; Medical Director, Post-Acute Care, University of Kansas Health System, Kansas
- **Marshall Barry Kapp**, JD, MPH; Professor Emeritus of Law, Florida State University, Florida

- **Morgan Jane Katz**, MD, MHS; Assistant Professor of Medicine, Johns Hopkins University, Maryland
- **Beverley L. Laubert**, MA; State Long-Term Care Ombudsman, State Department of Aging, Ohio
- **Rosie D. Lyles**, MD, MHA, MSc, FACA; Director of Clinical Affairs, Medline Industries, Illinois
- **Jeannee Parker Martin**, MPH, BSN; President and CEO, LeadingAge California
- **G. Adam Mayle**, CHFM, CHC, CHE; Administrative Director of Facilities, Memorial Healthcare System, Florida
- **David A. Nace**, MD, MPH, CMD; President, AMDA – The Society for Post-Acute and Long-Term Care Medicine, Pennsylvania
- **Lori Porter**, LNHA, CNA; CEO, National Association of Health Care Assistants, Missouri
- **Neil Pruitt, Jr.**, MBA, MHA, LNHA; Chairman and CEO, PruittHealth, Inc., Georgia
- **Penelope Ann Shaw**, PhD; Nursing Home Resident and Advocate, Braintree Manor Healthcare, Massachusetts
- **Lori O. Smetanka**, JD; Executive Director, National Consumer Voice for Quality Long-Term Care, Maryland
- **Janet Snipes**, LNHA; Executive Director, Holly Heights Nursing Home, Colorado
- **Patricia W. Stone**, PhD, MPH, FAAN, RN, CIC; Professor of Health Policy in Nursing, Columbia University, New York
- **Dallas Taylor**, BSN, RN; Director of Nursing, Eliza Bryant Village, Ohio

"CMS Announces Membership of Independent Coronavirus Commission on Safety and Quality in Nursing Homes" is available at https://www.cms.gov/newsroom/press-releases/cms-announces-membership-independent-coronavirus-commission-safety-and-quality-nursing-homes and from the Center for Medicare Advocacy, on request.

4. CMS Press Release Announces Data on COVID-19 Cases and Deaths Reported by Nursing Facilities to CDC and on Targeted Infection Control Surveys

On June 4, 2020, the Centers for Medicare & Medicaid Services (CMS) posted data on COVID-19 deaths, nursing home staffing, and protective personal equipment (PPE), among other data reported by nursing facilities to the Centers for Disease Control and Prevention (CDC) as well as the results of the focused infection control surveys that have been conducted since March 20, 2020. CMS, "Nursing Home COVID-19 Data and Inspection Results Available on Nursing Home Compare" (Press Release, Jun. 4, 2020).

COVID-19 Nursing Home Data

As of May 31, 2020, 13,643 nursing facilities (88.5% of the country's 15,417 Medicare- and Medicaid-certified facilities) reported data to the CDC. They reported 95,515 confirmed COVID-19 cases and 31,782 deaths. CMS will update the data in two weeks and then weekly.

CMS cautions that the data are preliminary "and may be subject to fluctuations as facilities are given the opportunity to submit and correct their data on the NHSN [CDC] website." COVID-19 Nursing Home Data, https://data.cms.gov/stories/s/COVID-19-Nursing-Home-Data/bkwz-xpvg. It suggests using caution when analyzing the data and says "data reported over the first few weeks should ***not*** be used to perform trend analysis and longitudinal analyses [bold italics in original.]"

CMS includes three links:

> For a quick overview of the nursing home COVID-19 data visit here: https://www.cms.gov/files/document/covid-nursing-home-reporting-numbers-5-31-0.pdf
>
> To view the Nursing Home COVID-19 data, visit here: https://data.cms.gov/Covid19-nursing-home-data
>
> To view the state survey memo on COVID-19 nursing home data, visit here: https://www.cms.gov/files/document/qso-20-32-nh.pdf

Targeted Inspection Results

Infection control surveys have been conducted at more than 8300 facilities since late March. CMS reported the findings of 5700 targeted infection control surveys.

CMS includes four links:

> To view the inspections results, visit: https://www.medicare.gov/nursinghomecompare/search.html?
>
> To view the survey reports, visit: https://www.cms.gov/files/zip/nursing-home-infection-control-surveys.zip
>
> To see the state survey memo on nursing home inspections, visit here: https://www.cms.gov/files/document/qso-20-33-nh.pdf
>
> To view the frequently asked questions on the nursing home COVID-19 data and the inspection results visit here: https://www.cms.gov/files/document/covid-nursing-home-data-release-external-faqs.pdf
>
> **Editor's Note:** The Center for Medicare Advocacy's two reports on the targeted infection control surveys are discussed, *infra*, at #14.

"Nursing Home COVID-19 Data and Inspection Results Available on Nursing Home Compare" is available at https://www.cms.gov/newsroom/press-releases/nursing-home-covid-19-data-and-inspections-results-available-nursing-home-compare and from the Center for Medicare Advocacy, on request.

5. CMS Advises States and Nursing Home Stakeholders of Posting of Nursing Home Surveys on June 4

The Centers for Medicare & Medicaid Services (CMS) reports that beginning June 4, it is posting immediate jeopardy surveys and infection control surveys. CMS, "Posting of Nursing Home Inspections," QSO 20-33-NH (Jun. 4th 2020 (Memorandum from David R. Wright, Director, Quality Safety and Oversight Group, to State Officials and Nursing Home Stakeholders).

On March 4, CMS prioritized surveys, QSO-20-12-ALL, and on March 23, it suspended standard surveys, QSO-20-20-ALL.

> **Editor's Note:** These QSO letters were discussed in *Enforcement*, Issue No. 243, pp. 4-9, 2-4, respectively (Mar. 2020).

Surveys conducted after March 4 will be available in a new method through a link on *Nursing Home Compare*. The spreadsheet will list the health inspection, demographic information, and findings.

"Posting of Nursing Home Inspections" is available at https://www.cms.gov/files/document/qso-20-33-nh.pdf and from the Center for Medicare Advocacy, on request.

6. CMS Press Release Announces "Enhanced Enforcement" for COVID-19 Data and Inspection Results

The Centers for Medicare & Medicaid Services (CMS) announces "enhanced and targeted accountability measures . . . based on early trends in the most recent data regarding incidence of COVID-19 in nursing homes, as well as data regarding the results of the agency's targeted infection control inspections." CMS, "Trump Administration Unveils Enhanced Enforcement Actions Based on Nursing Home COVID-19 Data and Inspection Results" (Press Release, Jun. 1, 2020). CMS says it is "increasing enforcement (e.g., civil money penalties (CMPs)) for facilities with persistent infection control violations, and imposing enforcement actions on lower level infection control deficiencies to ensure they are addressed with increased gravity."

With money from the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), states will have an additional $80 million for survey activity. CMS will distribute the CARES money "based on performance-based metrics." States that do not complete infection control surveys at 100% of the nursing facilities by July 31 will be required to submit a corrective action plan to CMS. If States have not completed 100% of the infection control surveys by August 30, CMS may reduce their CARES Act fiscal year 2021 allocation by 10%.

As of May 24, 80% of the country's nursing facilities – about 12,500 facilities – reported COVID-19 information to the Centers for Disease Control and Prevention (CDC). These facilities reported more than 60,000 confirmed cases and nearly 26,000 deaths. One in four facilities reported at least one COVID-19 case; one in five, at least one death. "Early analysis shows that facilities with a

one-star quality rating were more likely to have large numbers of COVID-19 cases than facilities with a five-star quality rating."

> **Editor's Note:** The Kaiser Family Foundation reported a considerably higher number: 39,039 deaths from COVID-19 occurring in nursing facilities in 47 states, as of May 29, 2020. https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/#stateleveldata

CMS will post the COVID-19-related data on a link on *Nursing Home Compare* the first week of June and will update the data weekly.

CMS says that, since March 4, it has conducted more than 8300 infection control surveys, with 5700 surveys available as of June 1. These surveys represent approximately 54.1% of the facilities nationwide.

> **Editor's Note:** The Center for Medicare Advocacy's two reports on the targeted infection control surveys are discussed, *infra*, at #14.

CMS is providing additional support and technical assistance to facilities through Quality Improvement Organizations (QIOs), including a weekly training on "infection control, prevention and management."

"Trump Administration Unveils Enhanced Enforcement Actions Based on Nursing Home COVID-19 Data and Inspection Results" is available at https://www.cms.gov/newsroom/press-releases/trump-administration-unveils-enhanced-enforcement-actions-based-nursing-home-covid-19-data-and and from the Center for Medicare Advocacy, on request.

7. CMS Posts COVID-19 Data by State

The Centers for Medicare & Medicaid Services (CMS) posted COVID-19 data, by state, as of May 24, 2020. CMS, "Nursing Home COVID-19 Data." By state, CMS reports:

- Nursing Home COVID-19 Data
  - Total nursing home resident cases
  - Number home resident COVID-19 cases per 1,000 NH residents
  - Total nursing home resident COVID-19 deaths
  - Nursing home resident COVID-19 deaths per 1,000 NH residents
  - Total nursing home staff cases
  - Total nursing home staff cases per 1,000 NH residents
- State survey data
  - Total nursing homes
  - Total nursing home surveys

- Percentage of nursing homes surveyed

Nationwide, there are 60,439 nursing home resident cases, reflecting 62.0 cases per 1000 nursing home residents.

> **Editor's Note:** States may be reporting cases using different definitions (confirmed cases or suspected and confirmed cases).

States reporting the highest number of resident cases per 1000 residents are:

- District of Columbia: 255.4
- Massachusetts: 244.4
- Connecticut: 236.1
- New Jersey: 206.7

States reporting the lowest number of resident cases per 1000 residents are:

- Wyoming: 3.8
- South Dakota: 6.5
- Oregon: 7.0
- Kansas: 7.9
- Tennessee: 8.0

Nationwide, there are 27.5 resident deaths per 1000 residents. States reporting the highest number of resident deaths per 1000 residents are:

- New Jersey: 145.5
- District of Columbia: 131.2
- Connecticut: 236.0

States reporting the lowest number of resident deaths per 1000 residents are:

- Vermont: 0
- Wyoming: 0.6
- South Dakota: 2.1
- Utah: 2.9
- Tennessee: 3.1
- Wisconsin: 4.7

Nationwide, there are 34,442 staff cases, reflecting 39.5 cases per 1000 nursing home residents. States reporting the highest number of staff cases per 1000 residents are:

- District of Columbia: 206.2
- Massachusetts: 160.2
- Arizona: 135.6

States reporting the lowest number of staff cases per 1000 residents are:

- Vermont: 0.4
- Montana: 0.6
- Wyoming: 3.4

Nationwide, there are 449 staff deaths, reflecting 0.5 staff deaths per 1000 residents. States reporting the highest number of staff deaths per 1000 residents are:

- Nevada: 13.

Eight states report no staff deaths: Arkansas, Montana, North Dakota, South Dakota, Utah, Washington, West Virginia, and Wyoming.

"Nursing Home COVID-19 Data" is available at https://www.cms.gov/newsroom/press-releases/trump-administration-unveils-enhanced-enforcement-actions-based-nursing-home-covid-19-data-and.

8. CMS Issues Guidance on Surveys, "Enhanced Enforcement" for Infection Control Deficiencies, Quality Improvement Activities

In a June 1, 2020 memorandum, the Centers for Medicare & Medicaid Services (CMS) addresses survey and enforcement activities as well as funding and quality improvement activities. CMS, "COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes," QSO-20-31-All (Jun. 1, 2020) (Memorandum from David R. Wright, Director, Quality, Safety & Oversight Group, to State Survey Agency Directors).

In Background, CMS describes technical assistance efforts through the Centers for Disease Control and Prevention (CDC) and Focused Infection Control surveys, which have been completed in approximately 53% of nursing facilities nationwide. CMS is "calling on States to ensure that all Medicare and Medicaid certified nursing homes receive this onsite, targeted review and access to the new CARES Act funding will be tied to a state's progress on completing these surveys."

Focused Infection Control Surveys and Supplemental Funding from the CARES Act

On March 4, CMS called for focused surveys; on March 23, it provided "a streamlined tool to facilitate these efforts." States have varied in their completion of these surveys – 11% to 100%, with a national average of 54.1% [sic; earlier in the Letter, CMS said 53%].

States failing to complete focused infection control surveys in 100% of their facilities by July 31 must submit a corrective action plan to CMS for completing these surveys in the next 30 days. States failing to complete the surveys in the 30-day grace period (i.e., August 30) **may** see their CARES Act FY2021 allocation reduced by up to 10%. CMS may reduce states' funding by

additional 5% for states continuing to fail to complete focused infection control surveys in all nursing facilities.

"All states may request FY2020 CARES Act supplemental funding, up to their FY2020 proportional allocation cap." States completing 100% of focused infection control surveys can request "their entire FY2020-FY2023 CARES ACT funding allocation."

COVID-19 Survey Activities

In addition to focused infection control surveys, CMS requires states to complete additional COVID-related surveys as follows:

1. Within 30 days (i.e., July 1), on-site surveys of facilities "with previous COVID-19 outbreaks," which CMS defines as

    a. "Cumulative confirmed cases/bed capacity at 10% or greater; **or**

    b. "Cumulative confirmed plus suspected cases/bed capacity at 20% or greater; **or**

    c. "Ten or more deaths reported due to COVID-19."

    Editor's Note: "Bed capacity" presumably means total number of certified beds. Assume a 100-bed facility with 60 residents presently living in the facility. Ten percent of the 100 beds is 10 residents; 10% of 60 residents is six residents. By using the number of certified beds, rather than the number of residents actually in the facility, CMS increases the number of residents with confirmed or suspected COVID that is needed to require an on-site infection control survey.

2. On-site surveys within three to five days of identification at any nursing facility with three or more new COVID-19 suspected and confirmed cases since the last report to CDC (under the National Healthcare Safety Network) or "1 confirmed resident case in a facility that was previously COVID-free." CMS encourages state survey agencies "to communicate with their State Healthcare Associated Infection coordinators prior to initiating these surveys."

3. Beginning FY2021, states must "perform annual Focused Infection Control surveys of 20 percent of nursing homes based on State discretion or additional data that identifies facility and community risks."

States failing to complete these additional COVID-related surveys may "forfeit up to 5% of their CARES Act Allocation, annually."

CARES funding may also be used for State-specific interventions, including "Strike Teams, enhanced surveillance, or monitoring of nursing homes," and to reflect recommendations of the *Coronavirus Commission for Safety and Quality in Nursing Homes.*

Expanded Survey Activities

States expand the types of surveys they do, either when they reach Phase 3 of CMS's Nursing Home Reopening guidance "or earlier, at the state's discretion."

> **Editor's Note:** CMS's reopening guidance was discussed in *Enforcement*, Issue No. 245, pp. 1-4 (May 2020).

Expanded survey activities for all provider and supplier types, including nursing facilities, are:

- Complaints that are triaged as non-immediate jeopardy-high (now, only immediate jeopardy complaints and facility-reported incidents)
- Revisits at facilities that removed immediate jeopardy but remained out of compliance
- Special Focus Facility and Special Focus Facility Candidate recertification surveys
- Nursing home and intermediate care facilities for people with intellectual disability recertification surveys greater than 15 months.

CMS directs states to prioritize "more routine surveys" to providers that have a history of noncompliance, or allegations of noncompliance, related to

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

Enhanced Enforcement for Infection Control Deficiencies

CMS describes infection control as "an ongoing compliance concern" and writes, "Due to the heightened threat to resident health and safety for even low-level, isolated infection control citations (such as proper hand-washing and use of personal protective equipment (PPE), CMS is expanding enforcement to improve accountability and sustained compliance with these crucial practices."

- For a facility cited with noncompliance in infection control in a survey, but not in the prior year or prior standard survey,
    - If the deficiency is cited at D or E, directed plan of correction.

- If the deficiency is cited at F (widespread),

    - Directed plan of correction,
    - Denial of payment for new admissions (DPNA), "with 45 days to demonstrate compliance."

- For a facility cited with noncompliance in infection control AND cited for an infection control deficiency in the prior year or in the prior standard survey:

    - If the deficiency is cited at E or E,

        - Directed plan of correction
        - Denial of payment for new admission, "with 45 days to demonstrate compliance."
        - At CMS/state discretion, per instance civil money penalty (CMP) up to $5000.

    - If the deficiency is cited at F (widespread),

        - Directed plan of correction
        - Denial of payment for new admission, "with 45 days to demonstrate compliance."
        - Per instance civil money penalty of $10,000.

- For a facility cited with noncompliance in infection control AND cited twice or more in the last two years for infection control (or twice since last standard survey)

    - If the deficiency is cited at E or E,

        - Directed plan of correction
        - DPNA, with "30 days to demonstrate compliance"
        - Possibility of per instance CMP up to $15,000 ("or per day CMP may be imposed, as long as the total amount exceeds $15,000").

    - If the deficiency is cited at F (widespread)

        - Directed plan of correction
        - DPNA, with "30 days to demonstrate compliance"
        - Possibility of per instance CMP of $20,000 ("or per day CMP may be imposed, as long as the total amount exceeds $20,000").

- For a facility cited with noncompliance in infection control at a harm level (G, H, I), regardless of facility's history

    - Directed plan of correction

- DPNA, "with 30 days to demonstrate compliance"
- CMPs according to "current policy" in the CMP analytic tool

Editor's Note: The CMP analytic tool was set out in CMS, "Revision of Civil Money Penalty (CMP) Policies and CMP Analytic Tool," S&C: 17-37-NH (Jul. 7, 2017), https://www.es.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-37.pdf, which generally makes per instance CMPs the default (reversing "Civil Money Penalty (CMP) Analytic Tool and Submission of CMP Tool Cases," S&C: 15-16-NH (Dec. 19, 2014), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-16.pdf, which made per day CMPs the default).

The 2017 analytic tool, among other sub-regulatory changes to enforcement, makes a per day CMP the default for noncompliance found during the survey, unless the facility had a "good compliance history" or there was only "a single isolated incident causes harm to a resident, unless abuse has been cited." In those cases, the guidance calls for a per instance CMP.

- For a facility cited with noncompliance in infection control at immediate jeopardy (J, K, L), regardless of facility's history

  - Directed plan of correction
  - DPNA, "15 days to demonstrate compliance"
  - CMPs according to "current policy" in the CMP analytic tool

Quality Improvement Organization Support

Quality Improvement Organizations (QIOs) are hosting weekly trainings on infection control, prevention, and management.

QIOs also work with approximately 6000 "small, rural nursing homes and those serving vulnerable populations in areas where access to care is limited with helping them understand and comply with CMS and CDC reporting requirements, sharing best practices related to infection control, testing and patient transfers."

QIOs provide technical assistance to "approximately 3,000 low performing nursing homes who have a history of infection control challenges."

Finally, "States may request QIO technical assistance specifically targets to nursing homes that have experienced an outbreak." State requests should be directed to Anita Monteiro, Acting Director of the iQuality Improvement and Innovation Group, at anita.monteiro@cms.hhs.gov.

"COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes" is available at https://www.cms.gov/files/document/qso-20-31-all.pdf and from the Center for Medicare

Advocacy, on request.

CONGRESSIONAL HEARINGS AND BRIEFINGS

9. HOUSE WAYS AND MEANS COMMITTEE, SUBCOMMITTEE ON HEALTH, HOLDS HEARING ON CORONAVIRUS AND NURSING FACILITIES

On June 25, 2020, the Health Subcommittee of the House Ways and Means Committee, chaired by Congressman Lloyd Doggett (D, TX), held a hearing – "Examining the COVID-19 Nursing Home Crisis – to explore the impact of the coronavirus pandemic on nursing home residents and workers. Congressman Doggett said that the Administrator of the Centers for Medicare & Medicaid Services (CMS), Seema Verma, declined to appear before the Subcommittee. In his opening statement, Congressman Doggett said, "We will hear about years of regulatory rollback and relaxed oversight efforts that worsened a crisis that existed long before COVID-19 and left facilities even more ill- prepared to deal with the current emergency." He described the Trump Administration's response to the pandemic as "characterized by the three D's: denial, delay, and ongoing deception."

Seven witnesses testified:

> Delia Satterwhite described her brother's stay at a nursing facility in Austin, Texas. Stephan Morales died April 16 from COVID-19; Ms. Satterwhite had not seen her brother since the facility lockdown on March 13.
>
> Melinda Haschak, a licensed practical nurse, described the lack of sufficient personal protective equipment (PPE) at the Connecticut nursing facility where she works, her purchasing PPE for staff, and her getting (and recovering from) COVID-19.
>
> Nicole Howell, Executive Director, Ombudsman Services of Contra Costa, California, described how COVID-19 exploited weaknesses in the long-term care system that make higher-paying Medicare residents financially advantageous and the resulting discharges of residents, during the pandemic, to homeless shelters. Basic issues of training and adequate staffing as well as racial disparities have been magnified in the COVID-19 pandemic.
>
> Toby S. Edelman, Center for Medicare Advocacy, described the multiple deregulatory actions taken by the Trump Administration, culminating in waivers of statutory and regulatory protections during the pandemic. In the short run, CMS must reinstate resident protections and comprehensive surveys and enforcement. For the longer term, aa facilities must have sufficient numbers of well-trained, well-supervised, and well-compensated nursing staff; survey and enforcement must be strengthened, including enforcement on a corporate-wide basis; states and CMS must establish and enforce meaningful standards for licensure and certification; and a medical loss ratio needs to be enacted to require that facilities spend a specified proportion of their reimbursement on care for residents.
>
> David Grabowski, Professor of Health Care Policy, Harvard Medical School, testified that the COVID-19 crisis in nursing homes did not have to happen. "The way in which we

regulate and oversee care quality, how we pay for nursing home services, and the inability of many residents to oversee and monitor their care all have contributed to the longstanding crisis in nursing homes." Public payments are low, staffing is often inadequate, quality regulations are "extensive but inconsistent," and there is insufficient transparency about facilities and ownership. Grabowski identifies "location, size of the facility, and having greater percentage of African American residents . . . [as] factors most strongly related to having a COVID case." Potential policy solutions include universal testing of all residents and staff; nationalization of the supply chain to provide personal protective equipment to facilities; restoration of family visitation with PPE and testing; support for the workforce; specialized COVID-only facilities for patients leaving the hospital; and the need for complete, accurate, and comprehensive COVID data.

Dana Kennedy, State Director, AARP in Arizona, called for ensuring facilities' access to PPE and testing; ensuring adequate staffing levels for facilities and access for long-term care ombudsmen; ensuring transparency of information on COVID-19 cases and data (on transfer and discharge, use of provider relief funds, and racial disparities); requiring facilities to provide and facilitate virtual visitation; and rejecting proposals for facility immunity.

Rebeca Gould, President/Chief Executive Officer, Schuyler Hospital (New York), described providers' concerns during the pandemic: changing regulations and burdensome state regulations; staffing shortages, resulting in facilities operating with minimum staffing; diminished resident quality of life due to visitation restrictions; and reimbursement challenges.

A general theme of the hearing was the Administration's weak response to the pandemic, including lack of a clear plan for personal protective equipment, failure to mandate testing for residents and staff, and exclusion of assisted living and other institutional settings from coronavirus relief.

The full video of the hearing and Members' and witnesses' written statements are available at https://waysandmeans.house.gov/legislation/hearings/examining-covid-19-nursing-home-crisis and from the Center for Medicare Advocacy, on request.

10. House Briefing on COVID-19 and Nursing Homes Highlights Longstanding Problems in Staffing and Infection Control

"The Devastating Impact of the Coronavirus Crisis in America's Nursing Homes," a June 11, 2020 briefing by the Select Subcommittee on the Coronavirus Crisis of the House Committee on Oversight and Reform, identified nursing homes' longstanding problems in staffing levels and infection control, as well as the failure of the federal government to take a strong leadership position in confronting the coronavirus pandemic. Five witnesses testified: Alison Lolley, daughter of a Louisiana nursing home resident who died of COVID-19 in April; Chris Brown, a certified nursing assistant (CNA) at a Chicago nursing facility; Eric Carlson, Directing Attorney, Justice in Aging; Phil Kerpen, President, American Commitment; and David Grabowski, Professor of Health Care Policy, Harvard Medical School.

The two witnesses closest to day-to-day activities in nursing facilities – Ms. Lolley and Mr. Brown – testified that low staffing levels were a problem even before the pandemic. Ms. Lolley described her mother's disheveled appearance and statements that she had not been fed, following the March ban on visitors. Mr. Brown, a CNA for 10 years, testified that facilities were and remain understaffed, temporary workers do not have sufficient training or skills to provide necessary care to residents, and facilities continue to lack sufficient tests (he has still not yet been tested for COVID-19) and personal protective equipment (PPE).

The witnesses also generally agreed that the federal government needs to take a leading role in ensuring adequate tests and PPE, but has not done so. Another overriding concern, voiced strongly by Dr. Grabowski, was that data on COVID-19 are inadequate. CMS has required nursing facilities to report COVID-19 deaths and problems since May 8, not since the beginning of the pandemic. Good public health, he said, requires good data.

> **Editor's Note:** The interim final rules with comment requiring reporting of COVID data from May 8 were published as CMS, "Medicare and Medicaid Programs, Basic Health Program, and Exchanges: Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency and Delay of Certain Reporting Requirements for the Skilled Nursing Facility Quality Reporting Program," CMS-5531-IFC, 85 Fed. Reg. 27550 (May 8, 2020), https://www.govinfo.gov/content/pkg/FR-2020-05-08/pdf/2020-09608.pdf. They were discussed in *Enforcement,* Issue No. 245, pp. 6-7 (May 2020).

The full video of the briefing and Members' and witnesses' written statements are available at https://coronavirus.house.gov/subcommittee-activity/briefings/devastating-impact-coronavirus-crisis-america-s-nursing-homes and from the Center for Medicare Advocacy, on request.

OTHER CONGRESSIONAL ACTIVITIES

11. HOUSE SELECT SUBCOMMITTEE ON CORONAVIRUS LAUNCHES INVESTIGATION OF CMS AND FIVE NURSING HOME CHAINS

Following its June 11 Briefing (discussed at #10, *supra*), the Select Committee on the Coronavirus Crisis of the House Committee on Oversight and Reform launched an investigation into the Centers for Medicare & Medicaid Services's lax oversight of the pandemic and the Trump Administration's failure to provide testing, supplies, and personal protective equipment to nursing facilities. Select Subcommittee on the Coronavirus Crisis, "Clyburn Launches Sweeping Investigation into Widespread Coronavirus Deaths in Nursing Homes" (Press Release, Jun. 16, 2020). Chairman Clyburn said, "'Deregulation and lax enforcement of infection control violations by CMS – both before and during the pandemic – may have contributed to the spread of the virus.'" The Committee also sent letters to five for-profit nursing home chains (Genesis HealthCare, Life Care Centers of America, Ensign Group, SavaSenior Care, and Consulate Health Care) that provide care to more than 80,000 residents in 40 states and where hundreds of residents have died. The letters seek information about "coronavirus cases and deaths, testing, personal protective equipment, staffing levels and pay, legal violations, and efforts to prevent further infections" as well as information about "the use of federal funds by nursing homes during the pandemic."

"Clyburn Launches Sweeping Investigation into Widespread Coronavirus Deaths in Nursing Homes" is available at https://coronavirus.house.gov/news/press-releases/clyburn-launches-sweeping-investigation-widespread-coronavirus-deaths-nursing and from the Center for Medicare Advocacy, on request.

12. Five House Republicans Send Letters to Five Democratic Governors on Coronavirus

On June 15, 2020, Congressman Steve Scalise (R - CA) and four other Republican members of the Select Committee on the Coronavirus Crisis of the House Committee on Oversight and Government Reform sent letters to five Democratic Governors (Andrew Cuomo, New York; Gretchen Whitmer, Michigan; Gavin Newsom, California; Phil Murphy, New Jersey; and Tom Wolf, Pennsylvania) whom they claim required nursing facilities to admit COVID positive patients. "Scalise Demands Answers from Governors on Nursing Home Tragedies." Scalise quotes Select Subcommittee member Mark Green (R-TN): "'The vast majority of those dying in nursing homes are located in the states that blew off the President's direction and the CDC's guidance.'"

The letter to Governor Cuomo says:

> We write seeking information, at a granular level, about the science and information used to inform your decision to mandate nursing homes and long-term care facilities admit untested and contagious COVID-19 patients from hospitals. This decision likely contributed to the thousands of elderly deaths in New York State.

The letter cites the March 25, 2020 directive of the New York Department of Health, since withdrawn, that said individuals could not be denied admission or readmission to a nursing facility "'solely based on a confirmed or suspected diagnosis of COVID-10'" and that facilities "are **prohibited** from requiring a hospitalized resident who is determined medically stable to be tested from [sic] COVID-19 prior to admission or re-admission [bolt font in original].'" The letter asks the Governor to explain the "science or guidance you used to make this lethal decision."

The letters to the four other Governors are similar in content and tone.

"Scalise Demands Answers from Governors on Nursing Home Tragedies" is available at https://www.republicanwhip.gov/news/scalise-demands-answers-from-governors-on-nursing-home-tragedies/ and from the Center for Medicare Advocacy, on request.

OTHER FEDERAL ACTIVITIES

13. HHS Office Inspector General Announces It Is Studying Nursing Homes and Coronavirus

The Office of the HHS Inspector General (OIG) announced in June that it will conduct a nationwide, two-part study on nursing homes to

> examine how the COVID-19 pandemic has affected nursing homes. The first part will describe the characteristics of the nursing homes that were hardest hit by the pandemic (i.e. homes with high number of residents who had COVID-19 or had died. The second part will describe the strategies nursing homes have used to mitigate the effects of the COVID-19 on their residents and staff in the face of these unique circumstances.

OIG, "Meeting the Challenges Presented by COVID-19: Nursing Homes."

The report, *Meeting the Challenges Presented by COVID-19 Nursing Homes*, has an expected issue date of Fiscal Year 2021.

"Meeting the Challenges Presented by COVID-19: Nursing Homes" is available at https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000474.asp and from the Center for Medicare Advocacy, on request.

REPORTS

14. Center for Medicare Advocacy Issues Two Reports on Targeted Infection Control Surveys Conducted Since March 2020

Effective March 20, 2020, the Centers for Medicare & Medicaid Services (CMS) suspended standard and complaint surveys and limited surveys to two types: targeted infection control survey and complaint/facility report incidents as triaged as immediate jeopardy. CMS, 'Prioritization of Survey Activities," QSO-20-20-All (Mar. 23, 2020), https://www.cms.gov/files/document/qso-20-20-all.pdf. On June 4, 2020, CMS released data for both types of surveys, 5700+ surveys out of more than 8300 surveys completed by CMS and state inspectors since March.

Most of the surveys, 5724, were targeted infection control surveys; only 20 surveys were immediate jeopardy surveys. The Center for Medicare Advocacy analyzed the targeted infection control surveys in two reports.

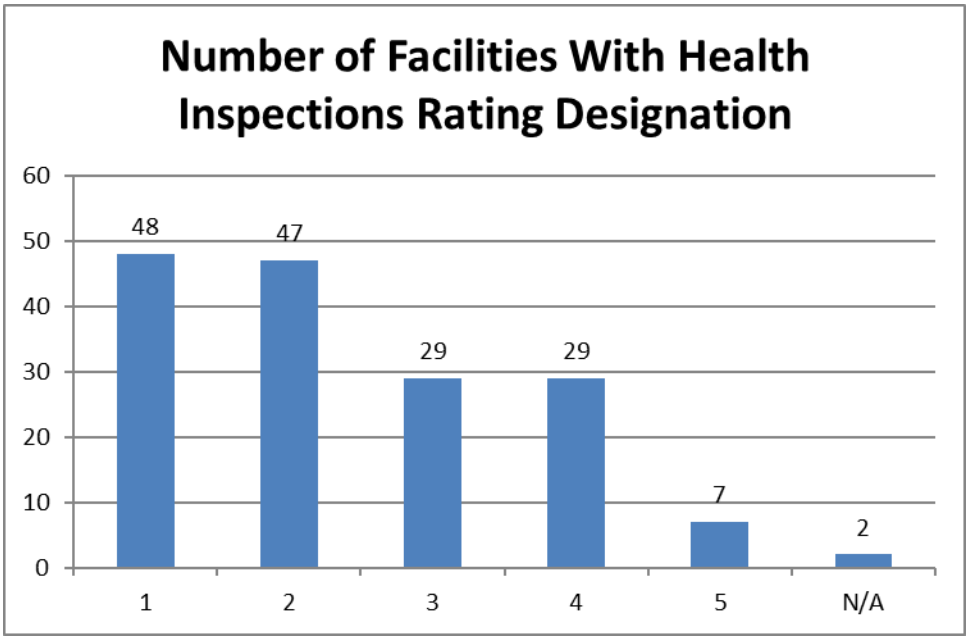
The first report, *Special Report: Infection Control Surveys at Nursing Facilities: CMS Data are Not Plausible* (Jun. 11, 2020), found that these data showed a dramatic and implausible decline in infection control deficiencies. Only 163 of the 5724 infection control surveys since March (2.83%) cited an infection control deficiency and 161 of 163 of the deficiencies (cited in 162 facilities) were classified as causing residents "no harm." Even if some additional deficiencies were cited but were not yet publicly reported because the facilities appealed them, the number of reported deficiencies was startlingly low.

The 5724 targeted infection control surveys cited a total of 163 deficiencies at 162 facilities for infection prevention and control, F-880. One deficiency (cited in Ohio) was cited as immediate jeopardy, one deficiency (cited in Florida), as actual harm, one, and the remaining 161 deficiencies were cited as no harm (levels D, E, or F).

The second report, *Special Report: Nursing Homes Cited with Infection Control Deficiencies during the Pandemic: Poor Results in Health Inspection, Low Staffing Levels* (June 17, 2020), found that by various measures, these facilities provide poor quality care. Facilities cited with infection control deficiencies had low star ratings, particularly in health surveys, and were more likely to be for-profit facilities. More than 40 percent of the facilities had remedies imposed (civil money penalties) for prior deficiencies and ten facilities were Special Focus Facilities or candidates for the SFF program.

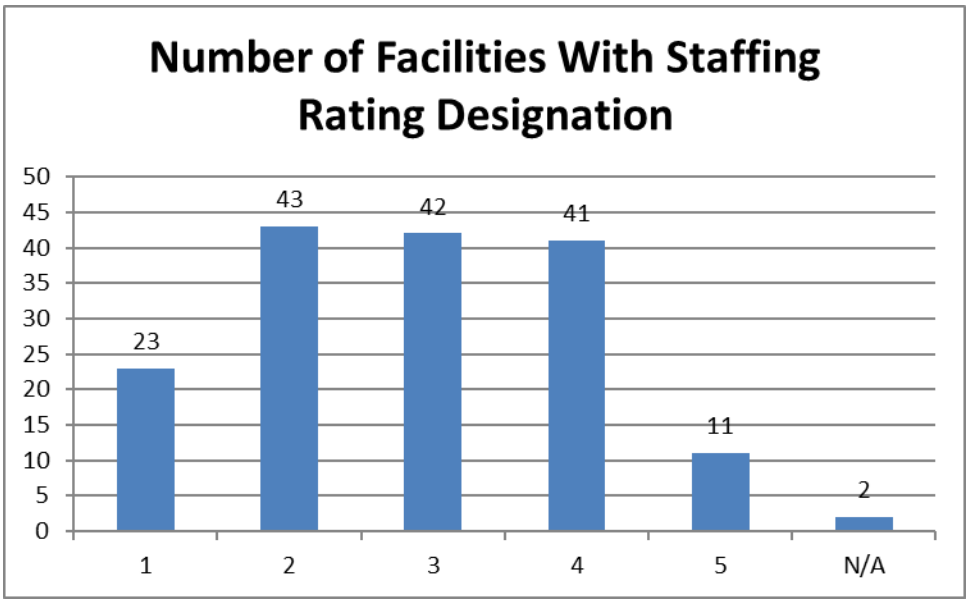
Health Inspections

As shown below, facilities with poorer survey results were more likely to be cited with an infection control deficiency. Of the 160 facilities cited with an infection control deficiency, 95 facilities (59.4%) had one or two stars in health inspection surveys. Only 36 facilities with four or five stars (22.5%) in health inspection surveys were cited with an infection control deficiency.



Staffing Rating

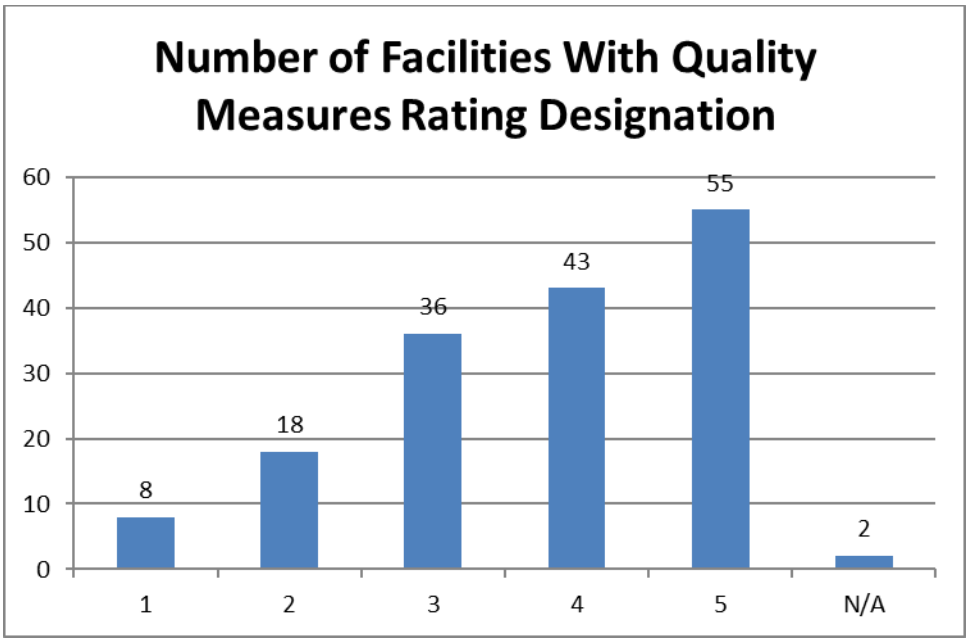
One-star facilities, those with the lowest staffing levels, were more than twice as likely to be cited with an infection control deficiency as facilities with five stars, the highest rating in staffing.



Quality Measures Rating

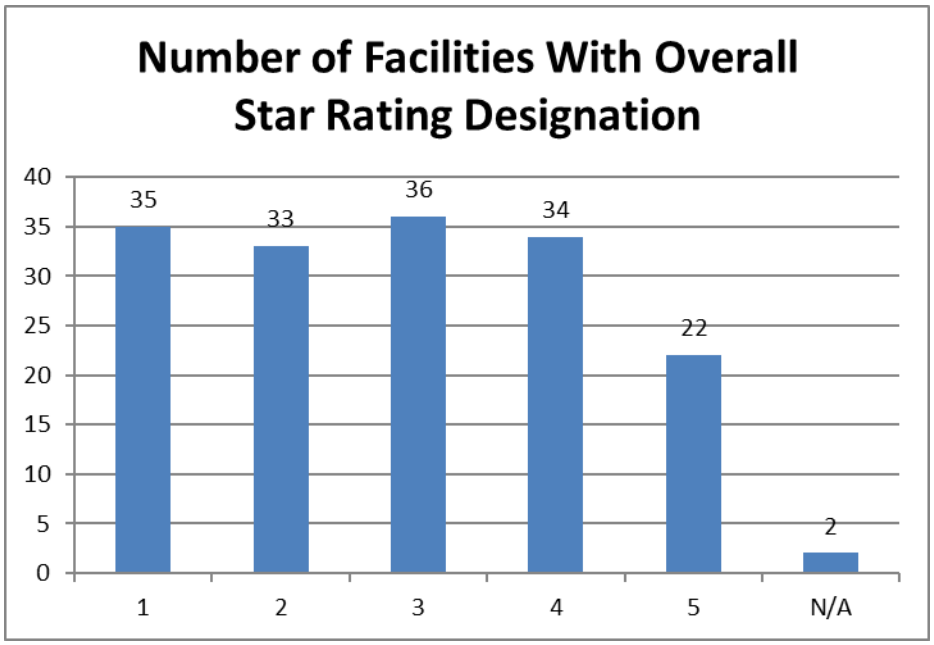
As shown, most facilities have a high rating in the quality measures domain and very few facilities have a low rating in quality measures. Nearly two out of three facilities (98 of 160 facilities) (61%) have four or five stars in the quality measures domain. Only 24 of 160 facilities (15%) have one or two stars in quality measures.

Nursing facilities have been gaming the quality measures ratings for a long time; gaming is not a new phenomenon. Evaluating the first five years of the federal rating system, 2009-2013, Abt Associates reported that four- and five-star ratings in the quality measures domain increased from 34.1 percent in January 2009 to 67.0 percent in July 2013, while one- and two-star ratings declined from 42.8 percent to 14.2 percent during the same period. Abt Associations, "Nursing Home Compare: The First Four Years of the Five-Star Quality Rating System" (PowerPoint at GSA Annual Scientific Meeting, Nov. 2013), slide 16, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/2013-The-First-Four-Years-of-Five-Star.pdf. *The New York Times* reached a similar conclusion about nursing homes' gaming of the rating system. Katie Thomas, "Medicare Star Ratings Allow Nursing Homes to Game the System," *The New York Times* (Aug. 24, 2014), https://www.nytimes.com/2014/08/25/business/medicare-star-ratings-allow-nursing-homes-to-game-the-system.html?searchResultPosition=3.



Overall Rating

The high ratings in the quality measures domain boost many facilities' overall ratings. Only 68 facilities (42%) have one- or two-star overall ratings (compared to 95 facilities, 59.4% receiving one or two stars in health inspection ratings).



Ownership Status

One hundred twenty-five (77%) of the infection control deficiencies were cited in for-profit facilities, although, in 2016, for-profit facilities represented 69.3% of facilities nationwide.

Remedies

Sixty-five of the 162 facilities (40.1%) have had civil money penalties imposed; the average fine for the 65 facilities was $36,866.78.

Twenty-two of the 162 facilities (13.6%) have denial of payment for new admissions imposed.

CMS does not provide comparative data on *Nursing Home Compare* to allow for the calculation of the percentages of facilities that are sanctioned, on either a statewide or national basis, with either of these remedies. Nevertheless, the rates of federal sanctions reported here are high; 40.1% of nursing facilities are not typically sanctioned with fines and 13.6% are not typically sanctioned with denial of payment for new admissions.

Special Focus Facilities and Candidates

Two of the 160 facilities are SFFs and eight of the 160 facilities were on the SFF candidate list (total, 6%, as of May 27, 2020). Facilities cited with infection control deficiencies are approximately twice as likely to be an SFF or SFF candidate as other facilities.

Special Report: Infection Control Surveys at Nursing Facilities: CMS Data are Not Plausible is available at https://medicareadvocacy.org/wp-content/uploads/2020/06/Infection-Control-Surveys-Report.pdf; *Special Report: Nursing Homes Cited with Infection Control Deficiencies during the Pandemic: Poor Results in Health Inspection, Low Staffing Levels*, at https://medicareadvocacy.org/dwp-content/uploads/2020/06/Coronavirus-Report-Infection-Control-Deficiencies-NHC.pdf. Both reports are available from the Center for Medicare Advocacy, on request.

DEPARTMENTAL APPEALS BOARD

APPELLATE DIVISION

15. PANEL MODIFIES ALJ HUGHES'S DECISION SUSTAINING IMMEDIATE JEOPARDY CITED AT ILLINOIS NURSING FACILITY FOLLOWING FIRE; HOLDS THAT JEOPARDY NOT POSSIBLE WHEN FACILITY MOVED RESIDENTS OUT AFTER FIRE, BUT SUSTAINS LOWER LEVEL CIVIL MONEY PENALTIES TOTALING $157,250

Following a fire at Cahokia Nursing and Rehabilitation Center on May 31, 2016, the Illinois nursing facility relocated all of the residents while repairs were made. It readmitted the residents on July 21. Following complaint investigation surveys on June 29 and July 12, 2016, the Centers for Medicare & Medicaid Services (CMS) cited immediate jeopardy and various Life Safety and

health deficiencies and imposed a per day civil money penalty (CMP) of $7250 for 51 days, May 31-July 20, 2016, totaling $369,750. The facility did not dispute the deficiencies but argued that the residents were not in jeopardy after it evacuated them. In a summary judgment decision, Administrative Law Judge (ALJ) Carolyn Cozad Hughes sustained the deficiencies and CMPs. *Cahokia Nursing and Rehabilitation Center v. CMS*, Docket No. C-16-919, Decision No. CR5374 (Jul. 19, 2019).

An appellate panel disagreed with the ALJ. Describing the case as "unusual," the panel holds that once the residents were safely relocated to other facilities, "it was not possible for conditions at Cahokia to present a likelihood of causing 'serious injury, harm, impairment, or death' to any resident. 42 C.F.R. §488.301." *Cahokia Nursing and Rehabilitation Center*, Docket No. A-19-132, Decision No. 2991, p. 1 (Mar. 12, 2020). When the residents returned to the facility July 21, 2016, "it is undisputed that the conditions that had created immediate jeopardy had been corrected." Decision 1. The panel modifies the CMP to one day of jeopardy-level noncompliance, May 31, 2016, and $3000 per day for the remaining 50 days, totaling $157,250.

> **Editor's Note:** As of June 9, 2020, the facility, now known as Autumn Meadows of Cahokia on *Nursing Home Compare*, has two stars for health surveys, two stars for staffing, and two stars for quality measures. Its overall rating is two stars. The 2016 deficiencies and CMPs were cited too long ago (more than three years earlier) to be reported on *Nursing Home Compare.*

The facility's maintenance supervisor and a maintenance worker were repairing mechanical systems in the attic when the fire alarm went off. They left the attic and silenced the alarm. The maintenance supervisor told the fire department that it was a false alarm, but there was actually a fire in the facility. Smoke was coming out a room. When a door was opened, the fire shot up the walls. Two residents were carried out of the room; one resident was found and rescued by firefighters. Fourteen residents were hospitalized and the remaining residents received emergency medical care and were relocated.

The panel finds that no one was in charge of the facility at the time of the fire, staff "were not properly trained to respond to a fire," and the facility's sprinklers did not work ("spraying out debris instead of water"). *Id.* 4. The facility had no plans to evacuate residents.

Nevertheless, the panel holds that it was "clear error, in this unusual situation," for the ALJ to find that the facility posed jeopardy "to a resident," as required by §488.301, after May 31 when the residents were all relocated. *Id.* 8. Decisions of the Board hold "that merely removing the resident(s) or staff involved in an event that triggered an immediate jeopardy determination is not sufficient to abate the immediate jeopardy" and that "as a general rule, facilities will not be considered to have successfully abated immediate jeopardy or to have attained substantial compliance respectively, until they have at least completed the steps to accomplish each of those that they have set out in their own plans of correction." *Id.* This case, however, presents "a novel issue for the Board's consideration: whether immediate jeopardy can continue to exist if *every* resident is relocated to other, appropriate facilities until such time as the situation that caused the likelihood of serious harm has been fixed [italics in original]." *Id.* 9.

The panel finds that the ALJ "conflates the requirements to demonstrate substantial compliance with the prerequisites for abatement of immediate jeopardy." *Id.*

> A facility deemed "not safe to enter" certainly remains out of substantial compliance with applicable conditions of participation and subject to appropriate penalties. However, a finding that the noncompliance persists at the level of immediate jeopardy arises not merely from how bad the conditions are at the facility but how likely those conditions are to endanger its residents. In other words, the conditions – like the initial event that exposes the noncompliance – are not themselves the immediate jeopardy. Rather, the conditions **may** be the source of the continuing likelihood of serious harm to **residents**. In that sense, the determination of immediate jeopardy is centered on protecting the residents from likely serious harm. [bold font in original]

Id. The panel concludes that relocating "all residents to new, appropriate facilities removed the likelihood of serious harm to any residents." *Id.* It finds, as the facility argued on appeal, that the cases cited by CMS actually involved one or more residents' continuing to be exposed to risk by the facility's noncompliance. Here, in contrast, all residents were safely relocated, no residents returned to the facility before July 21, and the facility "followed up" to ensure that residents were receiving the services they needed at their new facilities. *Id.* 10-11. The panel concludes that the facility met its burden of demonstrating that jeopardy was abated. *Id.* 12.

Having rejected the determination of jeopardy for the period June 1-July 20, the panel finds that the CMP of $7250 was not reasonable as a matter of law, when the upper limit for non-jeopardy CMPs was $3000. *Id.* 13. The panel finds the ALJ's analysis of the regulatory factors (the facility's extensive prior noncompliance with LSC requirements about which the facility had been repeatedly warned and the facility's culpability) was supported by substantial evidence, but it reduces the per day CMP to $3000.

The 14-page decision is available at https://www.hhs.gov/about/agencies/dab/decisions/board-decisions/2020/board-dab-2991/index.html and from the Center for Medicare Advocacy, on request.

CIVIL REMEDIES DIVISION

16. IN SUMMARY JUDGMENT DECISION, ALJ HUGHES SUSTAINS IMMEDIATE JEOPARDY DEFICIENCY CITED AT CALIFORNIA NURSING FACILITY FOR FOOD SAFETY; SUSTAINS PER DAY CIVIL MONEY PENALTIES TOTALING $33,739

Following a survey at St. Anthony Care Center on March 15, 2017 by the California state survey agency, the Centers for Medicare & Medicaid Services (CMS) cited four deficiencies – (1) dietary services, staffing, 42 C.F.R. 483.60(a)(1)-(2), F361; (2) dietary services, menus and nutritional adequacy, *id.*. §483.60(c)(1)-(7), F363; (3) dietary services, food safety, §483.70(i)(1)-(3), F371; and (4) physical environment, space and equipment, *id.* §483.90(d)(2), F456 – made a determination of immediate jeopardy for the food safety deficiency, and imposed per day civil money penalties (CMPs) – $8749, March 15, 2017, $510, March 16-May 3, 2017 – totaling $33,739. Finding no material factual issues in genuine dispute, Administrative Law Judge (ALJ)

Carolyn Cozad Hughes sustained the deficiencies and CMPs. *St. Anthony Care Center v. CMS*, Docket No. C-17-768, Decision No. CR5548 (Feb. 27, 2020).

Judge Hughes finds undisputed evidence that kitchen management and staff "disregarded dietary and food safety standards," in violation of §483.60(a), F361, §483.60(c), F363, and §483.60(i), F371, and facility policies on handwashing and sanitation; sanitation; dishwashing; food carts; and can opener and base. Decision 7-10.

The ALJ describes in detail surveyor observations of violations of the policies, most of which the facility did not dispute. *Id.* 10-14.

The facility similarly failed to comply with its food preparation policies, including food preparation; thermometers; and leftover foods. *Id.* 14-16. The facility again did not dispute the multiple surveyor observations of violations. *Id.* 16-19.

As observed by the surveyor, staff failed to follow facility policies for food storage, *id.*19-23, and for kitchen management, *id.* 23-25. The facility employed a registered dietician on a consultant basis, requiring her "to make *weekly* inspections of all food services functions to assure that quality control measures are continually maintained [italics in original]," but her contract authorized "*only three to five hours of consultation per month* [italics in original]" and, in fact, she "was seldom at the facility." *Id.* 24.

The facility fired both the dietary supervisor and the consultant dietician. *Id.* 25.

Judge Hughes also finds that staff did not regularly remove lint from the clothes dryer trap, creating a fire hazard. *Id.* 25-26.

Judge Hughes sustains CMS's determination of immediate jeopardy. *Id.* 27. The facility based its defense on three witnesses, but none of them defended the facility's practices and in fact, they largely criticized them. *Id.* 27-28.

The ALJ concludes that there almost "the complete absence of dietary oversight," "This was a rogue operation," and "Staff were effectively unsupervised and ill-trained." *Id.* 29-30.

Judge Hughes sustains the duration of the facility's noncompliance as "consistent with statutory and regulatory requirements." *Id.*30. Describing the magnitude of the facility's problems as "hard to overstate," the ALJ identifies the facility's need "to rebuild an entire dietary department, from the managers on down." *Id.* 31. The facility had to "review its practices, identify the areas of breakdown, and make changes to ensure that the problems did not recur." *Id.* It had to demonstrate "that staff capably followed the training that management put effective monitoring tools in place, and that those interventions resolved the problems." *Id.*

The 31-page decision is available at https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2020/alj-cr5548/index.html and from the Center for Medicare Advocacy, on request.

17. FOLLOWING HEARING BY VIDEO TELECONFERENCE, ALJ SICKENDICK SUSTAINS IMMEDIATE JEOPARDY DEFICIENCY CITED AT TEXAS NURSING FACILITY; SUSTAINS PER DAY CIVIL MONEY PENALTIES TOTALING $30,250

Following a survey at San Pedro Manor, conducted by the Texas Department of Aging and Disability Services on September 17, 2015, the Centers for Medicare & Medicaid Services (CMS) cited a deficiency at 42 C.F.R. §483.25, F309, made a determination of immediate jeopardy, and imposed a per day civil money penalty (CMP), $6050, September 9-13, 2015, totaling $30,250. Administrative Law Judge (ALJ) Keith W. Sickendick held a hearing, by video teleconference, on December 5-6, 2017. The ALJ sustained the deficiency and CMP. *San Pedro Manor v. CMS*, Docket No. C-16 -161, Decision No. CR5535 (Feb. 14, 2020).

The facts were not in dispute. The facility failed to provide cardiopulmonary resuscitation (CPR) for Resident 5, a 52-year old resident who was full code (that is, staff was to perform CPR and call 911). On September 8, 2015, R5 was placed in isolation, and her roommate was moved, because staff thought she had clostridium difficile. On September 9, a licensed vocational nurse (LVN) said R5 went downstairs to smoke at 3:30 a.m. and then returned to her room. When the LVN check on R5 at 4:10 a.m., "she was not responsive and not breathing." Decision. 8. The LVN did not begin CPR for at least 10 minutes after finding R5 in her bed, not breathing, but instead, and in violation of facility policy, left R5's room to find help. R5 was pronounced dead at 5:04 a.m.

Judge Sickendick finds that CMS provided the facility with adequate notice of its noncompliance, even though the statement of deficiencies lacked some clarity. *Id.* 10. He rejects the facility's defense that CMS could not cite the deficiency because of quality assurance, finding that the deficiency was based on R5's care plan, the police report, and the nurse's note. *Id.* 11-12. He also rejects the facility's claim that the LVN was a rogue employee, "who inexplicably department from Petitioner's training and policy." *Id.* 13. Moreover, the CNA who was CPR-qualified could have initiated CPR or sought assistance immediately.

Although it was conceded that the facility was in substantial compliance with federal Requirements at the time of the survey, Judge Sickendick cites CMS's statutory authority (Act §1819(h)(2)(A)) to impose a CMP "for failure to meet participation requirements during a period prior to the current survey." *Id.* 14. The regulations at 42 C.F.R. §488.430(b), as well as case law and the State Operations Manual, confirm this authority. *Id.* 14-15. Remedies are imposed "to not only prompt return to substantial compliance but also to ensure compliance is maintained." *Id.* 15.

The ALJ sustains CMS's determination of immediate jeopardy as not clearly erroneous, citing extensive case law, regulatory history, and the facts of the case. *Id.* 15-22. Multiple full-code residents were at risk and at least two staff members violated the rules; the incident did not involve a single resident and a single staff member, as the facility claimed. *Id.* 21.

Judge Sickendick sustains the $6050 per day CMP for six-day period as reasonable, rejecting the facility's "arguments concerning past noncompliance, its quality assurance defense, and that the incident occurred due to the actions of a 'rogue employee.'" *Id.* 23.

The 24-page decision is available at https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2020/alj-cr5535/index.html and from the Center for Medicare Advocacy, on request.

STATE NEWS

18. *Los Angeles Times* Reports that Surveyors Did Not Cite Infection Control Deficiencies at Nursing Facilities with Rampant COVID-19

On April 8, 2020, a day after a targeted infection control survey at Magnolia Rehabilitation and Nursing Center found "no deficiencies," the facility evacuated all 83 residents "after the staff refused to show up for work, terrified of the deadly infection already spreading within the facility." Jack Dolan, "As coronavirus raged through nursing homes, inspectors found nothing wrong," *Los Angeles Times* (Jun. 28, 2020). The *Los Angeles Times* reports that surveyors repeatedly found "no deficiencies at facilities that were in the midst of deadly outbreaks or about to endure one." On March 30, 2020, surveyors found no infection control deficiencies at Hollywood Premier Healthcare in Los Angeles; three days later, the facility had 68 confirmed cases. The National Guard provided care to residents because facility staff were sick and unable to work. Kingston Healthcare Center had no infection control deficiencies, but had 158 confirmed cases among residents and staff; 21 people died. Last year, state surveyors cited 85 deficiencies at the Kingston facility.

The *Los Angeles Times* reports that the state conducted more than 1700 infection control surveys but cited just 14 infection control deficiencies. 2441 residents and staff in California have died of COVID-19, accounting for 43% of the state's COVID-19 deaths.

A spokeswoman for the California health department described instructions to surveyors as providing support to facilities rather than enforcement. She said,

> "Focusing only on enforcement in the rapidly changing environment of the early pandemic response would not have been beneficial to the vulnerable nursing home residents we work every day to serve. We needed to find solutions to save as many lives as we could, and to limit the spread of COVID-19 among this very vulnerable population."

Patricia L. McGinnis, executive director of California Advocates for Nursing Home Reform, said,

> "These weren't real inspections; they were more like courtesy call visits. At a time when residents desperately needed the California Department of Public Health to help protect their lives, it tolerated infection control violations that have proven so deadly. Why even have nursing home inspectors if they are not going to enforce life-threatening infection control violations in the midst of a pandemic?"

The *Los Angeles Times* quoted the Center for Medicare Advocacy's reporting that less than 3% of the targeted infection control surveys nationwide cited an infection control deficiency and the Center's conclusion that the infection control deficiency data are not plausible.

Editor's Note: The Center for Medicare Advocacy's two reports on the infection control deficiencies are discussed, *supra,* at #14.

The Centers for Medicare & Medicaid Services's Administrator, Seema Verma, blamed facilities for the COVID-19 out breaks and suggested, as described by the *Los Angeles Times*, that staff might have "stopped following infection control protocols once inspectors were gone."

The son of a Magnolia resident who was admitted to the facility for rehabilitation in late March 2020 said the family had been unaware of COVID-19 cases in the facility. His father's physician soon stopped going to the facility, however, because of concerns that staff did not wear masks or use personal protective equipment. The family learned about the facility's evacuation through the news and did not find out where the father had been sent until midnight.

Magnolia Rehabilitation and Nursing Center

The most recent data for Magnolia Rehabilitation and Nursing Center (site visited June 29, 2020) indicate 17 health deficiencies, including one immediate jeopardy deficiency, at the facility for the most recent standard survey on February 14, 2019: 1 B, 10 D, 5 E, and **1 K**. Ten complaint surveys conducted in the 12-month period April 1, 2019 – March 3, 2020 cited 16 deficiencies:

Apr. 3, 2019: 2 D
Apr. 16, 2019: 1 D
Jul. 11, 2019: 1 D
Sep. 4, 2019: 2 E
Sep. 2, 2019: 1 D

Jan. 6, 2020: 4 D
Jan. 16, 2020: 2 D
Feb. 5, 2020: 1 D
Feb. 20, 2020: 1 D
Mar. 3, 2020: 1 E

As of June 29, the facility had one star in health surveys, four stars in staffing, and five stars in quality measures (no rating for short-stay residents because there were not enough data, five stars for long-stay residents). Its overall rating is two stars.

Editor's Note: The five-star rating in quality measures boosted the facility's overall rating so that the one-star facility (based on the health surveys) became a two-star facility.

Nursing Home Compare indicates that one federal civil money penalty (Mar. 15, 2018: $21,393), but no denials of payment for new admissions, were imposed against the facility in the prior three years. Thirty-three complaint or facility-reported incidents in the prior three years resulted in 57 deficiencies, including one actual harm health deficiency and one immediate jeopardy health deficiency:

May 4, 2017: 1 D

Jun. 16, 2017: 2 D
Jul. 12, 2017: 2 D
Jul. 26, 2017: 1 D
Aug. 4, 2017: 1 E
Oct. 12, 2017: 1 D
Dec. 27, 2017: 2 D
Dec. 28, 2017: 1 D

Jan. 25, 2018: 1 D
Mar. 15, 2018: 2 D
Mar. 22, 2018: 2 D
Apr. 16, 2018: **I H, 1 L**
Apr. 24, 2018: 1 D
May 21, 2018: 1 D
Aug. 21, 2018: 1 D
Aug. 29, 2018: 1 D
Sep. 6, 2018: 1 D
Dec. 3, 2018: 1 D
Dec. 18, 2018: 1 D

Jan. 2, 2019: 3 D
Jan. 8, 2019: 1 D
Feb. 25, 2019: 1 D
Mar. 20, 2019: 1 D
Apr. 3, 2019: 2 D
Apr. 16, 2019: 1 D
Jul. 11, 2019: 1 D
Sep. 4, 2019: 2 E
Sep. 23, 2019: 1 D

Jan. 6, 2020: 4 D
Jan. 16, 2020: 2 D
Feb. 5, 2020: 1 D
Feb. 20, 2020: 1 D
Mar. 3, 2020: 1 E

Four quality measures reflect influenza vaccinations. The facility reported better performance only on long-stay residents: better performance on one measure, worse performance on one measure.

On the other quality measures used to calculate the quality measure star rating, the facility reported performance on only long-stay residents: better performance on five measures, worse performance on two measures, and information not available on two measures (not enough residents to report on two measures).

Staffing

Magnolia Rehabilitation and Nursing Center reported considerably higher RN hours, considerably lower LPN hours, and considerably lower CNA hours, compared to statewide averages.

Editor's Note: The hours reported on *Nursing Home Compare* do not seem plausible.

	Magnolia Rehabilitation and Nursing Center	**State average in California**	**National average**
RN hours	3 hours 52 minutes [sic]	38 minutes	41 minutes
LPN/LVN hours	12 minutes	1 hour 8 minutes	52 minutes
Total licensed nursing staff hours	4 hours 5 minutes [sic]	1 hour 46 minutes	1 hour 34 minutes
CNA hours	33 minutes [sic]	2 hours 35 minutes	2 hours 18 minutes
Physical therapy staff hours per resident per day	0 minutes	6 minutes	5 minutes

"As coronavirus raged through nursing homes, inspectors found nothing wrong" is available at https://www.latimes.com/california/story/2020-06-28/coronavirus-nursing-homes-state-inspector-covid-19 and from the Center for Medicare Advocacy, on request.

STATE ENFORCEMENT NEWS

REGULATORY ENFORCEMENT

19. CALIFORNIA DEPARTMENT OF HEALTH SUSPENDS NURSING FACILITY'S LICENSE; STATE ATTORNEY GENERAL ORDERS EVACUATION OF ALL RESIDENTS

At 11:00 p.m. on June 12, 2020, 60 residents of Golden Cross Health Care were evacuated from the Pasadena nursing facility and taken to other nursing facilities, following the state's suspension of the facility's license and the state Attorney General's order to evacuate the facility. Alex Wigglesworth, "Residents evacuated from Pasadena skilled nursing facility after state suspends license," *Los Angeles Times* (June 14, 2020). Although some of the state's and city's concerns involved COVID-19, a spokeswoman for the City of Pasadena said that additional patient care concerns were at issue. These concerns included lack of sufficient nutrition and water and basic medical care as well as the facility's efforts to conceal information about residents from the city.

Two weeks earlier, the state's Emergency Medical Services Authority and a National Guard medical team reported serous concerns about poor quality of care for residents. The Pasadena fire chief and health officer visited the facility on May 7 and identified a need for quick action to protect residents.

The *Los Angeles Times* reports that the state has cited care problems at the facility for many years. In 2012, the facility failed to prevent and treat wounds and to identify cases of dehydration. A resident's open wound contained maggots. An April 2020 survey report cited a dozen deficiencies, "including failing to obtain informed consent from residents before giving out medication, to provide appropriate ulcer care, to implement plans to prevent falls, and to properly label and store medicine."

> **Editor's Note:** As shown below, *Nursing Home Compare* does not reflect these serious longstanding care problems. California may have cited these deficiencies only as violations of state law.

The facility has had more than 100 confirmed cases of COVID-19 – 72 residents and 32 staff; eight people have died.

Golden Cross Health Care

The most recent data for Golden Cross Health Care (site visited June 29, 2020) indicate 17 health deficiencies at the facility for the most recent standard survey on April 11, 2019: 1 B, 11 D, and 5 E. There were no complaint surveys between April 1, 2019 and March 3, 2020.

As of June 29, the facility had two stars in health surveys, three stars in staffing, and five stars in quality measures (two stars for short-stay residents, five stars for long-stay residents). Its overall rating is three stars.

> **Editor's Note:** The five-star rating in quality measures boosted the facility's overall rating so that the two-star facility (based on the health surveys) became a three-star facility. It is not clear why the facility received five stars in quality measures when its short-stay quality measures were rated with two stars.

Nursing Home Compare indicates that no federal civil money penalties or denials of payment for new admissions were imposed against the facility in the prior three years. Two complaint or facility-reported incidents in the prior three years resulted in two no-harm health deficiencies:

> Nov. 17, 2017: 1 D
>
> Sep. 27, 2018: 1 D

Four quality measures reflect influenza vaccinations. The facility reported worse performance on all four measures.

On the other quality measures used to calculate the quality measure star rating, the facility reported performance better performance on 11 measures and worse performance on three measures.

Staffing

Golden Cross Health Care reported considerably lower RN hours, considerably lower LPN hours, and lower CNA hours, compared to statewide averages.

	Golden Cross Health Care	**State average in California**	**National average**
RN hours	18 minutes [sic]	38 minutes	41 minutes
LPN/LVN hours	55 minutes	1 hour 8 minutes	52 minutes
Total licensed nursing staff hours	1 hour 13 minutes [sic]	1 hour 46 minutes	1 hour 34 minutes
CNA hours	2 hours 28 minutes	2 hours 35 minutes	2 hours 18 minutes
Physical therapy staff hours per resident per day	0 minutes	6 minutes	5 minutes

"Residents evacuated from Pasadena skilled nursing facility after state suspends license" is available at https://www.latimes.com/california/story/2020-06-13/residents-evacuated-pasadena-nursing-facility-state-suspends-license and from the Center for Medicare Advocacy, on request.

20. PENNSYLVANIA IMPOSES $62,000 FINE AT NURSING FACILITY, WHERE 80 RESIDENTS DIED OF COVID-19, FOR INFECTION CONTROL DEFICIENCIES

In April 2020, the Pennsylvania department of health helped install a Connecticut company as temporary manager of Brighton Rehabilitation and Wellness Center. In May, federal surveyors conducted a survey at the nursing facility where at least 76 residents had died of COVID-19. The facility has been a Special Focus Facility for 28 months. Natasha Lindstrom, "U.S. Health Secretary says feds investigating Brighton nursing home coronavirus outbreak," *TribLive* (May 29, 2020).

The 589-bed facility, now with 334 residents, has been fined $62,580, so far. Jamie Martines, "Feds to fine Brighton nursing home at least $62K for coronavirus response," *TribLive* (June 11, 2020). As of June 10, at least 80 residents had died.

The May 5, 2020 survey cited infection control as immediate jeopardy (level K), identifying staff's repeated failures "to use proper personal protective equipment, perform proper hygiene, and store/handle linens in the proper manner to prevent the potential for cross-contamination" at nine of eleven nursing units, in violation of federal rules and facility policies. The report describes repeated surveyor observations of multiple staff members.

Brighton Rehabilitation and Wellness Center

The most recent data for Brighton Rehabilitation and Wellness Center (site visited June 30, 2020) indicate 14 health deficiencies at the facility for the most recent standard survey, which was also

a complaint survey, on September 13, 2019: 7 D, 6 E, and 1 F. Four additional complaint surveys between April 1, 2019 and March 3, 2020 cited nine deficiencies, including one actual harm deficiency:

May 16, 2019: 1 D, 1 E
Aug. 14, 2019: **1 G**
Dec. 13, 2019: 1 D, 1 E

Jan. 9, 2020: 4 D

As of June 30, the facility had one star in health surveys, two stars in staffing, and five stars in quality measures (four stars for short-stay residents, five stars for long-stay residents). Its overall rating is two stars. The facility also has an abuse icon.

Editor's Note: The five-star rating in quality measures boosted the facility's overall rating so that the one-star facility (based on the health surveys) became a two-star facility.

Nursing Home Compare indicates that three federal civil money penalties (May 16, 2019: $9,623; Apr. 2, 2018: $8,908; Jul. 11, 2017: $5,448) totaling $63,979, but no denials of payment for new admissions were imposed against the facility in the prior three years. Twelve complaint or facility-reported incidents in the prior three years resulted in 23 deficiencies, including two actual harm deficiencies and two immediate jeopardy deficiencies:

Jul. 11, 2017: 1 D, **1 G**
Sep. 12, 2017: 1 E

Aug. 7, 2018: 1 E
Dec. 14, 2018: 2 E

Jan. 28, 2019: **2 K**
Feb. 1, 2019: 1 E
Feb. 6, 2019: 2 D, 2 E
May 16, 2019: 1 D, 1 E
Aug. 14, 2019: **1 G**
Sep. 13, 2019: 1 F
Dec. 13, 2019: 1 D, 1 E

Jan. 9, 2020: 4 D

Four quality measures reflect influenza vaccinations. The facility reported worse performance on all four measures.

On the other quality measures used to calculate the quality measure star rating, the facility reported performance better performance on nine measures and worse performance on four measures.

Staffing

Brighton Rehabilitation and Wellness Center reported considerably lower RN hours, considerably lower LPN hours, and considerably higher lower CNA hours, compared to statewide averages.

	Brighton Rehabilitation and Wellness Center	**State average in Pennsylvania**	**National average**
RN hours	25 minutes [sic]	49 minutes	41 minutes
LPN/LVN hours	41 minutes	51 minutes	52 minutes
Total licensed nursing staff hours	1 hour 6 minutes [sic]	1 hour 40 minutes	1 hour 34 minutes
CNA hours	2 hours 25 minutes	2 hours 9 minutes	2 hours 18 minutes
Physical therapy staff hours per resident per day	2 minutes	6 minutes	5 minutes

"U.S. Health Secretary says feds investigating Brighton nursing home coronavirus outbreak" ids available at https://triblive.com/local/regional/u-s-health-secretary-says-feds-investigating-brighton-nursing-home-coronavirus-outbreak/;
"Feds to fine Brighton nursing home at least $62K for coronavirus response," at https://triblive.com/local/regional/feds-to-fine-brighton-nursing-home-at-least-62k-for-coronavirus-response/; survey report, at https://htv-prod-media.s3.amazonaws.com/files/otfs11430738900l-pdf-1592359442.pdf. Both articles and the survey report are available from the Center for Medicare Advocacy, on request.

NURSING HOME INDUSTRY NEWS

21. American Health Care Association's CEO Issues Message to Members: "We Won't Back Down"

In an undated (June 2020) Message, the American Health Care Association's President and CEO Mark Parkinson tells member nursing facilities "Our profession faces its greatest challenge in history" and "the very survival of our sector." AHCA, "A Message from the President & CEO Mark Parkinson; We Won't Back Down."

Parkinson begins by reporting that that people who have COVID-19 may be contagious while asymptomatic. As a consequence, and citing researchers from Harvard (David Grabowski), Brown (Vincent Mor), and the University of Chicago (R. Tamara Konetzka), he writes that facilities are not at fault when residents and staff become infected with COVID-19:

> It wasn't a matter of bad operators getting COVID-19 and good operators not getting it. The facts indicate that your Five-Star rating, profit vs. not for profit status, or prior deficiency history are not predictors of whether COVID-19 gets in your buildings. The

most important factor determining whether COVID-19 ends up in a building is the surrounding community of where the building is located. If you are located in New York, you likely ended up with COVID-19 in your building. If you are located in the rural Midwest, you are less likely to have COVID-19 in your building. It depends on the outbreak in the surrounding community, which impacts the number of carriers without symptoms.

Parkinson reports that facilities are fighting back and that AHCA is as well in Washington, D.C. He reports a series of "small wins," including Medicare Advanced Payments, a 2% increase in Medicare rates as a result of the lifting of the Medicare sequester, a 2.3% increase in reimbursement beginning October 1, 2020, and no changes in the Patient-Driven Payment Model reimbursement (the new Medicare reimbursement system for skilled nursing facilities).

Parkinson reports "an historic media campaign to fight back." Funded by a $10 per skilled nursing facility bed assessment in June 2020 and a similar assessment in June 2021, AHCA will have $15 million for media and social media campaigns "to shape the national conversation."

Next steps for AHCA include getting financial relief for assisted living, getting federal liability immunity for COVID-19, and getting additional funding for nursing facilities from the $62 billion that remain in the Provider Relief Fund.

"A Message from the President & CEO Mark Parkinson; We Won't Back Down" is available at https://files.constantcontact.com/64f0b60b701/f86b03a3-a859-4098-b6d0-3866c56672d5.pdf and from the Center for Medicare Advocacy, on request.