DignityAlliance Massachusetts
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Joint Committee on Elder Affairs 6/30/21 Hearing:
S.414/H.727 An Act to ensure quality of care in nursing homes

June 30, 2020

Senator Patricia Jehlen
Joint Committee on Elder Affairs, Chair
Delivered by email: Patricia.Jehlen@masenate.gov

Representative Thomas M. Stanley
Joint Committee on Elder Affairs, Chair
Delivered by email: Thomas.Stanley@mahouse.gov

Dear Chair Jehlen and Chair Stanley:

Dignity Alliance Massachusetts (Dignity Alliance) is providing this testimony in strong support of **S.414/H.727 An Act to ensure quality of care in nursing homes** in order to improve the quality of care, dignity, and quality of life of Massachusetts nursing home residents. Dignity Alliance is a broad-based group representing a wide range of stakeholders dedicated to transformative change to ensure the dignity of older adults, people with disabilities, and caregivers. We are committed to advancing new ways of providing long-term services, support, living options, and care while respecting choice and self-determination. Dignity Alliance works through education, legislation, regulatory reform, and legal strategies for this mission to become reality throughout the Commonwealth.

The components of S.414/H.727 are constructed to protect Massachusetts nursing home residents from ever repeating the suffering they endured during the COVID-19 pandemic. The pandemic took a devastating toll on nursing home residents nationally, and in particular in Massachusetts. Nursing home residents account for over 30% of COVID-19 deaths in the Commonwealth[1], even though they account for less than half of 1% of the state's population[2]. Sadly, countless other nursing home residents have suffered from isolation and neglect from a year-long ban on visitations. The care improvements called for in these bills are necessary to prevent such tragedies from happening again. The bills include requirements for responsible staffing levels, customized outbreak response plans, social isolation prevention policies, a blueprint to minimize congregate living, and career ladder training and advancement opportunities for caregivers. All of these improvements are necessary to protect nursing home residents going forward.

Section 1 – Nursing Personnel

We strongly support 4.1 minimum hours of care per resident per day (HPRD), which includes at least 0.75 HPRD by a registered nurse. We also fully agree with the HPRD calculation --- includes hours of care by registered nurses, licensed practical nurses, and certified nurse aides (CNAs), and excludes "nurse aides in training" hours currently included in the HPRD calculation[3].

4.1 HPRD minimum, inclusive of at least .75 RN HPRD:
Research shows that staffing is the most important indicator of a nursing home's quality and safety. We commend the Commonwealth for recently implementing regulations requiring a

Section 1 – Nursing Personnel (continued)

4.1 HPRD minimum, inclusive of at least .75 RN HPRD (continued):

3.58 HPRD, which includes a 0.508 HPRD for a registered nurse. However, S.414/H.727 will codify a higher standard of 4.1 HPRD, which includes a .75 RN HPRD. According to a 2001 CMS study, these higher levels are necessary just to prevent harm or jeopardy to residents[4]. While this higher level is critical for the safety of residents, S.414/H.727 recognizes that these CMS standards do not take into account the higher acuity level of the resident population that exists 20 years after publication of the 2001 report, and do not consider quality of life and dignity issues which are important components of the nursing home requirements and rightful expectations for residents and their families. Consequently, the proposed legislation sets these standards as a minimum, allowing for increases "to meet resident nursing care needs, based on acuity, resident assessments, care plans, census, and other relevant factors…"[5]

- It's important to note how MA nursing homes measure up to these important staffing standard goals. As of Q4, 2020, the latest CMS data available (based on facility submitted payroll-based journals), much work needs to be done to bring staffing to safe levels:
  - ✓ 50% of MA nursing homes were staffed below the new 3.58 HPRD requirement which became regulation in April, 2021. However, nursing homes were encouraged to implement this standard as early as 9/10/20[6], and beginning 1/1/21, a nursing home that fails to meet an average of at least 3.58 HPRD will be subject to a 2% downward adjustment of the facility's standard rate for that calendar quarter.[7]
  - ✓ 80% of MA nursing homes were staffed below the 4.1 HPRD required by S.414/H.727 and recommended by the 2001 CMS study.

In further support of the 4.1 HPRD goal, a recent study of US nursing homes with one or more COVID-19 cases found that high nursing aide and total nursing hours were associated with a lower probability of a COVID-19 outbreak and with fewer deaths[8]. As a matter of fact, New Jersey implemented staffing standards equivalent to 4.1 HPRD[9] in 2020 in an effort to improve nursing home care during the pandemic. Also, Washington, DC[10] was a leader in improving resident care by implementing the 4.1 HPRD more than a decade ago.

A number of organizations have also endorsed the minimum of 4.1 HPRD standard and have recommended that at least 30% of hours should be provided by RNs and LVNs/LPNs[11], and that facilities should have 24/7 RN[12] care. Currently, RN care is only required 8 hours/day, 7 days/week.

In addition, it has been found that higher RN staffing levels are associated with better resident care quality in terms of fewer pressure ulcers; lower restraint use; decreased infections; lower pain; improved activities of daily living (ADLs) independence; less weight loss; less dehydration; less improper and overuse of antipsychotics; and lower mortality rates[13].

- The misuse of antipsychotics is a special concern since Massachusetts reports much higher percentages of residents on antipsychotics than many other states. MA had the 8th highest antipsychotic usage rate in the country as of Q2, 2019 (updated 1/24/20), according to the last reported statistics by the CMS Partnership to Improve Dementia Care[14].

HPRD Calculation: In March, 2020 at the beginning of the pandemic, the Centers for Medicare and Medicaid Services (CMS) issued a blanket waiver that allowed nurse aides to work for longer than four months without first completing 75 hours of training and without passing a competency test on topics such as infection control, residents' rights, and basic nursing skills.

Section 1 – Nursing Personnel (continued)

HPRD Calculation (continued):

Then on April 8, 2021, CMS maintained the blanket waiver, said the four-month training period would begin when the waiver ends, and suggested "states consider allowing some of the time worked by the nurse aides during the pandemic to count towards the 75-hour training requirement". This potential weakening of the 75-hour training requirement is concerning. It's unknown how many nurse aides in training are working in MA nursing homes, how much training they have received and from whom, or which CNA tasks they are performing and how well.

In addition, federal regulations demand a higher proficiency than "nurse aides in training". According to federal law, "…sufficient nursing personnel with the appropriate competencies and skills sets to provide nursing and related services must be maintained to assure safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, based on acuity, resident assessments, care plans, census and other relevant factors in accordance with the facility assessment..."[15]

The pandemic has proven that well-trained staff are crucial for nursing home resident safety, and there's no reason to assume work experience would equate to training. We fully support solely using nurses and CNAs in the HPRD calculation to keep federal training standards high.

Section 2 – Outbreak Response Plan

We strongly support the requirement for an "outbreak response plan" customized to each nursing home, updated annually, and submitted to the Department of Public Health (DPH). The plan would include, at a minimum, protocols for isolating and cohorting infected and at-risk residents, outbreak notification policies, testing protocols for staff and visitors, monitoring policies for residents and staff, and outbreak reporting policies to public health officials. The outbreak response plan must also include written policies to meet staffing, training, and facility demands during an infectious disease outbreak. To carry out the plan, the facility must either employ or contract a full- or part-time infection preventionist.

Nursing homes are required to have an emergency preparedness plan to protect nursing home residents during a natural disaster. An outbreak response plan is equally as important, and the following outcomes further support the need for a comprehensive and coordinated plan:

- On 5/20/20, the Government Accountability Office (GAO) published an analysis of the prevalence of infection prevention and control deficiencies in nursing homes prior to the pandemic. The GAO analysis[16] of CMS data shows that infection prevention and control deficiencies were the most common type of deficiency cited in surveyed nursing homes, with most nursing homes having an infection prevention and control deficiency cited in one or more years from 2013 through 2017. About 64% of Massachusetts nursing homes had an infection prevention and control deficiency cited in one or more years during that 5-year period. Also, about 16% of Massachusetts nursing homes were cited in multiple consecutive years which is an indicator of persistent problems.
- On 11/5/20, DPH initiated temporary admissions freezes at nursing homes and rest homes to prevent and contain uncontrolled transmission of COVID-19[17]. DPH monitors the following factors to determine which facilities pose the greatest risk in determining

Section 2 – Outbreak Response Plan (continued)

placement on the admissions freeze list: COVID-19 cases within the facility; staffing levels; failure to report a lack of adequate PPE, supplies, or staff; infection control survey results; and surveillance testing compliance. Currently, there are 14 facilities with temporary admissions freezes, but earlier this year as of 1/25/21, 56 facilities (15% of MA nursing homes) were required to halt admissions immediately. Admission freeze facilities may also be subject to financial penalties from MassHealth.

We submit the following recommendation:

1. Regarding the part-time infection preventionist position, we recommend making this position full-time, as recommended by the CDC and the Association for Professionals in Infection Control and Epidemiology (APIC)[18]. The federal requirement[19] that nursing homes have an infection preventionist in the facility at least on a part time basis was established in 2016 due to concerns about high rates of infections and deaths among nursing home residents. However, in July 2019, in response to nursing home industry lobbying efforts, CMS issued a proposed rule to roll back the infection preventionist standard from "part-time" to "sufficient" time. We strongly opposed the proposed rule because a facility's determination of what is "sufficient" is a vague description open to interpretation and may be based on profit incentives, rather than resident safety. Also, enacting the full-time position in MA law effectively protects the role of infection preventionist from any changes that may happen on the federal level.

Section 3 – Social Isolation Prevention Policies

We strongly support the requirements for "social isolation prevention policies" when in-person contact, communication, or activities are prohibited, restricted, or limited by federal or state statute, rule, or regulation. Supportive policies would include protocols and procedures for residents to connect with loved ones and others through electronic or virtual means and methods, including the development of a visitation plan. Communicative technologies and accessories shall be provided, including assistive and supportive devices and methods for residents with disabilities or cognitive impairments. Protocols for the acquisition, maintenance and replacement of the communication devices are also required. And staff shall be made available to assist the residents with communication, as well as acquiring, maintaining, and cleaning the devices. DPH shall determine compliance and issue financial penalties for non-compliance.

"…Nursing home residents have suffered in so many ways over the course of this pandemic, but the most emotional impact has been from being cut off from their families, friends, and each other. "Social isolation is a potent killer," declared the American Academy of Social Work and Social Welfare (AASWSW).[20] In fact, some death certificates during the pandemic have read "failure to thrive" in cases where doctors believe the despair and desperation of being cut off from loved ones played a significant role.[21] It is one of the most tragic lessons learned over the course of this pandemic, and we must emerge with the conviction to find a better path…"[22]

We submit these recommendations:

1. In regard to a visitation plan, we recommend allowing every resident to designate an essential support person (ESP). The ESP can be a family member or representative (includes geriatric care giver/manager, guardian, health care proxy, other designated representative,

2. Section 3 – Social Isolation Prevention Policies (continued)

We submit these recommendations: (continued)

friend, or anyone who has been providing in-person support similar to an ESP)[23]. The ESP must be allowed unrestricted access to residents to provide physical and emotional support and assistance in meeting residents' needs. ESPs should be treated as employees of the facility for infection control purposes, including routine COVID-19 testing and the wearing of PPE (cost to be borne by the facility). Until full visitation rights are restored, ensure that visits are no less than one hour weekly.[24]

There is precedent for similar social isolation prevention legislation enacted 10/23/20 in New Jersey, S2785[25] An Act concerning the implementation, by long-term care facilities, of policies, protocols, and procedures to prevent the social isolation of facility residents, and enacted 6/24/21 in Connecticut, H6634[26], Public Act No. 12-71, An Act concerning essential support persons and a state-wide visitation policy for residents of long-term care facilities (nursing homes and managed residential community). Both laws designate two essential support persons. However, while both provide good plans for visitation on a normal basis, they do not cover visitations in a public health emergency declared by the Governor.

Most recently, on 6/30/21, federal bipartisan legislation was introduced in Congress --- the Essential Caregivers Act, H.R. 3733[27] --- that says, unequivocally, the government cannot ever again totally ban families. Regardless of any public health emergency, the bill guarantees that all residents can choose up to two people as essential caregivers who can provide them with assistance 12 hours each day and for an unlimited number of hours at the end of a resident's life. H.R. 3733 also includes language on how to resolve any non-compliance with visitation requirements, enforcement protocols, and a wide range of stakeholders named for consultation to promulgate regulations (residents, family members, long-term care ombudsmen, other advocates of nursing home residents, and nursing home providers). The bill's original sponsors are Congresswoman Claudia Tenney (R-NY) and Congressmen John Larson (D-CT) and John Rutherford (R-FL).

2. It's important to impose a meaningful financial penalty for non-compliance with these proposed policies in order to protect nursing home residents at a time when they are extremely vulnerable in the midst of a pandemic or other threat to their well-being. It's all too easy for facilities to accept a low financial penalty as a "cost of doing business" and then continue non-compliance to the potential harm of residents. The threat of fines is a critical deterrent to abuse and substandard care, particularly when fines are large enough to impact a facility's actions. Consequently, we recommend codifying federal penalty language in Massachusetts statute to ensure nursing home residents receive the care and support they deserve. We recommend the language used in S.424 An Act to prevent patient abuse and death in nursing homes, Sen. Montigny, to accomplish a meaningful penalty, namely: "… a fine not to exceed $22,320, unless the department determines a higher amount is permitted pursuant to 42 CFR 488.438…" $22,320 is the current federal maximum penalty.

Section 4 - Resident Bedrooms

We strongly support the codifying the resident bedroom criteria proposed by S.414/H.727 which further improves recently implemented regulations in 105 CMR 150.00: Standards for Long-Term Care Facilities[28] . The legislation addresses reducing the maximum number of beds per room from "no more than four beds" to "no more than two beds", including additional spacing and other requirements.

Codifying these spatial requirements is critical to protecting nursing home residents, and recent studies support the importance of this legislation. According to a *JAMA Internal Medicine* study which examined the association between nursing home crowding and COVID-19, COVID-19 incidence in rooms and bathrooms with a higher number of people per room was 9.7% compared to 4.5% with a lower number of people per room and bathroom. Furthermore, the death rate was higher in those rooms and bathrooms with more people (2.7%) vs. COVID-19 deaths in rooms with fewer people (1.3%).[29]

In congregate living settings where closely quartered older adults are at particular risk for greater infection rates and mortality, managing the structural environment to minimize risk becomes central to any infection control strategy.

<u>We submit these recommendations:</u>

1. The dangers of congregate living extend to shared bathrooms, and while it may be intended to require private bathrooms as part of this legislation, it's important to clarify this.
2. The legislation states "no resident bedroom shall contain more than two beds" which also allows expanding the availability of single occupancy rooms. We recommend stating the joint requirement of "single and double" occupancy rooms to also promote private rooms. Private rooms are the best safeguard against infection transmission, while still maintaining the double occupancy rooms for married couples or those agreeing to shared rooms (i.e.siblings, friends, etc.).
3. The legislation also states that "in double occupancy situations, resident beds must be spaced at least 6 feet apart". We recommend updating the spacing requirement based on the most recent scientific recommendation which may be well beyond 6 feet. See study in footnote[30] supporting at least 12 feet, and also according to this 5/7/21 Centers for Disease Control and Prevention announcement[31]: "…Although infections through inhalation at distances greater than six feet from an infectious source are less likely than at closer distances, the phenomenon has been repeatedly documented under certain preventable circumstances. These transmission events have involved the presence of an infectious person exhaling virus indoors for an extended time (more than 15 minutes and in some cases hours) leading to virus concentrations in the air space sufficient to transmit infections to people more than 6 feet away, and in some cases to people who have passed through that space soon after the infectious person left…" The air flow or ventilation in the room is critical, and nursing home ventilation systems are typically not very good. There's also the issue of length of time in contact, and of course residents share a room 24/7.

Section – Career Ladder

We strongly support creating a career ladder grant program to upgrade the skill of certified nurse aides and entry-level workers in order to improve retention rates and improve the quality of care to residents. The proposed program would establish a three-level career pathway for certified nurses' aides and develop employee competencies in specialized areas of care.

We submit this recommendation:

1. As part of creating the career ladder grant program, we recommend increasing the 75 hours of training required to become a certified nursing assistant to at least 120 hours, the level recommended by the National Academy of Medicine (formerly the Institute of Medicine) in its report on the adequacy of the healthcare workforce for older Americans (Retooling for an Aging America, 2008, Recommendation 5-1). Massachusetts is one of only 19 states that have not changed these basic requirements in nearly 30 years.[32]

   The federal government requires that within four months of working at a facility, new nursing assistants must complete a minimum of 75 hours of training, including 16 hours of clinical training under direct supervision of a registered or licensed practical nurse[33]. However, states are allowed to adjust requirements above this federal minimum, and 32 states (including Washington, D.C.) have done so – up to a maximum of Maine's 180 hours. However, Massachusetts and 18 other states remain at the federal minimum.[34] Training standards have real impacts on resident well-being, and research indicates that nursing homes in states that required clinical training hours above the federal minimum had significantly lower odds of adverse outcomes – particularly pain, falls with injury, and depression.[35]

Thank you for the opportunity to provide testimony regarding so many critical issues to protect nursing home residents and their caregivers. We must learn from the devastation of the pandemic and make improvements to ensure the safety and dignity of all living and working in long-term care.

Sincerely,

Paul Lanzikos, paul.lanzikos@gmail.com
for DIGNITY ALLIANCE MASSACHUSETTS
35 High Street
Beverly, MA 01915
info@DignityAllianceMA.org

Arlene Germain, agermain@manhr.org
for DIGNITY ALLIANCE MASSACHUSETTS
Policy Director, Massachusetts Advocates for Nursing Home Reform
More than 20 years of unwavering advocacy!
POB 560224 | Medford, MA 02156 | 800-988-4450 | www.manhr.org

[1] 5,502 MA nursing home resident COVID-19 deaths /17,623 Total MA COVID-19 deaths=31%.
Mass. COVID-19 death toll in nursing homes drops by 1,200 as the state adopts a new way to report long-term-care deaths, Boston Globe, Robert Weisman and Kay Lazar, 4/15/21 --- 5,502 nursing home resident deaths. https://www.bostonglobe.com/2021/04/15/metro/covid-19-death-toll-is-about-drop-state-adopts-new-way-report-long-term-care-deaths/?s_campaign=8315.
17,623 Total COVID-19 MA deaths as of 6/24/21, reported 6/25/21: https://www.mass.gov/info-details/covid-19-response-reporting.
[2] 31,974 MA nursing home residents per Q1 '21 Minimum Data Set database [AO800 Gender] https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/Minimum-Data-Set-3-0-Frequency-Report
7,029,917 4/1/20 MA residents https://www.census.gov/quickfacts/MA
[3] **105 CMR 150.000: STANDARDS FOR LONG-TERM CARE FACILITIES (Mass. Register #1440 4/2/21)**
https://www.mass.gov/regulations/105-CMR-15000-standards-for-long-term-care-facilities
150.001 Definitions: Hours of care per resident per day (PPD) shall mean the total number of hours worked by registered nurses, licensed practical nurses, and nursing assistants, including certified nurse aides, and nurse aides in training with direct resident care responsibilities for each 24 hour period, divided by the total census of the facility for each day.
[4] Appropriateness of Minimum Nurse Staffing Ratios in Nursing Homes, Report to Congress: Phase II Final Volume 1 Contract # 500-0062/TO#3, Prepared for Centers for Medicare and Medicaid Services, Prepared by Abt Associates Inc. Cambridge, MA, December 24, https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf Overview of Phase II Report-Background: https://theconsumervoice.org/uploads/files/issues/HHS_Staffing_Study_-_Background_(1).pdf, page 6: "..For each measure, there was a pattern of incremental benefits of increased staffing until a threshold was reached at which point there were no further significant benefits with respect to quality when additional staff were utilized.
[5] Op.Cit., page 11: "…Although the Phase II analysis did not identify different staffing levels that maximized quality for different case mix groupings, it did find that adverse outcomes were significantly higher at the same staffing levels for facilities of higher case mix. The investigators concluded that higher staffing levels are warranted for facilities with residents of higher acuity and functional limitations…"
[6] Nursing Facility Accountability and Supports Package 2.0, September 10,2020: https://www.mass.gov/doc/covid-19-nursing-facility-accountability-and-supports-package-20/download
[7] Standard Payments to Nursing Facilities 101 CMR 206.00, Mass. Register #15433 5/14/21 https://www.mass.gov/doc/101-cmr-206-standard-payments-to-nursing-facilities/download, 206.13: Average Staffing Hours Incentive (2) Beginning January 1, 2021, a nursing facility that fails to meet an average of at least 3.58hours per patient day, in accordance with 101 CMR 206.13(1), will be subject to a downward adjustment equal to 2% of the facility's standard rate for that calendar quarter. The dollar amount resulting from this adjustment will be considered an overpayment pursuant to 130 CMR 450.235:Overpayments.
[8] Georges RJ, Konetzka RT (2020) Staffing Levels and COVID-19 Cases and Outbreaks in U.S. Nursing Homes. JAGS 68: 2462-2466 https://agsjournals.onlinelibrary.wiley.com/doi/full/10.1111/jgs.16787.
[9] New Jersey staffing law, equivalent to 4.1 HPRD: S2712 - Mandatory Minimum Staffing Ratios for Direct Care Workers in Nursing homes
[10] Washington, DC – see 3211.5 in the following link: https://doh.dc.gov/sites/default/files/dc/sites/doh/publication/attachments/Nursing_Facility_Regulations_Health_Care_Facilities_Improvement_2012.pdf.
[11] Op.Cit., Libertas Academica, *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes*: "CMS and experts recommend higher minimum staffing levels"
[12] Op.Cit., Libertas Academica, *The Need for Higher Minimum Staffing Standards in U.S. Nursing Homes* Page 15.
[13] *Appropriate Nurse Staffing Levels for U.S. Nursing Homes*; Harrington, Dellefield, Halifax, Frlming, Baerjian; 6/29/20; https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7328494/.
[14] https://www.cms.gov/files/document/antipsychotic-medication-use-data-report-updated-01242020.pdf

[15] Electronic Code of Federal Regulations, Title 42: Public Health, PART 483—REQUIREMENTS FOR STATES AND LONG TERM CARE FACILITIES, 2/11/21, https://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=e3979b25f8d8b29c78b1b3f6c66dbdaa&rgn=div5&view=text&node=42:5.0.1.1.2&idno=42#se42.5.483_135 §483.35 Nursing services.
The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e).
(a) *Sufficient staff.* (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
(i) Except when waived under paragraph (e) of this section, licensed nurses; and
(ii) Other nursing personnel, including but not limited to nurse aides.
(2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.
(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs...".

[16] *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic*, General Accounting Office, 5/20/20, https://www.gao.gov/assets/gao-20-576r.pdf.

[17] https://www.mass.gov/doc/control-of-covid-19-in-long-term-care-facilities/download. Current data on admissions freezes: https://www.mass.gov/info-details/long-term-care-covid-19-family-information-center#temporary-admissions-freeze-. Admissions freezes as of 7/2/21: Ann's Rest Home, Brandon Woods of New Bedford, Burgoyne Rest Home, Chestnut Hill of East Longmeadow, Courtyard Nursing Care Center, Hathaway Manor Extended Care, Hellenic Nursing and Rehabilitation Center, Homestead Hall, Maplewood Center, Medway Country Manor Skilled Nursing & Rehab, Mission Care (Mount Saint Vincent) Care Center, New England Sinai Hospital Transitional Care Unit, Oosterman's Melrose Rest Home, Plymouth Harborside Healthcare, Revolution Charwell, Royal at Wayland Rehabilitation and Nursing Center, Stonehedge Healthcare Center, Vero Health & Rehab of Worcester, Wingate at Harwich.

[18] *APIC Calls for Properly Trained Infection Prevention Expertise in All New York State Nursing Homes*, 2/11/21, https://apic.org/apic-calls-for-properly-trained-infection-prevention-expertise-in-all-new-york-state-nursing-homes/.

[19] Electronic Code of Federal Regulations, Title 42, Part 483, as of 5/21/20: §483.80 Infection control.
The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections…
…(b) *Infection preventionist.* The facility must designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's IPCP. The IP must:
(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;
(2) Be qualified by education, training, experience or certification;
(3) Work at least part-time at the facility; and
(4) Have completed specialized training in infection prevention and control.
(c) *IP participation on quality assessment and assurance committee.* The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis…"

[20] *Geography Is Not Destiny: Protecting Nursing Home Residents from the Next Pandemic*, Center for Medicare Advocacy, 2/14/21, https://medicareadvocacy.org/wp-content/uploads/2021/02/CMA-NH-Report-Geography-is-Not-Destiny.pdf, page 28.

[21] Sedensky, M., & Condon, B., "Not just COVID: Nursing home neglect deaths surge in shadows" *Associated Press* (Nov. 19, 2020), available at: https://apnews.com/article/pandemics-us-news-coronavirus-pandemicdaac7f011bcf08747184bd851a1e1b8e

[22] *Geography Is Not Destiny: Protecting Nursing Home Residents from the Next Pandemic*, Center for Medicare Advocacy, 2/14/21, Action Needed #2: Make it a *home* – prioritize social connection and engagement of residents, https://medicareadvocacy.org/wp-content/uploads/2021/02/CMA-NH-Report-Geography-is-Not-Destiny.pdf, page 28

[23] *Visitation Policy and Isolation Prevention Recommendations; Nursing Homes, Rest Homes, and Assisted Living Residences*, Dignity Alliance Massachusetts, Approved 9/25/20

[24] A National Tragedy: COVID-19 in the Nation's Nursing Homes, Hearing before the US Senate Committee on Finance, 3/17/21, The National Consumer Voice for Quality Long-Term Care Letter dated 3/29/21: https://theconsumervoice.org/uploads/files/issues/Statement_for_the_Record-A_National_Tragedy-COVID-19_in_the_Nations_Nursing_Homes.pdf

[25] Senate, No. 2785, **AN ACT** concerning the implementation, by long-term care facilities, of policies, protocols, and procedures to prevent the social isolation of facility residents and supplementing Title 26 of the Revised Statutes, https://legiscan.com/NJ/text/S2785/id/2217426/New_Jersey-2020-S2785-Chaptered.html.

[26] HB6634, Public Act No. 21-71, An Act concerning essential support persons and a state-wide visitation policy for residents of long-term care facilities, https://trackbill.com/bill/connecticut-house-bill-6634-an-act-concerning-essential-support-persons-and-a-state-wide-visitation-policy-for-residents-of-long-term-care-facilities/2072604/?emci=aeb77bd8-ced9-eb11-a7ad-501ac57b8fa7&emdi=5c61074b-a2da-eb11-a7ad-501ac57b8fa7&ceid=4142517.

[27] H.R. 3733 Essential Caregivers Act of 2021, Congresswoman Claudia Tenney (R-NY) and Congressmen John Larson (D-CT) and John Rutherford (R-FL). https://www.congress.gov/bill/117th-congress/house-bill/3733/text?q=%7B%22search%22%3A%22HR+3733%22%7D.

[28] Voted on at 3/10/21 Public Health Council Meeting Public Health Council Meeting, March 10, 2021:
105 CMR 150.017 –150.017 was amended to require, on and after January 31, 2022, nursing homes built prior to 1968 to convert multiple occupancy bedrooms to single or double occupancy bedrooms and to increase the square footage requirements in some single occupancy and all double occupancy resident bedrooms. The proposed amendments align with the May 2020 amendments to the Facility Guidelines Institute's 2018 Edition of the *Guidelines for Design and Construction*, with the exception of the requirement to space beds 6 feet apart, which the Department recommends for strengthening infection control in nursing homes.
105 CMR 150.320 - The Department proposes amending 150.320 to require, on and after January 31, 2022, nursing homes to convert multiple occupancy bedrooms to double occupancy bedrooms and to increase the square footage requirements in double occupancy resident bedrooms. The Department's proposed amendments align with the May 2020 amendments to the Facility Guidelines Institute's 2018 Edition of the *Guidelines for Design and Construction*, with the exception of the requirement to space beds 6 feet apart which the Department recommends for strengthening infection control in nursing homes.

[29] Brown, K. A., Jones, A., Daneman, N., Chan, A. K., Schwartz, K. L., Garber, G. E., . . . Stall, N. M. (2020). "Association Between Nursing Home Crowding and COVID-19 Infection and Mortality in Ontario, Canada" *JAMA Internal Medicine*. doi:10.1001/jamainternmed.2020.6466 https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2772335

[30] Healthline, *Staying 6 Feet Apart Often Isn't Enough During COVID-19 Pandemic*, 8/28/20, https://www.healthline.com/health-news/staying-6-feet-apart-often-isnt-enough-during-covid-19-pandemic.

[31] Scientific Brief: SARS-CoV-2 Transmission, Summary of Recent Changes, updates as of 5/7/21. https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/sars-cov-2-transmission.html.

[32] http://phinational.org/advocacy/nurse-aide-training-requirements-state-2016/ On the Table tab, Texas is listed as 100 training hours which is correct, but on the interactive map Texas is noted at the old 75 training hours. Consequently, the total number of states at the 75 training hours is 19, not 20.

[33] 42 CFR § 483.152 - Requirements for approval of a nurse aide training and competency evaluation program https://www.law.cornell.edu/cfr/text/42/483.152

[34] See Endnote 26.

[35] Trinkoff, A. M., Storr, C. L., Lerner, N. B., Yang, B. K., & Han, K. (2016), "CNA Training Requirements and Resident Care Outcomes in Nursing Homes" *The Gerontologist*. doi:10.1093/geront/gnw049 https://pubmed.ncbi.nlm.nih.gov/27059825/