NEW YORK STATE BAR ASSOCIATION

Report and Recommendations of the **Task Force on Nursing Homes and Long-Term Care**

June 2021

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New York State Bar Association

Task Force on COVID-19 in New York

Nursing Homes and Long-Term Care

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Finally, we want to thank Thomas Richards, NYSBA's Deputy General Counsel, for all the support he provided in multiple ways to the Task Force.

Introduction

The COVID-19 pandemic – a public health crisis unmatched in a hundred years – has been a devastating ordeal. As of this writing, more than 569,000 Americans have died, including more than 40,000 New Yorkers. The virus has been particularly devastating to older individuals. Nursing home residents, an older and more vulnerable

population, including older people of color and those living with disabilities, have been disproportionately impacted by the pandemic. As members of the New York State Bar Association and the larger legal community, we are committed to ensuring that laws and policies adequately protect vulnerable populations and guarantee equitable access to high quality care.

The challenge of unraveling the complex picture presented by the intersectionality of age, race, ethnicity, neighborhood, income inequality, disability, chronic illness, and place of residence in the long-term care system as affected by the pandemic is a daunting one. Nursing homes, as well as other long-term care settings, have emerged as sites of suffering, isolation and loss of loved ones. The Task Force has been asked to examine what has happened during the pandemic to those receiving long term care. Further, the Task Force examines whether the adverse events suffered by those receiving long-term care in New York systems could have been avoided. The Report focuses first on those in New York's nursing homes. There, the level of death from COVID-19 has been greatest. The Report also examines what has occurred in other long-term care settings: namely, adult care facilities, facilities and residences operated or certified by the State Office for Developmental Disabilities, facilities and residences licensed by the Office of Mental Health, and in-home care.

Pre-existing structures account at least in part for the catastrophic nature of the pandemic we have experienced over the last year. A range of issues that the Task Force have identified as critical and integral components of the pandemic experience and outcomes are addressed in this Report. The issues span structural, governmental, and provider level systems. Allocation of resource decisions at all levels impacted the

provision of care, particularly in allocations to the hospital systems before allocations were made to nursing facilities and then to other levels of long-term care. Pre-existing resource allocations to infection control, staffing and training at the provider level all affected the pandemic's impact upon long-term care recipients. Although considerable evidence documenting the pandemic's impacts across multiple domains is available, including certain systems data and data analyses, the evidence available for review is by no means complete. The Report is written as the numbers of individuals becoming ill continues to rise and fall, throughout the State, nation and the world. The virus continues to mutate. The advent and distribution of effective vaccines is cause for great optimism. Thankfully, vaccines seem to have curbed further virus outbreaks in the State's nursing homes, though vaccination reluctance among staff is a cause for concern. The virus continues as a threat, and may even threaten the vaccinated. But for the successful vaccine development, nursing home and other long-term care residents would still be at grave risk.

The history of the virus is still being created, and it is far from being fully written. Further in-depth studies will need to be conducted to glean insights into the multiple and variegated dimensions of COVID-19.

Although the Task Force was unable to resolve all questions, or perhaps even most questions, the Task Force has been able to identify certain linkages, and does make certain recommendations based upon existing evidence, including systems reforms. We can say with certainty that major policy changes will be necessary to address the needs of those affected by the present pandemic and minimize the consequences of future emergent diseases.

A. Task Force Appointment and Mission

The Long-Term Care Task Force of the New York State Bar Association was appointed by current President Scott Karson in July 2020. The mission of the Task Force is to systematically review the long-term care sector pandemic experience. In particular, the Task Force undertook a review of the statutory and regulatory framework under which nursing homes and other long-term care providers operate in New York State; examined the effects of the COVID-19 crisis on institutional and community-based providers and the individuals they serve; and now makes recommendations for change including to applicable statutes, policies, and regulations where needed.

The Task Force commenced its work in August 2021 and conducted biweekly meetings over seven months. The Task Force heard from representatives of a number of organizations who were involved in or with expertise in the impact of the pandemic in different long-term care settings.

They were:

Richard Mollot, Long Term Care Community Coalition

Bryan O'Malley, Consumer Directed Personal Assistance Association of New York State

James Clyne, LeadingAge NY

Stephen Hanse, NYS Health Facilities Association

Christina Towne, Sivan Rosenthal, NYS Nurses Association

Claudette Royal, NYS Nursing Home Ombudsman

Ruth Heller, Todd Hobbler, Service Employees International Union (SEIU) Local 1199

J.R. Drexelius, Developmental Disabilities Alliance of Western New York

Bill Hammond, Empire Center for Public Policy

Task Force member Sheila Shea also made a presentation to the Task Force on the systems operated and governed by the Office of Mental Health and Office for People with Developmental Disabilities.

After hearing from most of the experts, Task Force members were assigned to one of three committees to prepare the Report:

- Examination of Nursing Homes – to review what occurred in nursing homes.
- Examination of Other Long-Term Care Settings – to review what occurred in other long-term care settings such as community-based care, and care in facilities overseen by the Office for Mental Health and the Office for People with Developmental Disabilities.
- Government/Regulatory Structure – to review the role of government and the current laws, regulations and guidance, including guidance developed in response to COVID-19, related to nursing homes and other long-term care settings.

This Report is based on the period from the onset of the pandemic through the end of April 2021. As such, the Task Force recognizes that it is attempting to review and provide recommendations while the pandemic is still ongoing. The charge ahead is to better manage the remainder of the pandemic and emerge from the COVID-19 crisis better prepared for future public health emergencies and disasters – both those foreseen and unforeseen.

B. Descent Into the Pandemic[1]

1. Recognition of COVID-19[2]

The novel coronavirus, what we now commonly refer to as COVID-19, is a new disease. COVID-19 is itself an acronym for Coronavirus disease 2019, meaning that this form of coronavirus was discovered in 2019. COVID-19 is caused by the severe acute respiratory syndrome coronavirus-2 ("SARS CoV-2"). The disease first appeared in Wuhan, China in late 2019.[3] On the third of January, 2020, the BBC ran a story about a mystery virus in Wuhan that had infected 44 people.[4] The Chinese government made little public comment.[5] Nevertheless, the Taiwanese government, alarmed by what it was observing in Wuhan, sent an email to the International Health Regulations ("IHR") focal point under the World Health Organization ("WHO"), informing WHO of its understanding of the disease and also requesting further information from the WHO.[6] Taiwan activated enhanced border control measures that day. On January 11th, China announced its first death.[7]

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[2] Derrick Bryson Taylor, *A Timeline of the Coronavirus Pandemic*, N.Y. TIMES (Mar. 17, 2021), https://www.nytimes.com/article/coronavirus-timeline.html.

[3] The first identifiable case of what is now known as COVID-19 appeared in Wuhan, China on November 17, 2019. Susie Neilson & Aylin Woodward, *A Comprehensive Timeline of the Coronavirus Pandemic at 1 Year, From China's First Case to the Present*, BUS. INSIDER, (Dec. 24, 2020), https://www.businessinsider.com/coronavirus-pandemic-timeline-history-major-events-2020-3.

[4] *China Pneumonia Outbreak: Mystery Virus Probed in Wuhan*, BBC (Jan. 3, 2020), https://www.bbc.com/news/world-asia-china-50984025.

[5] On December 31, 2019, Chinese health officials informed the World Health Organization of a cluster of forty-one pneumonia patients in Wuhan. *Archived: WHO Timeline - COVID-19*, WORLD HEALTH ORG, (Apr. 27, 2020), https://www.who.int/news/item/27-04-2020-who-timeline---covid-19.

[6] The Facts Regarding Taiwan's Email to Alert WHO to Possible Danger of COVID-19, TAIWAN CTR FOR DISEASE CONTROL, (Apr. 11, 2020), https://www.cdc.gov.tw/En/Bulletin/Detail/PAD-lbwDHeN_bLa-viBOuw?typeid=158.

[7] *See* Derrick Bryson, *supra* note 2.

On January 23rd, China shut down Wuhan.[8] People were not allowed in or out of the city. At the same time, we watched in amazement as a hospital city was built seemingly overnight, with rows of long white buildings covering a large open area in Wuhan.

In the United States, the Centers for Disease Control ("CDC") issued its first advisory regarding the virus on January 16th.[9] On January 21st, the first case reported in the United States – in Washington State – was announced. The WHO announced a Public Health Emergency of global concern on January 30th.[10] On January 31st, President Donald Trump announced a partial ban on travel to and from China.[11].

2. Early Spread of COVID-19

By the end of January, the virus had been identified in four countries on three continents, China, Thailand, Italy, and North America – in Washington State. Clearly, the virus was spreading. The focus, though, remained on China.

On February 4th, the CDC announced that it had developed a test to identify individuals who were positive for COVID-19.[12] Notably, South Korea announced it had developed a test for COVID-19 the same day.[13] Testing was crucial to the plans to keep COVID-19 in check. The plan at its core was very simple. Individuals showing

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[8] *Id.*
[9] *Id.* The CDC was issuing statements at this time that the risk to the public was low. "For the general public, no additional precautions are recommended at this time . . . ." *CDC Confirms Person-to-Person Spread of New Coronavirus in the United States* CTRS. FOR DISEASE CONTROL (Jan. 30, 2020), https://www.cdc.gov/media/releases/2020/p0130-coronavirus-spread.html.
[10] *See* World Health Organization, *supra* note 5.
[11] Geoff Whitmore, *When Did President Trump Ban Travel from China? And Can You Travel To China Now?*, FORBES (Oct. 19, 2020), https://forbes.com/sites/geoffwhitmore/2020/10/19/when-did-president-trump-ban-travel-from-china-and-can-you-travel-to-china-now/?sh=627f29f97484.
[12] *Shipping of CDC 2019 Novel Coronavirus Diagnostic Test Kits Begins*, CTRS. FOR DISEASE CONTROL (Feb. 6, 2020), https://cdc.gov/media/releases/2020/p0206-coronavirus-diagnostic-test-kits.html [hereinafter "CDC"].
[13] Victor Cha, *A Timeline of South Korea's Response to Covid-19*, CTR. FOR STRATEGIC AND INT'L STUDIES (Mar. 26, 2020), https://www.csis.org/analysis/timeline-south-koreas-response-covid-19.

symptoms of COVID-19 would be tested. Those testing positive would be isolated until they were no longer symptomatic, which was regarded as being no longer contagious. The intent was to stay ahead of the disease to manage the disease.

The plan collapsed within a week. On February 8th, the CDC announced problems with the test it had developed. On February 11th, the CDC shut down testing. At that time, CDC did not authorize any other entity to develop alternative tests. CDC believed keeping centralized control of the testing process was crucial to managing the response to COVID-19.[14]

Further signs appeared that the State and the nation were not well prepared for COVID-19. On February 6th, in a letter to health care executives, NYS Health Commissioner Howard Zucker warned of expected shortages of Personal Protective Equipment ("PPE").[15] That warning was a strong indication that the State's public health authorities were expecting difficulties in meeting the challenge of COVID-19. The WHO issued its own warning the next day of expected worldwide PPE shortages.[16]

The warning bells began to ring louder. On February 24th, Italy locked down eleven towns.[17] What had been seen as an authoritarian response to a public health problem in China was now being used in the liberal West. Italy, left with no other effective measure, had revived the medieval measure of quarantine.

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[14] Shawn Boburg et al., *Inside the Coronavirus Testing Failure: Alarm and Dismay Among the Scientists Who Sought to Help*, WASH. POST (Apr. 3, 2020), https://www.washingtonpost.com/investigations/2020/04/03/coronavirus-cdc-test-kits-public-health-labs/.
[15] N.Y. ST. DEP'T OF HEALTH, DEAR ADMINISTRATOR LETTER 20-3 (Feb. 6, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/03/2020-02-06_ppe_shortage_dal.pdf.
[16] Lisa Schnirring, *WHO Warns of PPE Shortage; nCoV Pace Slows Slightly in China*, CTR. FOR INFECTIOUS DISEASE RES AND POL'Y (Feb. 7, 2020), https://www.cidrap.umn.edu/news-perspective/2020/02/who-warns-ppe-shortage-ncov-pace-slows-slightly-china.
[17] Angela Giuffrida, *Italians Struggle with 'Surreal' Lockdown as Coronavirus Cases Rise*, THE GUARDIAN (Feb. 24, 2020), https://www.theguardian.com/world/2020/feb/24/italians-struggle-with-surreal-lockdown-as-coronavirus-cases-rise.

Almost at the same time, a COVID-19 outbreak began in a nursing home in King County, Washington. The first COVID-positive resident was identified there on February 27th. By March 9th, there had been 129 cases and 23 people had died in that one nursing home.[18]

The first confirmed case in New York was announced on March 1st.[19] On March 2nd, Governor Cuomo very confidently stated that New York was ready to meet the pandemic, that New York had faced epidemics successfully before and would do so again.[20] "This isn't our first rodeo. We are fully coordinated, and we are fully mobilized, and we are fully prepared to deal with the situation as it develops."[21] The Governor went on to say: "Excuse our arrogance as New Yorkers – I speak for the mayor also on this one – we think we have the best health care system on the planet right here in New York. So, when you're saying, what happened in other countries versus what happened here, we don't even think it's going to be as bad as it was in other countries."[22] The Governor was not alone in his confidence. That same day, alongside the Governor, New York City Mayor DeBlasio said, "The facts are reassuring. We have

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[18] Temet M. McMichael et al., *COVID-19 in a Long-Term Care Facility- King County, Washington, February 27–March 9, 2020*, CDC (Mar. 18, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6912e1.htm.

[19] Joseph Goldstein & Jesse McKinley, *Coronavirus in N.Y.: Manhattan Woman is First Confirmed Case in State*, N.Y. TIMES (Mar. 5, 2020), https://www.nytimes.com/2020/03/01/nyregion/new-york-coronvirus-confirmed.html.

[20] Press Release, N.Y. ST. OFF. OF THE GOVERNOR, *At Novel Coronavirus Briefing, Governor Cuomo Announces State is Partnering with Hospitals to Expand Novel Coronavirus Testing Capacity in New York*, (Mar. 2. 2020), https://www.governor.ny.gov/news/novel-coronavirus-briefing-governor-cuomo-announces-state-partnering-hospitals-expand-novel.

[21] *Id. See also* Ella Torres, *A Timeline of Cuomo's and Trump's Responses to Coronavirus Outbreaks*, ABC NEWS (April 3, 2020), https://abcnews.go.com/US/timeline-cuomos-trumps-responses-coronavirus-outbreak/story?id=69914641.

[22] J. David Goodman, *How Delays and Unheeded Warning Hindered New York's Virus Fight*, N.Y. TIMES (Apr. 8, 2020), https://www.nytimes.com/2020/04/08/nyregion/new-york-coronavirus-response-delays.html; *see also Watch a Timeline of Disease Expert Dr. Anthony Fauci's Comments on Coronavirus*, CNBC (Mar. 26, 2020), https://www.cnbc.com/video/2020/03/26/watch-a-timeline-of-disease-expert-dr-anthony-faucis-comments-on-coronavirus.html.

a lot of information now, information that is actually showing us things that should give us more reason to stay calm and go about our lives."[23] The Mayor added this on March 5th: "We'll tell you the minute we think you should change your behavior."[24]

Despite that confident statement, on that same March 2nd, Governor Andrew Cuomo asked for and was granted emergency powers by the Legislature to meet the expected epidemic.[25] Seemingly, the Governor knew that the threat was grave, was bracing for an onslaught, and had convinced the Legislature that New York was facing an unprecedented risk.

The warning signs continued to mount. By March 6th, there were confirmed COVID-19 cases in twelve states.[26] Secretary of State Mike Pompeo said the United States was "behind the curve."[27] Colleges and universities were closing their study abroad programs, bringing their students home.[28] The nation of Italy quarantined on March 9th.

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[23] Chris White, *De Blasio, NYC Officials Downplayed COVID-19 Threat After Trump Restricted Travel to China. Here Are 5 Examples*, DAILY CALLER (Mar. 29, 2020), https://dailycaller.com/2020/03/29/de-blasio-coronavirus-trump-response/.
[24] *See supra*, note 23.
[25] Press Release, N.Y. ST. OFF. OF THE GOVERNOR, *During Coronavirus Briefing, Governor Cuomo Signs $40 Million Emergency Management Authorization for Coronavirus Response*, (Mar. 3, 2020), https://www.governor.ny.gov/news/during-coronavirus-briefing-governor-cuomo-signs-40-million-emergency-management-authorization; Chapter 23 of the Laws of 2020.
[26] Will Feuer et al., *NBA, NHL Owners Oppose Playing Games Without Fans, NY Coronavirus Cases Quadruple in 48 Hours*, CNBC (Mar. 6, 2020), https://www.cnbc.com/2020/03/06/coronavirus-latest-updates-outbreak.html.
[27] *Id.*
[28] Melissa Korn, *Colleges Shutter Study-Abroad Programs Amid Coronavirus Fears*, WALL ST. J. (Feb. 27, 2020), https://www.wsj.com/articles/colleges-shutter-study-abroad-programs-amid-coronavirus-fears-11582821434.

3. The Virus Continues to Spread

On March 7th, the Governor first invoked his emergency powers.[29] On the 14th, New York had its first death.[30] Four days before New York's first death, on March 10th, the Governor declared the "New Rochelle Containment Zone", and identified a New Rochelle resident, a lawyer with a Manhattan practice, as "Patient Zero".[31] By March 25th, there had been 234 positive cases in New Rochelle.[32]

To meet the crisis in New Rochelle, a mobile drive-through testing site was established. The mobile testing site was initially expected to test up to 200 people a day, rising to 500. According to the Governor: "The single most important thing we can do to combat and contain the novel coronavirus is test for it, and while the federal government was caught flatfooted in the midst of this crisis, New York has stepped up to fill in the gaps and ramp up testing capacity . . . As we run our own test and test more people, the number of people that we find with the virus is going to keep going up, but New Yorkers should continue to remain calm and remember that the more positive tests we find, the more we can limit the virus and reduce its spread."[33]

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[29] N.Y. Exec. Order 202 (Mar. 7, 2020), https://www.governor.ny.gov/news/no-202-declaring-disaster-emergency-state-new-york.
[30] Melanie Grayce West & Jimmy Vielkind, *New York State Has First Coronavirus Deaths*, WALL ST. J. (Mar. 14, 2020), https://www.wsj.com/articles/new-york-state-has-first-coronavirus-death-11584198758.
[31] Press Release, N.Y. ST. OFF. OF THE GOVERNOR, *Governor Cuomo Accepts Recommendation of State Health Commissioner for New Emergency Measures to Contain Novel Coronavirus Cluster in New Rochelle* (Mar. 10, 2020), https://www.governor.ny.gov/news/governor-cuomo-accepts-recommendation-state-health-commissioner-new-emergency-measures-contain.
[32] Zak Failla, *COVID-19: New Rochelle Containment Zone Ends*, DAILY VOICE (Mar. 26, 2020), https://dailyvoice.com/new-york/newrochelle/news/covid-19-new-rochelle-containment-zone-ends/785602.
[33] Press Release, N.Y. ST. OFF. OF THE GOVERNOR, *Governor Cuomo Opens the State's First Drive-Through COVID-19 Mobile Testing Center in New Rochelle* (Mar. 13, 2020), https://www.governor.ny.gov/news/governor-cuomo-opens-states-first-drive-through-covid-19-mobile-testing-center-new-rochelle-0. New York had also secured approval from the Food and Drug Administration to develop and implement its own COVID-19 test. M. Hill, *New York Gets Green Light to Test for COVID-19 Virus*, ASSOCIATED PRESS (Feb. 29, 2020), https://apnews.com/article/2eacb3ac17c9bdd10f2a314515a2a3c1.

Events continued to accelerate. The NBA shut down and other sports quickly followed.[34] Offices and schools began to close. Closings became a flash point between Governor Cuomo and Mayor DeBlasio, with the Mayor moving to shut down New York City and its schools, only to be delayed by the Governor.[35] Looking back, that delay had consequences. In northern California, where a COVID-19 outbreak was also occurring, the San Francisco Bay area shut down on March 16th.[36] The Governor, perhaps to build public acceptance, perhaps for other reasons, closed New York over three days, with the full shutdown taking effect on March 22nd.[37] San Francisco fared better than New York City in the first surge.[38]

The hope that testing could control the virus was soon dashed. The number of identified positive cases exploded. According to the New York Forward, a web site maintained by the New York State government, on March 8, 2020, the first date the site reports, out of 307 individuals tested, 28 tested positive, a positivity rate of 9.1%. By March 14th, the date of New York's first death, the number of individuals tested was up to 1,293; 131 were positive. The numbers continued to climb to a one-day positivity

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[34] Scott Cacciola & Sopan Deb, *N.B.A. Suspends Season After Player Tests Positive for Coronavirus*, N.Y. TIMES (Mar. 11, 2020), https://www.nytimes.com/2020/03/11/sports/basketball/nba-season-suspended-coronavirus.html; *see also NCAA Cancels Men's and Women's Basketball Championships Due to Coronavirus Concerns*, N.Y. TIMES (Mar. 17, 2020), https://www.nytimes.com/2020/03/11/sports/basketball/nba-season-suspended-coronavirus.html.

[35] Bernadette Hogan & Julia Marsh, *Cuomo, de Blasio Clash Over Possible Shelter-in-Place System for NYC*, N.Y. POST (Mar. 17, 2020), https://nypost.com/2020/03/17/cuomo-de-blasio-clash-over-possible-shelter-in-place-system-for-nyc/; *see also* Luis Ferre-Sadurni, *New York Schools, Restaurants and Bars Are Shut Down Over Coronavirus*, N.Y. TIMES (Mar. 16, 2020), https://www.nytimes.com/2020/03/15/nyregion/coronavirus-nyc-shutdown.html.

[36] Erin Allday, *Bay Area Orders 'Shelter in Place,' Only Essential Businesses Open in 6 Counties*, S.F. CHRON. (Mar. 19, 2020), https://www.sfchronicle.com/local-politics/article/Bay-Area-must-shelter-in-place-Only-15135014.php.

[37] N.Y. Exec. Order 202.8 (Mar. 20, 2020).

[38] Joe Sexton & Joaquin Sapien, *Two Costs. One Virus. How New York Suffered Nearly 10 Times the Number of Deaths as California*, PROPUBLICA (May 16, 2020), https://www.propublica.org/article/two-coasts-one-virus-how-new-york-suffered-nearly-10-times-the-number-of-deaths-as-california.

peak of 48.6% on April 2nd, and a seven-day rolling average peak of 48.2% on April 4th. In raw numbers, 10,841 New Yorkers tested positive on April 3rd, a number that would not be surpassed until December 11th, during New York's second surge, when 11,129 New Yorkers tested positive, but the positivity rate was only 4.6%.[39] In little more than a month, New York went from one case to 10,841 new cases in a single day. New York was in a health care emergency unknown in living memory.

Hospitalizations tracked those numbers. There were six people hospitalized in New York for COVID-19 on March 14th.[40] Only twelve days later, 6,481 COVID-19 patients were in the State's hospitals, a mind-boggling increase;[41] 1,583 of those patients were in intensive care units. By April 13th, hospitalizations had almost tripled, peaking at 18,825, and patients in ICU beds had more than tripled to 5,225. Notably, and showing how the epidemic was centered in the New York metropolitan area, 16,292 of the hospitalizations on April 13th were in New York City and Long Island, 86.5% of the State's total. By contrast, during New York State's second surge, which occurred in December and January, 2020–21, hospitalizations peaked at the far lower number of 8,888 on January 15, 2021, and those hospitalizations were spread throughout the State, with 5,051 in New York City and Long Island, 56.8% of the total.[42]

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[39] New York Forward, *Percentage Positive Results by Region Dashboard* (Apr. 26, 2021), https://forward.ny.gov/percentage-positive-results-region-dashboard.

[40] *Tracking Coronavirus in New York: Latest Map and Case Count*, N.Y. TIMES, https://www.nytimes.com/interactive/2021/us/new-york-covid-cases.html (last visited Apr. 27, 2021).

[41] The data reported by the New York Times states the hospitalization number as 926 for that date, significantly below the number reported on NY Forward. The Times also reports peak hospitalization at 14,126, lower, but proportionately much closer to the peak number of 18,825 reported on NY Forward. The Times does state that "Hospitalization numbers early in the pandemic are undercounts due to incomplete reporting by hospitals to the federal government." *Id.*

[42] Deaths, too, had begun their meteoric rise. From the first death reported on March 14th, the daily death count had risen to 117 on March 25th. The number of daily deaths reported reached its tragic peak on April 14th. The New York Times reports the peak number as 1,003. *Id.* The Governor reported the peak as 799 on April 8th. https://www.wamc.org/post/coronavirus-daily-death-toll-ny-increases. Either number is a staggering loss of life.

4. The Need for Sufficient Hospital Capacity.

As COVID-19 exploded in New York in March of last year, the almost singular health care focus of Governor Andrew Cuomo, and, therefore, of the State government, was on assuring that there would be sufficient hospital capacity to meet the expected surge of patients in need of hospital care for COVID-19. To that end, the Governor ordered that hospitals in the State cease all elective procedures[43] The Jacob Javits Convention Center, a 1,800,000 square foot facility, was converted to a field hospital with a bed capacity of 2,000.[44] The Governor began his repeated calls to bring the U.S. Navy Hospital ship, the USNS Comfort, to New York. The Comfort arrived to much fanfare and relief on March 30th.[45] The calls began for retired and out-of-state physicians, nurses, and other health care professionals to come to New York and make themselves available to meet this centennial emergency.[46] Patients, including COVID-19 patients, were transferred to hospitals with capacity, sometimes at great distance.

Because of the anticipated need for large numbers of hospital beds, the Governor, in his first Executive Order issued under his emergency powers, authorized hospitals to "rapidly discharge" patients[47]. An especially important event in terms of the State's health care capacity occurred on March 23rd. On that date, Governor Cuomo

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[43] N.Y. Exec. Order 202.10 (Mar. 23, 2020).
[44] C. Todd Lopez, *Corps of Engineers Converts NYC's Javits Center Into Hospital*, U.S. DEP'T OF DEFENSE (Apr. 1, 2020), https://www.defense.gov/Explore/News/Article/Article/2133514/corps-of-engineers-converts-nycs-javits-center-into-hospital/#:~:text=The%20New%20York%20District%20of,non%2DCOVID%2D19%20patients.
[45] Erin Durkin, *USNS Comfort Arrives in New York City*, POLITICO (Mar.30, 2020), https://www.politico.com/states/new-york/albany/story/2020/03/30/usns-comfort-arrives-in-new-york-city-1269589.
[46] Press Release, N.Y. ST. OFF. OF THE GOVERNOR, *During Coronavirus Briefing, Governor Cuomo Announces New Mass Gatherings Regulations* (Mar. 12, 2020), https://www.governor.ny.gov/news/during-novel-coronavirus-briefing-governor-cuomo-announces-new-mass-gatherings-regulations.
[47] N.Y. Exec. Order 202 (Mar. 7, 2020).

issued an Executive Order requiring that all hospitals cancel elective surgeries to free up hospital beds,[48] and urged that hospitals go beyond the order and increase their capacity by 100%. Health officials said that day that New York had 53,000 hospital beds with an anticipated need due to COVID-19 of 113,000. Officials also stated that New York had 3,000 ICU beds with an anticipated need due to COVID-19 of 18,000.[49]

Two days later, on March 25th, the Department of Health issued the now infamous Advisory to nursing homes. The Advisory was explicitly issued out of concern for hospital capacity. It said so in its second sentence. "There is an urgent need to expand hospital capacity in New York State to be able to meet the demand for patients with COVID-19 requiring acute care."[50] The Advisory went on to state the expectations for nursing homes.

> During this global health emergency, all NHs must comply with the expedited receipt of residents returning from hospitals to NHs. Residents are deemed appropriate for return to a NH upon a determination by the hospital physician or designee that the resident is medically stable for return. Hospital discharge planners must confirm to the NH, by telephone, that the resident is medically stable for discharge. Comprehensive discharge instructions must be provided by the hospital prior to the transport of a resident to the NH. No resident shall be denied re-admission or admission to the NH solely based on a confirmed or suspected diagnosis of COVID-19. NHs are prohibited from requiring a hospitalized resident who is determined medically

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[48] N.Y.Exec. Order 202.10 (Mar. 23, 2020).
[49] Bill Chappell, *Cuomo Orders All Hospitals to Add Beds as New York Confirms 20,000 Coronavirus Cases*, NPR (Mar. 23, 2020), https://www.npr.org/sections/coronavirus-live-updates/2020/03/23/820150795/cuomo-orders-all-hospitals-to-add-beds-as-new-york-confirms-20-000-coronavirus-c#:~:text=New%20York%20currently%20has%2053%2C000%20hospital%20beds%3B%20it,Equipment%20%26%20Supplies%20at%20Javits%20Center%20Temporary%20Hospital.
[50] N.Y. ST. DEP'T OF HEALTH, DEAR ADMINISTRATOR LETTER (Mar. 25, 2020), https://skillednursingnews.com/wp-content/uploads/sites/4/2020/03/DOH_COVID19__NHAdmissionsReadmissions__032520_1585166684475_0.pdf.

> stable to be tested for COVID-19 prior to admission or readmission.
>
> As always, standard precautions must be maintained, and environmental cleaning made a priority, during this public health emergency. Critical personal protective equipment (PPE) needs should be immediately communicated to your local Office of Emergency Management, with the appropriate information provided at the time of request.

Thankfully, New York never did exceed its pre-COVID-19 Statewide hospital capacity, although many individual hospitals saw their capacity exceeded. New York's pre-COVID-19 statewide ICU capacity was exceeded by over sixty percent.[51]

C. The Pandemic Comes to Nursing Homes

Less than two weeks before the issuance of the March 25th directive, the State Department of Health had closed nursing homes to visitors.[52] This was to prevent the introduction of COVID-19 into the facilities.

Although the Governor would later describe the March 25th directive as in accordance with CDC guidance, there appears to be significant difference between then-current CDC guidance and the March 25th directive. The CDC guidance emphasized that a nursing home should admit residents with COVID-19 only if able to follow CDC guidance for transmission-based precautions. If the nursing home could not do so, "it must wait until these precautions are discontinued"[53] before admitting

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[51] The on-line publication Gothamist has published comprehensive and useful data, which it updates, about the course of the pandemic in New York, especially New York City from the start of the outbreak in March 2020 until the present. The data is broken down in a number of ways, including by race, poverty, gender, and zip code. J. Dobkin, C. Diaz, Z. Gottehrer, *Coronavirus Statistics, Tracking the Epidemic in New York*, GOTHAMIST, https://gothamist.com/news/coronavirus-statistics-tracking-epidemic-new-york (last visited May 6, 2021).

[52] N.Y. Exec. Order 202.1 (Mar. 12, 2020).

[53] *Guidance for Infection Control Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 13, 2020), https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf.

residents with COVID-19. The Centers for Medicare and Medicaid Services ("CMS") had also issued infection control guidance, including a self-assessment checklist that long-term care facilities could use to determine their compliance with these crucial infection control actions.[54]

There were several directives or mandates imposed upon nursing homes during the course of the pandemic, some of which have been previously mentioned. Some had greater impacts than others.

The Executive Order closing nursing homes to visitors was obviously intended to check the spread of the virus. Whatever that order's efficacy in controlling the introduction of the virus, the order had certain, unavoidable negative consequences. Visitors benefit nursing home residents in a number of ways. There are the emotional benefits of continued connection to friends and family. Visitors also provide care support, supplementing the efforts of staff, and sometimes identifying care shortcomings. There is at least anecdotal evidence that the loss of visitation has had a negative impact on the well-being of many nursing home residents. The complete bar on visitation has been removed through a number of orders, but open visitation has not yet been fully restored.[55]

While the March 25th Department of Health directive remained in place, and seemingly in response to criticism of that directive, the Department issued an order requiring that nursing home employees be tested for the virus twice weekly.[56] A

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[54] *Prioritization of Survey Activities*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 20, 2020), https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0 .

[55] N.Y. ST. DEP'T OF HEALTH, DEAR ADMINISTRATOR LETTER (Mar. 25, 2021), https://coronavirus.health.ny.gov/system/files/documents/2021/03/updated_nursing_home_visitation_guidance.pdf.

[56] N.Y. Exec. Order 202.30 (May 10, 2020). *See also* N.Y. ST. DEP'T OF HEALTH, *Executive Order 202.30-Nursing Home and Adult Care Facility Staff Testing Requirement FAQ* (June 24, 2020),

subsequent order reduced the testing frequency to weekly.[57] Because the receipt of testing results often took as many as ten days, these testing orders were of dubious usefulness. They did, however, greatly increase nursing home costs.

As the March 25th directive began to receive public attention, the Department also ordered that nursing homes secure and maintain a sixty day supply of PPE.[58] When the Department issued this order, PPE was in short supply and expensive. No one would argue with the need for nursing homes to maintain adequate levels of PPE, but this was an order to stockpile PPE at the moment of highest cost and least supply. The order did nothing for patient care at the time, but did increase nursing home costs.

a. The March 25th Directive

The order that has received the most attention is the now infamous March 25th Advisory to New York's nursing homes calling for the admission of COVID-19 positive residents. This Advisory was controversial from the start. The consequences of the Advisory have been far reaching, and unexpected, including investigation of the Governor himself. Remarkably, the Advisory was so controversial that the State Department of Health issued a report that was in effect a direct rebuttal to the criticism. The Department did so in July 2020, with a report entitled, "*Factors Associated with Nursing Home Infections and Fatalities in New York State During the COVID-19 Global*

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https://coronavirus.health.ny.gov/system/files/documents/2020/06/nursinghome_stafftestingrequirementfaq_0624.pdf.

[57] Press Release, N.Y. ST. DEP'T OF HEALTH, *Statement from New York State Health Commissioner Dr. Howard Zucker on Successful Nursing Home Testing Program* (June 10, 2020), https://www.health.ny.gov/press/releases/2020/2020-06-10_nursing_home_testing_program.htm .

[58] *Codified at* 10 N.Y.C.R.R. § 405.19. The Department issued this regulation after the Commissioner had testified before the State Legislature that nursing homes had had sufficient supplies of PPE. 10 N.Y.C.R.R. § 405.191; *see also* Bernadette Hogan, *Health Department Mandates PPE Supply for Nursing Homes Ahead of 'Second Wave'*, N.Y. POST (Aug. 21, 2020), https://nypost.com/2020/08/21/ny-health-department-mandates-ppe-supply-for-nursing-homes/.

Health Crisis."[59] The report concluded that nursing homes had admitted "approximately 6,326 COVID-positive residents" between March 25, 2020 and the May 8th withdrawal of the advisory, but that the March 25 directive "could not be the driver of nursing home infections or fatalities."[60] The report took the position that the admission of COVID-positive residents did not introduce COVID-19 into nursing homes or contribute to nursing home infections and subsequent fatalities.[61]

On August 3 and August 10, 2020, the Legislature held joint hearings on the issue of COVID-19 in nursing homes. In his appearance before the Legislature on August 3rd, the Commissioner of Health declared that the advisory should not have been read as prohibiting the denial of admission to COVID-19 positive residents, but that nursing homes always had the right to deny admission to individuals for whom they could not provide adequate care. Notably, despite concerns raised while the advisory was in effect, the Department had not issued any such clarification.

b. The Attorney General Report

On January 28, 2021, the Office of the Attorney General ("OAG") released a report entitled *Nursing Home Response to the COVID-19 Pandemic.*[62] The report directly challenged the Department of Health's conclusions regarding the number of deaths that had occurred in the State's nursing homes. The Attorney General's report

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[59] Press Release, N.Y. ST. DEP'T OF HEALTH, *Factors Associated with Nursing Home Infections and Fatalities in New York State During the Covid-19 Global Health Crisis* (Feb. 11, 2021), *https*://www.health.ny.gov/press/releases/2020/docs/nh_factors_report.pdf.
[60] *Id.*
[61] *Id.*
[62] *See* Press Release, N.Y. ATT'Y GEN., *Attorney General James Releases Report on Nursing Homes' Response to COVID-19*, (Jan. 28, 2021), https://ag.ny.gov/press-release/2021/attorney-general-james-releases-report-nursing-homes-response-covid-19. [hereinafter *Press Release*]; *see also Nursing Home Response to COVID-19 Pandemic*, N.Y. ATT'Y GEN. (Jan. 30, 2021), https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf [hereinafter *Attorney General Report*].

concluded that the Department of Health had been undercounting nursing home deaths and estimated that the full toll was 50% higher than what the Department had reported. The Attorney General's report also found that New York's "guidance requiring the admission of COVID-19 patients into nursing homes may have put residents at increased risk of harm in some facilities and may have obscured the data available to assess that risk."[63]

Immediately following the release of the OAG report, Health Commissioner Zucker released a statement with revised COVID-19 mortality data.[64] According to the Health Commissioner's statement, from March 1, 2020 to January 19, 2021, there were: (i) 9,786 confirmed fatalities associated with skilled nursing facility residents, including 5,957 fatalities within nursing facilities, and 3,829 within hospitals: and (ii) 2,957 additional "presumed" COVID nursing home fatalities, that is, fatalities that occurred when testing was scarce and lack confirmed evidence the deceased had COVID.

The Department of Health further revised the numbers following a Freedom of Information ("FOIL") request and litigation with the Empire Center for Public Policy. On February 8, 2021, the Department of Health posted updated facility-level death counts in nursing homes, assisted living residences and other adult-care facilities, including 5,596 deaths that had occurred in hospitals.[65] The update pushed the known COVID-19 toll in long-term care facilities to almost 15,000. On February 10, 2021, the Department of Health released the dates and locations of more than 14,000 deaths

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[63] *Id.*

[64] Press Release, N.Y. ST. DEP'T OF HEALTH, *Statement from New York State Health Commissioner Dr. Howard Zucker* (Jan. 28, 2021), https://www.governor.ny.gov/news/statement-new-york-state-health-commissioner-dr-howard-zucker-1.

[65] Press Release, EMPIRE CTR. FOR PUB. POL., *Cuomo Administration Releases FOIL-Requested Nursing Home Data* (Feb. 10, 2021), https://www.empirecenter.org/publications/cuomo-administration-releases-foil-requested-nursing-homes-data/.

involving residents of nursing homes and assisted living facilities, including 4,775 residents who died outside of the facilities from confirmed cases of COVID-19. Omitted from the data were: 671 residents who died outside the facilities with presumed cases of COVID-19, and approximately 1,000 deaths in adult-care facilities that were not categorized as "assisted living."[66]

II. The Role of Government in Responding to a Pandemic

In preparing for and responding to an emergency, various levels of government have extensive authority, to take action to protect the health, safety and welfare of the population. Some of the responsibilities are discussed below and include:

- protecting the public health;
- preparing for emergencies;
- responding to emergencies;
- preventing the spread of communicable disease;
- collecting and disseminating information; and
- allocating scarce resources.

In New York, State government, in conjunction with New York City and county governments, has taken on responsibilities to check the spread of contagious diseases. In response to the COVID-19 epidemic, the State government has taken on the responsibility to protect individuals from exposure, to provide access to testing, diagnosis, treatment and, as available, immunization. The effective discharge of government's role involves balancing a wide variety of competing considerations,

[66] Press Release, EMPIRE CTR. FOR PUB. POL., *Update on DOH compliance with the Empire Center's nursing home FOIL request* (Feb. 17, 2021), https://www.empirecenter.org/publications/update-on-doh-compliance/.

objectives and constituencies, as well as coordination among numerous government agencies at the federal, state and local level.

III. Responsibilities of Government in Responding to a Pandemic

A. Protecting the Public Health.

At the federal, state and local levels, government plays an essential role – before, during and after an emergency – in protecting the health and safety of the public.

Through its superior spending power, the federal government has substantial resources to respond in the event of an emergency. Individual states, hold the police power, which gives them broad authority over public health matters within their borders.[67].

Under the New York State Constitution, "[t]he protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine."[68] The New York State Department of Health has broad authority under the Public Health Law to protect and promote public health.[69] New York is one of 26 states with a decentralized public health system: At the local level, 57 county health departments and the New York City Department of Health and Mental Health have the major responsibility for provision of public health services.[70] The NYC Health Department, one of the largest and oldest

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[67] *See* Santiago Legarre, *The Historical Background of the Police Power*, 9 U. PA. J. CONST. L. 745 (2007), https://scholarship.law.upenn.edu/cgi/viewcontent.cgi?article=1250&context=jcl.
[68] N.Y. Const., Art. 17, § 3.
[69] N.Y. Pub. Health Law §§ 201, 206, 225.
[70] Press Release, N.Y. ST. DEP'T OF HEALTH, *Strengthening New York's Public Health System for the 21st Century*, https://www.health.ny.gov/press/reports/century/phc_nyssystem.htm (last visited Apr. 28, 2021).

public health agencies in the world, has a mission to protect and promote the health and mental health of a population of more than eight million in the five boroughs.[71] The protection of public health depends on an effective collaboration between and among the federal, state and local governments.

B. Preparing for Emergencies.

Before a crisis develops, various statutes impose responsibilities on various levels of government to anticipate potential disasters, to prepare plans to prevent disasters and, when disasters occur, to minimize their effects, and for guiding the public in taking actions to prevent and mitigate disasters. Disaster preparedness can also include preparing for emergencies.

At the federal level, the Department of Homeland Security has general operational responsibility for U.S. federal disaster response,[72] and the Department of Health and Human Services ("HHS") has medical responsibility for federal preparedness and disaster response efforts.[73] There are at least fourteen federal departments and agencies responsible for the administration of dozens of programs related to disaster preparedness, response, and recovery.

Within the Department of Homeland Security, the Federal Emergency Management Agency ("FEMA") is responsible for coordinating responses to disasters that occur in the U.S. and overwhelm the resources of local or state authorities.[74] To

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[71] *See About the NYC Department of Health and Mental Hygiene*, NYC HEALTH, https://www1.nyc.gov/site/doh/about/about-doh.page.
[72] Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. 68 § 5121 et seq.; *See also Disaster Authorities*, FEMA, https://www.fema.gov/disasters/authorities#.
[73] The Office of the Assistant Secretary for Preparedness and Response, the Centers for Disease Control and Prevention and National Institutes of Health are within HHS. *See* https://www.phe.gov/about/aspr.
[74] 6 U.S.C. § 313 (creates FEMA to "reduce the loss of life and property and protect the Nation from all hazards, including natural disasters, acts of terrorism, and other man-made disasters, by leading and

trigger FEMA assistance, the governor of the state in which the disaster occurs must declare a state of emergency and request from the President that FEMA and the federal government respond to the disaster.

In New York, the Executive Law establishes a Disaster Preparedness Commission, consisting of 29 State agencies and the American Red Cross.[75] The statute requires the Disaster Preparedness Commission to prepare a State comprehensive emergency management plan;[76] to direct and coordinate State disaster operations in a State disaster emergency; to assist in the coordination of federal recovery efforts; and to provide for periodic briefings, drills and exercises.[77] For nursing homes and assisted living facilities, the statute specifically requires the Commission to establish standards for disaster preparedness[78] and to assist these facilities in establishing a disaster preparedness plan addressing the maintenance of food, water and medication supplies; access to a generator, and the establishment of an evacuation plan for residents and disaster staffing plans.[79]

C. Responding to Emergencies.

When an emergency develops, various levels of government have responsibility for responding, controlling and mitigating its impact on the population.

In the event of an emergency that severely challenges state or local response capabilities, the federal government has broad authority to provide surge capacity to support state and local efforts to control and mitigate the emergency. A Presidential

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supporting the Nation in a risk-based, comprehensive emergency management system of preparedness, protection, response, recovery, and mitigation").

[75] N.Y. Exec. Law Art. 2-B (State and Local Natural and Man-made Disaster Preparedness).

[76] N.Y. Exec. Law Art. 22.

[77] N.Y. Exec. Law § 21; see NYS Comprehensive Emergency Management Plan.

[78] N.Y. Exec. Law § 23-B(1).

[79] N.Y. Exec. Law § 23-B(2).

declaration of a major disaster or emergency (a Stafford Act declaration),[80] a declaration from the Secretary of HHS of an Incident of National Significance, or a request from another federal department or agency may trigger the federal response.[81] Federal public health and medical assistance can consist of medical materiel, personnel, and technical assistance.[82] In addition, the federal government has authority to waive or to temporarily modify normal operating requirements of federal programs during a major emergency or disaster.

In New York, the Executive Law authorizes the governor to issue an executive order declaring a disaster emergency upon finding that a disaster has occurred or may be imminent for which local governments are unable to respond adequately.[83] When the disaster is beyond the capabilities of the State and affected jurisdictions, the governor has authority to request federal assistance and may make available sufficient funds to provide the required state share of grants made under any federal program for meeting disaster related expenses including those available to individuals and families.[84] The Executive Law also permits the governor to suspend laws as he deems necessary for the duration of the emergency. [85] As discussed above, the Legislature expanded that authority in March of last year to permit the Governor for the duration of

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[80] Under the Robert T. Stafford Disaster Relief and Emergency Assistance Act, 42 U.S.C. § 5121, a presidential disaster declaration or an emergency declaration triggers federal financial and physical assistance through the Federal Emergency Management Agency (FEMA). Additionally, the National Emergencies Act, 50 U.S.C. § 1601-1651, provides a framework for declaring national emergencies and for the exercise of emergency powers and authorities.

[81] *See generally Congressional Primer on Responding to and Recovering from Major Disasters and Emergencies*, CONG. RES. SERV. (June 3, 2020), https://fas.org/sgp/crs/homesec/R41981.pdf.

[82] Section 319 of the Public Health Service Act, 42 U.S.C. § 247d, allows the HHS Secretary, after consultation with public health officials, to take action to respond, including making grants, entering into contracts and conducting and supporting investigations into the cause, treatment, or prevention of a disease or disorder and establishes the Public Health Emergency Fund).

[83] N.Y. Exec. Law § 28(1).

[84] N.Y. Exec. Law § 28(4).

[85] N,Y, Exec. Law § 29-a.

the emergency to declare rules by Executive Order.[86] That further authority has now been repealed, but the Governor can continue for the duration of emergency to extend the Executive Orders previously issued, subject to legislative invalidation.[87]

These federal and state emergency response systems are interdependent, and each relies heavily on the active participation of the other for effective implementation.

D. Preventing the Spread of Communicable Disease.

The states have primary responsibility under their police powers for protecting the public's health by taking action to control and prevent the spread of communicable disease. Under the Public Health Law, the NYS Department of Health is responsible for supervising the reporting and control of disease; producing, standardizing and distributing diagnostic, prophylactic and therapeutic products; conducting laboratory examinations for the diagnosis and control of disease; promoting education in the prevention and control of disease; advising local units of government and their public health officials in the performance of their official duties, and regulating the financial assistance granted by the State in connection with all public health activities, among many other public health-related activities.[88] Authority under the Public Health Law includes, in certain instances, quarantine[89] and mandatory treatment.[90] Federal law authorizes the federal government to make regulations necessary to prevent communicable diseases from foreign countries from entering into the states and from one state to another.[91] This federal authority does not supersede state law and

[86] Chapter 23 of the Laws of 2020.
[87] Chapter 71 of the Laws of 2021 (Mar. 7, 2021).
[88] N.Y. Pub. Health Law §§ 201, 206, 225.
[89] 10 N.Y.C.R.R. § 2.13.
[90] N.Y. Pub. Health Law. § 2120(3).
[91] 42 U.S.C. § 264.

regulations, "except to the extent that such a provision conflicts with an exercise of Federal authority."[92]

Although an individual state has primary responsibility, a pandemic knows no boundaries. Therefore, an effective response requires not only federal-state coordination, but also interstate cooperation to minimize disruption and limit the spread of disease. We have seen during the pandemic several instances of interstate cooperation between New York and neighboring states, especially with New Jersey and Connecticut.[93]

E. Collecting and Disseminating Information.

One of the most important roles of government, before, during, and after an emergency, is to collect information and use it effectively to guide policy decisions.

At the federal level, HHS sponsors a variety of public health and health care data systems and activities. For example, the CDC coordinates case surveillance, that is, information on individuals with the infection in a population, to provide information needed for taking public health action to prevent cases and the spread of disease and to control outbreaks. The CMS collects administrative data on the Medicare and Medicaid programs and conducts healthcare provider surveys. Other federal agencies also collect data that are important for public health purposes.[94]

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[92] *Id.*

[93] *'Worst is Over,' Cuomo Says as 7 States Ally to Reopen* Economy, N.Y. TIMES (Apr. 13, 2020), https://www.nytimes.com/2020/04/13/nyregion/coronavirus-new-york-update.html; *New York Governor Cuomo and Other Governors Coronavirus News Conference*, C-SPAN (Apr. 13, 2020), https://www.c-span.org/video/?471176-1/york-gov-cuomo-governors-announce-coordinated-reopening-effort.

[94] On April 19, CMS announced that it would issue a rulemaking requiring nursing homes to report data, through the CDC's National Health Safety Network (NHSN) system, about residents or staff with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or three or more residents or staff with new onset respiratory symptoms within 72 hours of each other. *Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons Under Investigation) Among Residents and Staff in Nursing Homes*, *QSO-20-26-NH*, CTRS. FOR MEDICARE &

In New York, the Health Electronic Response Data System, HERDS, is a statewide electronic web-based data collection system that allows healthcare providers to relay resources or needs to the State Department of Health during emergencies and to respond immediately to rapid request surveys in preparedness planning efforts.[95]

F. Allocating Scarce Resources.

In fulfilling mutual responsibilities, federal and state governments must anticipate and respond to supply chain disruptions, which may create shortages in crucial supplies.

At the federal level, a federal emergency declaration enables the Secretary of Health and Human Services to take appropriate actions, consistent with other authorities, to control and mitigate the emergency. This may include supporting investigations into the cause, treatment, or prevention of the emergency; accessing the Public Health Emergency Fund and other funds to facilitate a response; and adjusting the requirements to meet the needs of individuals who benefit from government-funded insurance programs. Under the Defense Production Act[96] the President has authority to expedite and expand the supply of materials and services from the U.S. industrial base to promote the national defense. In New York, the declaration of an emergency authorizes the governor to request federal assistance, as well as access State governmental emergency funds.

MEDICAID SERVS. (Apr. 19, 2020), https://www.cms.gov/files/document/qso-20-26-nh.pdf. Prior to that time, neither CMS nor CDC nor FEMA collected that information.

[95] *HERDS Quick Reference Card*, WADSWORTH CTR., https://www.wadsworth.org/sites/default/files/WebDoc/HERDS_QuickReferenceCard%20%28002%29.pdf .

[96] 50 U.S.C. §§ 4501–4568. The federal government also maintains the Strategic National Stockpile, which contains medications and medical equipment available for distribution to states.

IV. A State and Nation Unprepared

In this section of the Report, we will examine the multiple considerations that weighed in the balance and the confluence of decisions that may have created the perfect public health storm in this first quarter of the twenty first century.

a. Conceptual Framework: Syndemic Theory and Paradigmatic Example of Nursing Homes

The nursing home pandemic crisis is a paradigmatic example of syndemic theory[97] at work. The syndemic integrative conceptual framework helps us make sense of patterns of disease interaction and disease concentration among clustered epidemics, and their underlying social, political, and economic driving forces.[98] In the current pandemic, the novel coronavirus has interacted with chronic illness and comorbidities, especially in older adult populations. These patterns of interaction are both shaped by, and shaping and exacerbating, pre-existing social inequities, including structural racism. We add the critical importance of structural ageism and age discrimination as pre-existing social inequities shaped by social, economic, and political forces.[99] In addition, at least one research study has documented the relationship between race and virus cases and deaths in nursing homes during the pandemic.[100] The cumulative disadvantage and struggle that accompany growing old at the intersection of age, race, ethnicity, and gender calls attention to the social and economic determinants of health, especially for those living at the margins of society.

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[97] Clarence C. Gravelee, *Systemic Racism, Chronic Health Inequities, and COVID-19: A Syndemic in the Making?*, AM. J. HUM. BIOLOGY (Aug. 4, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7441277/.
[98] *Id.*
[99] Morrissey, *Pandemic Threats to Older Women: Government's Policy Failures, United Nations Commission on Status of Women* (Mar. 17, 2021).
[100] Rebecca J. Gorges & R Tamara Konetzka, *Factors Associated with Racial Differences in Deaths Among Nursing Home Residents with COVID-19 Infection in the US*, NIH (Feb. 1, 2021), https://pubmed.ncbi.nlm.nih.gov/33566110/.

Institutionalized older adults have been hit hard during the pandemic because of the convergence of historical policy failures at both the federal and state levels. Available study data on nursing home deaths during the pandemic reflect patterns of structural ageism and racism in the formulation and implementation of health policy in the United States[101] and, more specifically, long-term care policy.

b. Convergence of Historical Policy Failures: Federal Policymaking

Any meaningful analysis of the vulnerability of the nursing home population to the syndemic force of the pandemic would be incomplete without careful attention to the history of long-term care policymaking in the United States. The most glaring void in that history at the federal level has been the failure to enact a comprehensive long-term care policy itself, including long-term care financing outside of the Medicaid program.[102] The last attempt to correct this gap, at least in piecemeal fashion, was as a part of the Affordable Care Act, [103] but that provision was repealed in 2011 as policymakers had not been successful in designing a funding plan to ensure its viability.[104]

The failure to enact a comprehensive long-term care policy in the United States must be contextualized in the larger picture of health policy failures at the federal level. The highly fragmented U.S. health care delivery and financing systems undermine the possibility of achieving meaningful access to long-term care services for older adults and other vulnerable persons.

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[101] Woolhandler et al, 2021.
[102] Joe Caldwell & Howard Bedlin, *Beyond the CLASS Act: The Future of Long-Term Care Financing Reform*, 24 THE GERONTOLOGICAL SOC'Y OF AM. 55 (Mar. 16, 2014), https://heller.brandeis.edu/community-living-policy/images/pdfpublications/2014marchbeyondtheclassact.pdf.
[103] Letter from Kathleen Sebelius to The Honorable John A. Boehner (Oct. 14, 2011), https://www.kff.org/wp-content/uploads/sites/2/2011/10/boehner-.pdf.
[104] *Id.*

Compounding the failures are other major federal policy gaps. While certain steps had been taken at the federal level post-Katrina to strengthen preparedness, including The National Response Framework ("NRF"); National Incident Management System; and The Post-Katrina Emergency Management Reform Act ("PKEMRA"),[105] these frameworks did not go far enough in strengthening the public health infrastructures needed to deal with a pandemic of the magnitude of COVID-19. This has been all too evident, for example, in breakdowns in the supply chain. Underinvestment in public health workforce education and training, as well as appropriate education and training for other health care workers, has left the workforce ill-equipped to respond to the public health crisis. Further, the direct care workforce, largely comprising people from racial and ethnic minorities, has historically been marginalized through both low wages and lack of appropriate training.[106]

c. State Policymaking, Lack of Emergency Preparedness and Crisis Standards, and Public Health Infrastructure Failures

The State's reluctance to take timely preparatory steps, such as in failing to enact crisis standards of care and adopt uniform triage guidelines for allocation of scarce resources in crisis conditions, left State and local government scrambling as the virus descended upon New York. The lack of these preparatory statutory and regulatory structures contributed to the State's default reliance on executive orders during the pandemic.

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[105] Pets Evacuation and Transp. Standards Act, Pub. L. No. 109-308, 120 Stat. 1725 (2006); Pub. L. No. 109-295, tit. VI, 120 Stat. 1355, 1394 (2006);

[106] *New Public Health Policy Statements Adopted by APHA 2020*, AM. PUB. HEALTH ASS'N (Oct. 25, 2020), https://apha.org/News-and-Media/News-Releases/APHA-News-Releases/2020/2020-APHA-policy-statement.

The Medicaid funding level of the State's nursing homes also placed stress on the system before the arrival of the virus. Of the State's nursing home residents, 67% were Medicaid recipients in 2017. [107] Medicaid revenue accounted for just over 56% of the State's nursing home revenues in 2016.[108] Although there is some dispute as to the adequacy of Medicaid reimbursement rates, nursing home representatives contend that Medicaid reimbursement rates compensate less than two-thirds of the cost of care of those residents.[109] That funding gap has contributed to a reduction in the number of publicly operated and not-for-profit nursing homes in favor of for-profit homes. It has also contributed to low wage rates and staffing levels.[110] In addition to staffing and wage rates, such underfunding affects every level of service in a nursing home, including staff training, infection control, the availability of system-wide palliative care, provision of PPE, and other critical resources and supports. These resources are essential not only to reduce risk of infection, but to assure humane care.

Compounding the State's lack of attention to emergency preparedness and its necessary legal pillars, New York has not developed a comprehensive plan for long term care. There have been various efforts, such as the Delivery System Reform Incentive Payment Program ("DSRIP")[111], but more often than not, the State has been

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[107] *Medicaid's Role in Nursing Home Care*, KAISER FAM. FOUND. (June 20, 2017), https://www.kff.org/infographic/medicaids-role-in-nursing-home-care/.

[108] *Regional Payor Mix – Revenue*, LEADINGAGE NY, https://www.leadingageny.org/linkservid/A68E4BB4-FE50-B80C-9A9896DBFC7857B1/showMeta/0/.

[109] Statements of James Clyne, Executive Director, LeadingAge NY and of Stephen Hanse, President, NY Healthcare Facilities Association to this Task Force in their respective appearances

[110] Halley Bondy, *39% of Covid-19 Deaths Have Occurred in Nursing Homes- Many Could Have Been Prevented: Report*, NBC NEWS (Dec. 8, 2020), https://www.nbcnews.com/know-your-value/feature/39-covid-19-deaths-have-occurred-nursing-homes-many-could-ncna1250374.

[111] As described by the State Department of Health, DSRIP is intended to fundamentally restructure the health care delivery system. *Delivery System Reform Incentive Payment (DSRIP) Program*, N.Y. ST. DEP'T OF HEALTH, https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/ (last visited Apr. 28, 2021).

reactive, with its seeming focus on how to control spending, or efforts at coordination have been siloed. Despite the United States Supreme Court decision in *Olmstead v. L.C.*[112] and calls for a shift to community care paradigms, and the use of non-institutionalized settings with expanded social services and supports and integrated palliative medical and social care, the State has been resistant. The number of nursing home deaths suggests that the reliance on institutional care had consequences for the pandemic.

V. The Impact on Nursing Homes and their Residents

Before going into what has occurred in the State's nursing homes, it is useful to understand what a nursing home is. Under the New York Public Health Law, a nursing home is a residential setting providing skilled nursing care and services and residential health-related care and services to residents who need skilled nursing or other professional services but who do not require the services of a general hospital.[113] A similar definition applies under federal law. A "skilled nursing facility" is an institution primarily engaged in providing skilled nursing care and related services for residents requiring medical or nursing care, or rehabilitation services for injured, disabled, or sick persons (but not primarily for the care and treatment of mental diseases), which meets

[112] *Olmstead v. L.C.*, 527 U.S. 581 (1999).
[113] N.Y. Pub. Health Law § 2801(2)–(4); 10 N.Y.C.R.R. §§ 415.1(b)(2), 415.2(k).

statutory requirements relating to: (a) quality of life;[114] (b) resident rights;[115] and (c) administration and other matters and which has a transfer agreement with one or more hospitals. All nursing homes provide the basic services, and some also provide specialized services, such as long-term ventilator care, specialized services for neurobehavioral disorders or involving behavioral interventions, long-term inpatient rehabilitation or extended care for brain injuries, and care for acquired immune deficiency syndrome.[116]

The legal definition of a nursing home is admittedly dense. Stepping back from the statutory definitions, a nursing home can be most easily understood as a hospital extender. Residents typically are in need of twenty-four-hour nursing care. Unlike patients in hospitals, nursing home residents are medically stable. Residents fall into two broad categories: long-term residents and patients receiving rehabilitation services. Rehabilitation patients are typically recovering from an injury and expect to be discharged when the recovery from their injury has been completed. Long-term residents typically do not expect to be discharged. There is little likelihood of recovery from their condition.

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[114] These include: (1) the delivery of care in a manner and an environment to promote the maintenance or enhancement of each resident's quality of life; (2) the "delivery of services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident; (3) the conduct of a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity meeting specified requirements; (4) the provision of services and activities; (5) the provision of nurse aide training; (6) the provision of medical care under physician supervision; (7) to have at least one social worker (in a facility with more than 120 beds); and (8) the posting of information on nurse staffing. Soc. Security Act § 1819(b), 42 U.S.C. § 1395i-3(b).

[115] These include, among others, the right to freedom of choice; freedom from restraints; privacy; confidentiality; accommodation of needs; to voice grievances; to participate in resident and family groups; to participate in other activities; to examine facility survey results; to refuse certain transfers; and other rights established by the Secretary. Soc. Security Act § 1819(c), 42 U.S.C. § 1395i-3(c).

[116] 10 N.Y.C.R.R. §§ 415.36–415.41.

According to the Kaiser Family Foundation, there were 89,775 residents in New York's nursing homes in 2019. CDC data compiled by the NHHS show that 85% of nursing home residents are over the age of 65, and over 40% are over the age of 85.[117] Nursing home residents typically have numerous comorbidities.

The modern nursing home arose from the enactment of Medicare and Medicaid in 1965 and related legislation of that period.[118] Prior to those enactments, nursing homes were more in the nature of old age homes, rest homes, and boarding houses. The Medicare Act did three things. First, it established a financing mechanism for the building of nursing homes. Second, it ensconced nursing homes in a medical model, authorizing Medicare payments for skilled nursing care following a period of hospitalization for those over the age of 65. Third, it enacted Medicaid, health insurance for the poor[119]. Medicaid provides payment for long-term care for qualified Medicaid beneficiaries. Medicare and Medicaid fueled the development of the modern nursing home industry.

Nursing homes do not have operating or emergency rooms, but resident units look remarkably like hospital wards. The residential area of nursing homes are centered on nursing stations, as is a hospital ward. Resident rooms, although they may have personal touches, look much like hospital rooms. As in hospitals, rooms are usually doubles, filled with two residents. Nursing home residents may eat in common

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[117] *2004 NNHS Tables – Estimates - Demographics*, CDC, https://www.cdc.gov/nchs/data/nnhsd/Estimates/nnhs/Estimates_Demographics_Tables.pdf#Table05 (last visited Apr. 28, 2021).
[118] *See* J. Hoyt, Senior Living History: 1960–1969 for a summary of events.
[119] Public Law 89–97, 79 Stat. 286, Title XIX (1965)

dining rooms, and they may enjoy common activities, but when they return to their rooms, the experience is hospital-like.

In New York, nursing homes may be for-profit or not-for-profit entities.[120] New York, though, prohibits publicly traded corporations from owning or operating nursing homes.[121] When a not-for-profit nursing home is established, the New York Public Health and Health Planning Council must approve the original members of the Board of Directors.[122] For for-profit nursing homes, that same council must approve any individual that owns ten percent or more of the nursing home entity.[123]

A. The Regulatory Structure for Nursing Homes in New York

1. The Federal-State Regulatory Structure

The delivery of care and services in a nursing home is subject to pervasive regulation at the state and federal level. The Department's regulations at 10 N.Y.C.R.R. Part 415 set out the New York nursing home operational requirements.

To qualify to receive payment under the Medicare or Medicaid program, a nursing home must comply with the federal requirements of participation. The SSA authorizes the Secretary of Health and Human Services (the Secretary) to promulgate implementing regulations, and the Secretary has delegated that authority to the Centers for Medicare and Medicaid Services ("CMS").[124] The CMS nursing home regulations are at 42 C.F.R. Part 483, Subpart B.

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[120] N.Y. Pub. Health Law § 2801-a.
[121] N.Y. Pub. Health Law § 2801-a(4)(d),(e),(f).
[122] N.Y. Pub. Health Law § 2801-a(1).
[123] *Id.*
[124] 42 C.F.R. § 1819(h)(2).

2. The Nursing Home Inspection Process

To oversee nursing home compliance, CMS contracts with state agencies – in New York, the Department of Health – to conduct periodic surveys, i.e. inspections, to determine whether nursing homes are in substantial compliance with federal participation requirements.[125] Under federal law, the state agency must survey each nursing home annually, with no more than 15 months elapsing between surveys, and must survey them more often, if necessary, to ensure the correction of identified deficiencies.[126] The state agency must also investigate all complaints.[127]

CMS's regulations differentiate among deficiencies, that is, violations of a participation requirement,[128] according to three levels of scope – whether the deficiencies are isolated, constitute a pattern, or are widespread – and four levels of severity – from (i) relatively minor conditions presenting no actual harm with a potential for minimal harm; to (ii) no actual harm with a potential for more than minimal harm but not immediate jeopardy; to (iii) actual harm that is not immediate jeopardy; to (iv) immediate jeopardy to resident health or safety.[129]

CMS and the states have the authority to impose enforcement remedies against a nursing home that is not in substantial compliance with federal participation requirements.[130] CMS is authorized to impose a civil monetary penalty ("CMP") for the

[125] Soc. Security Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20, 488.10–488.28, 488.300–488.335.
[126] Soc. Security Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.
[127] Soc. Security Act § 1819(g)(4).
[128] Soc. Security Act § 1819(b)–(d); 42 C.F.R. Part. 483, subpart B.
[129] 42 C.F.R. § 488.404.
[130] 42 C.F.R. § 1819(h)(2).

number of days of noncompliance – a per-day CMP – or for each instance of noncompliance – a per-instance CMP.[131]

Under Section 12 of the Public Health Law, the Department has authority to assess a civil penalty not to exceed $2,000 for every violation. The penalty may be increased to an amount not to exceed $5,000 for a subsequent violation if the person committed the same violation, with respect to the same or any other person or persons, within 12 months of the initial violation for which a penalty was assessed pursuant to paragraph (a) of this subdivision and if the violations were a serious threat to the health and safety of an individual or individuals, or to an amount not to exceed $10,000 if the violation directly results in serious physical harm to any patient or patients.

3. The CMS Five-Star Rating System

CMS maintains a website[132] which features a quality rating system that gives each nursing home a rating of between one and five stars. The rating system is intended to aid the public in choosing a nursing home. Nursing homes with five stars are considered to have substantially above average quality and nursing homes with one star are considered to have quality much below average. There is one overall five-star rating for each nursing home, and a separate rating for each of the following three categories:

- **Health Inspections** – The health inspection rating contains the three most recent health inspections and investigations due to complaints. The results are

[131] 42 C.F.R. § 488.430.
[132] Previously, the CMS website was known as the Nursing Home Compare. On December 1, 2020, CMS retired its Nursing Home Compare website and replaced it with Care Compare, which can be accessed at https://www.medicare.gov/care-compare/ (last visited Apr. 28, 2021).

weighted, with the most recent survey findings receiving more weight than those from prior years.

- **Staffing** – The staffing rating has information about the number of hours of nursing staff care the facility provides on average to each resident each day. The staffing rating is based on two measures: (1) Registered Nurse (RN) hours per resident per day; and (2) total nurse staffing (including RN, licensed practical nurse (LPN), and nurse aide) hours per resident per day. CMS adjusts reported staffing ratios to account for resident condition using the Resource Utilization Group (RUG-III) case-mix system.

- **Quality Measures** – The quality measure rating has information on 15 different physical and clinical measures for short-stay[133] and long-stay nursing home residents.[134] There are three short-stay measures: pressure ulcers; moderate to severe pain; and delirium. There are seven long-stay measures: activities of daily living (ADL) decline; mobility decline; catheter use; high-risk pressure ulcers; physical restraints; urinary tract infections; and moderate to severe pain.

For the health inspections and quality measure domains, the top 10% of nursing homes get five stars, the bottom 20% get one star, and the middle 70% receive two, three or four stars, with equal proportions (23.33%) in each category. For the staffing

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[133] Long-stay resident quality measures show the average quality of care for certain care areas in a nursing home for those who stayed in a nursing home for 101 days or more. Residents in a nursing home for a long-stay are usually not healthy enough to leave a nursing home and are unable to live at home or in a community setting. *See Long-Stay Quality of Resident Care Measures*, *Quality of Resident Care*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://data.cms.gov/provider-data/topics/nursing-homes/quality-of-resident-care#long-stay-quality-of-resident-care-measures (last visited Apr. 28, 2021).

[134] Short-stay resident quality measures show the average quality of resident care in a nursing home for those who stayed in a nursing home for 100 days or less or are covered under the Medicare Part A skilled nursing facility) benefit. These residents often are those who are recovering from surgery or being discharged from a hospital stay and who receive care in a nursing home until they're able to go back home or to the community. *See also Short-Stay Quality of Resident Care Measures*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://data.cms.gov/provider-data/topics/nursing-homes/quality-of-resident-care#short-stay-quality-of-resident-care-measures (last visited May 6, 2021).

measures, the facility receives a five-star rating based on where the nursing home ranks compared to the adjusted staffing hours for all freestanding nursing homes and where the nursing home ranks compared to optimal staffing levels. To earn five stars on the staffing rating, the nursing home must exceed the CMS staffing study thresholds for both RN and total nursing hours per resident day.

B. Pre-Existing Issues in Nursing Homes

1. Infection Control

The pandemic shed light on pre-existing issues in nursing homes. The United States Center for Medicare and Medicaid Services (CMS) has noted that infection is the leading cause of morbidity and mortality in nursing homes.[135]

Nursing homes must have an infection control program that includes a system for preventing, identifying, reporting and controlling infections and communicable diseases for all residents, staff, volunteers, visitors and other individuals providing services, and precautions to prevent the spread of infections. There must be an annual review of the plan. The Nursing Home Code also requires nursing homes to establish and maintain an infection control program to investigate, control and take actions to prevent infections at facilities, determine what procedures such as isolation and universal precautions should be utilized and maintain a record of incidents and corrective actions related to infections.10 N.Y.C.R.R. § 415.19. The regulations go on to require that the nursing home assure that all equipment and supplies are cleaned and properly sterilized and stored in a manner that will not violate the integrity of the sterilization. The regulation further provides that the facility must prohibit persons known to have a communicable

[135] *Updates and Initiatives to Ensure Safety and Quality in Nursing Homes*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Nov. 22, 2019), https://www.cms.gov/files/document/qso-20-03-nh.pdf.

disease or infected skin lesions from direct contact with residents or their food. Finally, the regulations provide standards for hand washing and linen handling and storage. Further, 10 N.Y.C.R.R. § 81.1(c) defines patient neglect to include the failure to provide sanitary clothing and surroundings. The infection control procedures in both the state and federal regulations added COVID-19-specific standards in 2020 and both the New York State Department of Health and the CDC provided additional guidance concerning infection control after the outbreak of the pandemic.

2. Staffing

A license to operate a nursing home comes with a special obligation to the residents who depend upon the facility to meet every basic human need.[136] Federal and state requirements express expectations for the operation of a facility with respect to performance and outcomes rather than by dictating structure and process.[137] Staffing is a structural measure that affects the processes and outcomes of care in nursing facilities.[138]

Federal law mandates that nursing homes have sufficient nursing staff with the appropriate competencies and skill sets in order to assure residents safety and to attain or maintain the highest practicable level of physical, mental, and psychosocial well-

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[136] Edward Livingston et al., *Sourcing Personal Protective Equipment During the COVID-19 Pandemic*, 323 J. AM. MED. ASS'N 1912 (2020), https://jamanetwork.com/journals/jama/fullarticle/2764031; *see also* Jennifer Abbasi, *"Abandoned" Nursing Homes Continue to Face Critical Supply and Staff Shortages as COVID-19 Toll Has Mounted*, 324 J. AM. MED. ASS'N 123 (2020), https://jamanetwork.com/journals/jama/fullarticle/2767282 [hereinafter "*Abandoned*"]; Jordan Rau, *Nursing Homes Run Short Of COVID-19 Protective Gear As Federal Response Falters*, NPR (June 11, 2020), https://www.npr.org/sections/health-shots/2020/06/11/875335588/nursing-homes-run-short-of-covid-19-protective-gear-as-federal-response-falters.

[137] *Id.*

[138] Gooloo S. Wunderlich et al., *Nursing Staff in Hospitals and Nursing Homes: Is It Adequate?*, INST OF MED. (US) COMMITTEE ON THE ADEQUACY OF NURSING STAFF IN HOSPITALS AND NURSING HOMES (1996), https://pubmed.ncbi.nlm.nih.gov/25121200/.

being of each resident.[139] This is determined by resident assessments and individual plans of care with consideration of the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment.[140]

Federal law also requires that the facility have sufficient numbers of Certified Nursing Assistants (CNAs),[141] Licensed Vocational Nurse/Licensed Practical Nurses (LVNs/LPNs),[142] and Registered Nurses (RNs)[143] on a 24-hour basis to provide nursing care to all residents including a charge nurse on each shift, an RN for at least eight consecutive hours a day, seven days a week, and a designated RN to serve as the director of nursing on a full-time basis unless the facility has a CMS waiver.[144] The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.[145]

Nursing homes are also required to post daily nurse staffing data on the total number and type of staff and the actual hours worked by nursing staff by shift.[146] In addition, facilities must ensure that nursing staff have the competency and skill sets to care for residents.[147]

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[139] 42 C.F.R. § 483.70(e).
[140] 42 C.F.R. § 483.70(e).
[141] CNAs provide assistance with activities of daily living, such as ambulation, transfers to/from bed, feeding, hygiene, toileting, bathing, dressing, bed cleaning and adjustments, turning and positioning of immobile patients, and other care and comfort
[142] Primarily focus on medication administration, monitoring vital signs, and providing certain treatments
[143] Primarily focus on acute care needs, complex treatments, compliance with medical orders, communication with physicians and specialists, record-keeping, and complex health assessments.
[144] *State Operations Manual - 7014.1.1 Waiver of 7-Day Registered Nurse (RN) Requirement for Skilled Nursing Facilities* CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R97SOMA.pdf (last visited Apr. 29, 2021).
[145] 42 C.F.R. § 483.35.
[146] 42 C.F.R. § 483.35.
[147] *Staffing Data Submission Payroll Based Journal (PBJ)*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Staffing-Data-Submission-PBJ.html (last visited Apr. 28, 2021).

Federal regulations require the following steps be taken into consideration when a staffing model is determined for any nursing home:[148]

(a) determine the collective resident acuity and care needs,[149]

(b) determine the actual nurse staffing levels,[150]

(c) identify appropriate nurse staffing levels to meet residents care needs,[151]

(d) examine evidence regarding the adequacy of staffing [152], and

(e) identify gaps between the actual staffing and the appropriate nursing staffing levels based on resident acuity.[153]

Federal regulations require nursing homes to conduct a facility self-assessment regarding the resources and qualified staff needed to meet patient care needs. This assessment must consider "the number, acuity and diagnoses of the facility's resident population" and must be updated at least annually.[154] The facility assessment should define the facility's strategy and resource allocation decisions.[155] Although corporate input may be included, the assessment must be conducted at the facility using many sources of information such as the residents, families, councils, and representatives.[156] Facility assessment is meant to be a thorough process and surveyors may issue a deficiency if the assessment is generic or designed to justify preexisting or budgeted staffing levels and not based on resident acuity.[157]

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[148] *Id.*
[149] *Id.* (indicating that Resident care needs differ depending on the acuity level (or case mix) of the facility residents. Higher acuity rates require higher staffing levels.)
[150] *Id.*
[151] *Id.*
[152] *Id.*
[153] *Id.*
[154] 42 C.F.R. § 483.70(e).
[155] *Id.*
[156] 42 C.F.R. § 483.35.
[157] *Id.*

The regulation goes on to state that the collective resident acuity and care needs are based on an aggregation of individual resident assessments and care needs and are the basis for the resident's plan of care.[158] Federal law further requires nursing homes to conduct a comprehensive resident assessment of each individual resident on admission, annually, and when a significant change in status occurs.[159] CMS developed a standardized resident assessment instrument using the Minimum Data Set ("MDS") to document resident's needs, strengths, goals, functional and health status, life history, and preferences.[160] The MDS data are reported electronically by each facility to CMS and are used by facilities to develop a comprehensive care plan that determines appropriate resident services, needs, and preferences.

A majority of states have established their own minimum staffing requirements for nursing homes.[161] For example, California requires all nursing homes to provide at least 3.5 nursing hours per resident day, although some waivers are allowed.[162] The New York State Legislature is actively considering legislation establishing minimum staffing levels for New York nursing home, though the bill's prospects are unknown as of this writing.[163] .

Finding nursing staff has been challenging for administrators and directors of nursing homes even with substantial recruitment efforts including providing H1B visas[164]

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[158] *Id.*
[159] *Id.*
[160] *Id.*
[161] *Appropriateness of Minimum Nurse Staffing Ratios*, CTRS. FOR MEDICARE & MEDICAID SERVS. (Dec. 24, 2001), https://theconsumervoice.org/uploads/files/issues/CMS-Staffing-Study-Phase-II.pdf.
[162] CAL. HEALTH & SAFETY §1276.5.
[163] *See* S.6346/A.7119 (2021). The bills have now passed both houses and are awaiting gubernatorial action.
[164] The H1B visa is an employment-based, non-immigrant visa for temporary workers. For this visa, an employer must offer a job in the US and apply for your H1B visa petition with the US Immigration

for nurses trained overseas. Aside from recruitment abroad, nursing staffing agencies and registries for supplemental staffing and overtime accrual were frequently used pre-pandemic. [165]

Studies of nursing homes have shown that there is a strong positive relationship between the number of nursing home staff who provide direct care to residents daily and the quality of care and quality of life of residents in the nursing home.[166] Poor staffing is known to have a negative impact on the quality and outcome of care in that it increases the likelihood of negligence, harm to residents and staff, poor infection control compliance and errors.[167] "In nursing homes, quality and staffing are important factors, and there already exists system-wide disparities in which facilities with lower resources and higher concentrations of socio-economically disadvantaged residents have poorer health outcomes"[168] At least one study has found that long-term care facilities with higher concentrations of disadvantaged residents, including Medicaid residents and racial and ethnic minorities, lower nurse staffing levels (particularly RNs), and lower scores on CMS five-star quality measures, had higher rates of confirmed COVID-19

Department. This approved petition is a work permit which allows the recipient to obtain a visa stamp and work in the U.S. for that employer.

[165] The outcomes of nursing home care include changes in health status and conditions attributable to the care provided or not provided. Outcomes of long-term care are "most fairly expressed in terms of the relationship between expected and actual outcomes." For some nursing home residents, realistic expectations for the outcomes of care may be maintained levels of health or slower-than-expected rates of decline, rather than improved health (R.L. Kane, 1995, p. 1379). The currently used measures of outcome include global measures such as mortality rates and rehospitalization rates (Lewis et al., 1985; GAO, 1988a, b; Spector and Takada, 1991) *Staffing and Quality of Care in Nursing Homes, in* NURSING STAFF IN HOSPITALS AND NURSING HOMES, IS IT ADEQUATE? (Gooloo S. Wunderlich, Frank Sloan, & Carolyne K. Davis eds., Nat'l Acad. Press, 1996), https://www.ncbi.nlm.nih.gov/books/NBK232672/.

[166] John F. Schnelle et al., Relati*onship of Nursing Home Staffing to Quality of Care*, 39 HEALTH SERV. RES. 225 (Apr. 2004), https://pubmed.ncbi.nlm.nih.gov/15032952/.

[167] *COVID-19 Toll in Nursing Homes Linked to Staffing Levels and Quality*, UNIV. OF ROCHESTER MED. CTR. (June 18, 2020), https://www.sciencedaily.com/releases/2020/06/200618073538.htm.

[168] Yue Li, Ph.D., professor in the University of Rochester Medical Center (URMC), Department of Public Health Sciences, Journal of the American Geriatrics Society. "These same institutional disparities are now playing out during the coronavirus pandemic." *Id.*

cases and deaths. Higher nurse staffing ratios was strongly associated with fewer cases and deaths[169].

Low or poor staffing is usually considered amongst the strongest causes of poor quality in nursing homes.[170] Poor staffing can cause staff to build in shortcuts to alter the amount of time needed to perform basic tasks, such as: not washing hands sufficiently as they move from one patient to the next,[171] failing to don masks, gloves and gowns when in the rooms of contagious patients in isolation,[172] partially dressing residents to cover only the obvious body areas,[173] not offering basic hygiene to residents,[174] engaging in improper disposal of items used for residents in isolation,[175] and failing to attend to the needs of the residents in isolation in a timely manner.[176] Low

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[169] *Id.*

[170] Charlene Harrington, RN, PhD, professor emeritus of sociology and nursing at the UCSF School of Nursing. Harrington also is director of the UCSF National Center for Personal Assistance Services. Adding that,"Poor quality of care is endemic in many nursing homes, but we found that the most serious problems occur in the largest for-profit chain." *See* Charlene Harrington, *supra* note ____. "Of the 401 for-profit facilities, more than two-thirds have the lowest possible CMS Staffing rating of 1-Star or 2-Stars. Similarly, of the 100 facilities in New York state with a CMS 1-Star overall rating, 82 are for-profit facilities." *See Attorney General Report*, *supra* note 62.

[171] Jordan Rau, *Coronavirus Stress Test: Many 5-Star Nursing Homes Have Infection-Control Lapses*, KHN (Mar. 4, 2020), https://khn.org/news/coronavirus-preparedness-infection-control-lapses-at-top-rated-nursing-homes/.

[172] *Id.*, reporting that inspectors also watched another nursing home employee work in the room of a patient with pneumonia without wearing a mask, gown and gloves as required by a sign outside the room. They noted in their report that the facility had experienced two outbreaks of influenza that year, affecting at least 17 residents and seven staff members.

[173] *Id.* In April 2019, it was reported that during inspection at the Kirkland nursing home the inspectors there observed a registered nurse treating a patient whose feet were touching the floor, even though one heel had a pressure sore. The resident's daughter also said she feared the heel was infected. "It was unhygienic," the daughter told inspectors. *Id.*

[174] *Id.* Reporting that during an interview, Hunter, the Washington state Ombud, said that during her recent visits to 14 nursing homes in three Northwestern states reporting that that aides were generally good about using hand sanitizer but rarely washed residents' hands. Not every resident room had a sink, she said. "I haven't seen one resident have their hands washed during lunchtime or dinnertime," she said. *Id.*

[175] *Id.*

[176] *Id.*

or poor staffing can lead to errors.[177] Not every error is life threatening, but an error in infection control could cause serious harm to a patient or staff member.

Long before the novel coronavirus, the nation's nursing homes were struggling to comply with basic infection prevention protocols.[178] According to a Kaiser Health News analysis of federal records in the beginning of 2017, government health inspectors cited more nursing homes for failing to ensure that all workers follow infection prevention and control rules than for any other type of violation.[179]

Since 2017, more than 9,300 nursing homes nationally have been cited for failing to follow prevention and control rules. These violations were more common in facilities that received low ratings for staffing levels from the Centers for Medicare & Medicaid Services. Sixty-five percent (65%) of 1-star nursing homes have at least one infection.

3. Ownership and Other Facility Characteristics

Numerous studies have been done to determine whether there is a relationship between cases and deaths in nursing home facilities and factors such as infection control, staffing levels and shortages, community spread, and facility characteristics including ownership, urban or non-urban location, racial/ethnic composition of population, and Medicaid funding.

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[177] *Id.*
[178] *Id.*
[179] Jordan Rau, *As Coronavirus Looms, Many Nursing Homes Fall Short On Infection Prevention*, NPR (Mar. 4, 2020), https://www.npr.org/sections/health-shots/2020/03/04/812162416/as-coronavirus-looms-many-nursing-homes-fall-short-on-infection-prevention.

A literature review of 30 published studies done by the Kaiser Family Foundation[180] reported the following findings using cases, deaths, and severity of outbreak, as well as other measures in long-term care facilities:

- Nursing homes with relatively high shares of Black or Hispanic residents were more likely to report at least one COVID-19 death than nursing homes with lower shares of Black or Hispanic residents.

- Among nursing homes that had at least one case of coronavirus, nursing homes with relatively high shares of Black or Hispanic residents reported more severe case outbreaks than nursing homes with low shares of Black or Hispanic residents, as measured by confirmed or suspected cases as a share of nursing home beds.

- National patterns of COVID-19 deaths and cases in nursing homes with relatively high shares of Black or Hispanic residents generally persist at the state level, based on data from 21 states.

Other facility-level characteristics findings were also reported based upon a literature review of 30 published studies:[181]

- Long-term care facilities that are for-profit, have a higher share of residents who are people of color, are located in urban areas, and have more beds are more likely to have COVID-19 cases and deaths.

- For-profit nursing facilities are at higher risk for COVID-19 cases and deaths, while nursing facilities with labor unions are less likely to have COVID-19 deaths.

- Long-term care facilities with higher shares of residents who are people of color are more likely to experience COVID-19 cases and/or deaths.

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[180] Priya Chidambaram et al., *Racial and Ethnic Disparities in COVID-19 Cases and Deaths in Nursing Homes*, KAISER FAM. FOUND. (Oct. 27, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/racial-and-ethnic-disparities-in-covid-19-cases-and-deaths-in-nursing-homes/.

[181] Nancy Ochieng, *Factors Associated With COVID-19 Cases and Deaths in Long-Term Care Facilities: Findings from a Literature Review*, KAISER FAM. FOUND. (Jan. 14, 2021), https://www.kff.org/coronavirus-covid-19/issue-brief/factors-associated-with-covid-19-cases-and-deaths-in-long-term-care-facilities-findings-from-a-literature-review/.

- Urban location may be associated with cases in long-term care facilities.

- Facilities with more beds and higher occupancy rates are more likely to have COVID-19 cases and/or deaths.

- There is some association between the share of residents covered by Medicaid as a primary payer and COVID-19 burden.

While the KFF report is neither exhaustive nor definitive and additional research will be necessary, the findings do give a preliminary picture of the issues and relationships that merit further study and examination.

C. The New York Nursing Home Experience During the Pandemic

Nearly 40% of the COVID deaths in the United States have occurred in nursing homes. As of March 3, 2021, it was reported that 13,625 residents of New York nursing homes had succumbed to the virus.[182] No single explanation will account for the dire and unjust outcomes, and no single actor bears responsibility for the tragedy we have witnessed. In this section of the Report, we will examine the multiple considerations that weighed in the balance and the confluence of decisions that may have created the perfect public health storm.

Things went strikingly wrong. They went wrong for a variety of reasons. They went wrong due to a failure to recognize the depth and scope of the problem early. They went wrong because information was suppressed, in China and at the hands of the President. They went wrong because too much faith was placed in the ability of the health care system to check the epidemic. They went wrong because elements of the public health structure had been weakened. They went wrong because early efforts to

[182] *See New York COVID-19 Fatality Data: Nursing Homes & Adult Care Facilities*, LONG TERM CARE CMTY. COAL. (Mar. 3, 2021), https://nursinghome411.org/ny-nursinghome-covid-data/.

check the virus' spread were ineffectual. They went wrong because testing failed. They went wrong because warning signs, big, flashing warning signs, were missed. They went wrong because the virus was not understood – especially that asymptomatic spread was a feature of this virus, unlike other recent viruses. They went wrong because there was not enough PPE. And, they went wrong because the virus arrived so quickly in New York and with so much virulence that adjustments could not be made in time to avoid catastrophic consequences.

This is not to overlook the performance of nursing homes. As discussed throughout this Report, collectively, nursing homes were poorly prepared for the onslaught. Already thin staffing became worse for nursing homes during the coronavirus pandemic.[183] During the COVID-19 pandemic, nursing homes, at least initially, were under pressure to maintain staff levels with limited access to PPE.[184] Nursing home caregivers were and are unable to social distance, as their job requires close contact with residents.[185] During the initial surge, the shortage of PPE put staff at increased risk of contracting the virus. Staff were lost for at least 14 days for

[183] *See* Harrington et al., *Nursing Home Staffing, supra* note 170; *see* Ari Min & Hye Chong Hong, *Effect of Nurse Staffing on Rehospitalizations and Emergency Department Visits Among Short-Stay Nursing Home Residents: A Cross-Sectional Study Using the US Nursing Home Compare Database*, 40 GERIATRIC NURSING 160 (2019), https://pubmed.ncbi.nlm.nih.gov/30292528/ [hereinafter *Effect of Nurse Staffing*]; *see also* Sophie Quinton, *Staffing Nursing Homes Was Hard Before the Pandemic. Now It's Even Tougher*, STATELINE (May 18, 2020), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2020/05/18/staffing-nursing-homes-was-hard-before-the-pandemic-now-its-even-tougher [hereinafter *Even Tougher*].

[184] *See* Edward Livingston et al., *Sourcing Personal Protective Equipment During the COVID-19 Pandemic*, 323 JAMA 1912 (2020); *see also* Abbasi, *"Abandoned", supra* note 136; Jordan Rau, *Nursing Homes Run Short Of COVID-19 Protective Gear As Federal Response Falters*, NPR (June 11, 2020), https://www.npr.org/sections/health-shots/2020/06/11/875335588/nursing-homes-run-short-of-covid-19-protective-gear-as-federal-response-falters.

[185] *Long-Term Care Nursing Homes Telehealth and Telemedicine Tool Kit*, CTRS. FOR MEDICARE AND MEDICAID SERVS. (2020).

quarantine due to illness or exposure[186] Other factors exacerbated staff pressures, including meeting the COVID protocols and isolating residents who were suspected of having the virus.

The ban on visitors also reduced the availability of informal care provided to residents by visiting family and friends. This created a situation in which time and effort needed from nursing home staff increased, yet structural factors made it more difficult to address exacerbating staff shortages.[187] Pandemic-induced staff shortages meant federal staffing standards were not met.

With all these problems, the experience in nursing homes cannot be separated from the State and nation's overall experience with COVID-19. Early opportunities to check the spread were missed, denied, or fumbled.

The missed opportunities start with China. Although China did release the genetic map of the virus (which actually triggered the ultimately successful efforts of BioNTech and Moderna to develop vaccines),[188] China refused to allow the Chinese Center for Disease Control to speak to the United States Centers for Disease Control.[189] Thus, the CDC was denied the chance to learn from the Chinese experience.

Even before the virus arose in China, public health resources had been allowed to weaken. This weakening had occurred over the years in a number of ways. Most

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[186] Alex Spanko, *Nursing Home Staffing Strain Could Hit 'High Point' This Week as COVID-19 Crisis Rages*, SKILLED NURSING NEWS (Apr. 12, 2020), https://skillednursingnews.com/2020/04/nursing-home-staffing-strain-could-hit-high-point-this-week-as-covid-19-crisis-rages/.
[187] Abbasi, *"Abandoned," supra* note 136.
[188] China releases genetic data on new coronavirus, now deadly | CIDRAP (umn.edu).
[189] Donald G. McNeil Jr. and Zolan Kanno-Youngs, *C.D.C. and W.H.O. Offers to Help China Have Been Ignored for Weeks*, N.Y. TIMES (Feb. 7, 2020), https://www.nytimes.com/2020/02/07/health/cdc-coronavirus-china.html.

directly related to COVID-19, the United States CDC staff in China had been cut by more than two-thirds, from 47 to 13.[190] The National Security Council's Directorate for Global Health and Security and Biodefense had been disbanded in 2018. The Directorate had responsibility for pandemic preparation.[191]

Then there was the failure of testing. The CDC took exclusive authority to develop a diagnostic test. Its efforts failed, costing a crucial month as the disease was beginning its spread in the United States.[192] New York State, after some weeks, was able to develop its own test, but the supply was insufficient, and the testing turnaround time was too long.[193] Too few people were able to be tested, and the results, by the time they were received, were often of little use. In this, our national experience can be compared to that of South Korea. South Korea was able to develop an early, successful testing regimen, which supported the all-important contact tracing effort. Even today, South Korea largely has been able to keep the spread of the virus largely in check.[194]

There was also the speed of the pandemic, lack of recognition, political tensions and short-term delays. The virus was here in New York quickly, too quickly for the body

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[190] M. Taylor, *U.S. Slashed CDC Staff in China Prior to Coronavirus Outbreak*, REUTERS (Mar. 25, 2020), https://www.reuters.com/article/us-health-coronavirus-china-cdc-exclusiv-idUSKBN21C3N5.
[191] Deb Riechmann, *Trump disbanded NSC pandemic unit that experts had praised*, ASSOC. PRESS (Mar. 14, 2020), https://abcnews.go.com/Politics/wireStory/trump-disbanded-nsc-pandemic-unit-experts-praised-69594177.
[192] Carolyn Y. Johnson and Laurie McGinley. *What went wrong with the coronavirus tests in the U.S.,* THE WASH. POST (Mar. 7, 2020). https://www.washingtonpost.com/health/what-went-wrong-with-the-coronavirus-tests/2020/03/07/915f5dea-5d82-11ea-b29b-9db42f7803a7_story.html.
[193] Joseph Goldstein and Michael Gold, *City Pleads for More Coronavirus Tests as Cases Rise in New York*, N.Y. TIMES (Mar. 6, 2020), https://www.nytimes.com/2020/03/06/nyregion/coronavirus-new-york.html?searchResultPosition=2.
[194] In fact, South Korea had a national plan for responding to an epidemic and began implementing that plan in January 2020 as soon as the first case was recognized in that nation. June-Ho Kim, et al., *Emerging COVID-19 Success Story: South Korea Learned the Lessons of MERS*, EXEMPLARS IN GLOB. HEALTH (Mar. 5, 2021), https://ourworldindata.org/covid-exemplar-south-korea.

politic to respond. There was the mistaken belief, or at least mistaken public statements, that New York was ready to control the virus. There were the political tensions between Governor Cuomo and Mayor DeBlasio, which interfered with communication between the State and City Departments of Health. And finally, there was the delay in shutting down New York's economy. That delay was only a matter of a few days, and it would be unfair to suggest any sort of criticism for a public official's brief delay in issuing such a significant order, but hindsight (and published reports) shows that the delay of a mere few days greatly contributed to the virus' spread and number of deaths.[195]

The speed with which the virus arrived in New York also adversely affected nursing homes. Nursing homes needed PPE. There was far from enough. The federal government in February had undertaken an effort to purchase PPE, only to find that China had cornered the market, having purchased all equipment available at the time to meet its own needs as the first nation impacted by the virus.[196]

Face masks, shields, gloves, and other protective items quickly became the most wanted items for households and healthcare alike. The public was discouraged from wearing masks, originally being told masks were not useful protection from the virus.[197] That rationale quickly changed – masks and PPE had to be preserved to be available

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[195] *See* J. David Goodman, *How Delays and Unheeded Warning Hindered New York's Virus Fight*, N.Y. TIMES (Apr. 8, 2020), https://www.nytimes.com/2020/04/08/nyregion/new-york-coronavirus-response-delays.html; *see also Watch a Timeline of Disease Expert Dr. Anthony Fauci's Comments on Coronavirus*, CNBC (Mar. 26, 2020), https://www.cnbc.com/video/2020/03/26/watch-a-timeline-of-disease-expert-dr-anthony-faucis-comments-on-coronavirus.html.

[196] *China's Epic Dash for PPE Left the World Short on Masks*, BLOOMBERG BUSINESSWEEK (Sept. 17, 2020), https://www.bloomberg.com/news/articles/2020-09-17/behind-china-s-epic-dash-for-ppe-that-left-the-world-short-on-masks.

[197] *How Mask Guidelines Have Evolved*, N.Y. TIMES (April 27, 2021), https://www.nytimes.com/2021/04/27/science/face-mask-guidelines-timeline.html.

for health care workers.[198] Thus, at the time the virus was quickly spreading, what later became recognized as one of the most effective means to check the virus' spread -- mask-wearing, was being discouraged.

At the same time, PPE was in short supply for nursing homes. Hospitals came first. All other health care providers came after. PPE items' cost increased several times over at the pandemic's heights, if a provider could even get them.[199] Massively increased consumption rates rapidly sapped providers' stored supplies and led to high competition levels for available shipments.[200] Orders frequently did not arrive or were appropriated and redistributed by federal agencies on behalf of state-level emergency responses.[201] Scarcity was made worse by slow, sometimes, international supply lines, and limited raw materials.[202] After its initial efforts, the federal government withdrew from pursuing PPE, leaving the states, including New York, on their own.[203]

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[198] *Id.*
[199] Daniella Diaz, Geneva Sands and Cristina Alesci, *Protective equipment costs increase over 1,000% amid competition and surge in demand*, CNN POLITICS (Apr. 17, 2020), https://edition.cnn.com/2020/04/16/politics/ppe-price-costs-rising-economy-personal-protective-equipment/index.html.
[200] Erin Schumaker, *How did the US come up so short on PPE?*, ABC NEWS (Apr. 14, 2020), https://abcnews.go.com/Health/us-short-ppe/story?id=70093430; Tucker Doherty and Brianna Ehley, *Trump called PPE shortages 'fake news.' Health care workers say they're still a real problem*, POLITICO (Apr. 26, 2020), https://www.politico.com/news/2020/04/26/trump-ppe-fake-news-207523.
[201] Terry Nguyen, *How the Trump administration has stood in the way of PPE distribution*, VOX (Apr. 4, 2020), https://www.vox.com/2020/4/4/21208122/ppe-distribution-trump-administration-states; Diana Falzone, *"Like a Bully at the Lunchroom": How the Federal Government Took Control of the PPE Pipeline*, VANITY FAIR (May 6, 2020), https://www.vanityfair.com/news/2020/05/how-the-federal-government-took-control-of-the-ppe-pipeline; Mia Jankowicz, *Officials in at least 6 states are accusing the federal government of quietly diverting their orders for coronavirus medical equipment*, BUSINESS INSIDER (Apr. 8, 2020), https://www.businessinsider.com/coronavirus-federal-govt-fema-accused-taking-states-masks-ventilator-orders-2020-4.
[202] ADB Briefs, *Global Shortage of Personal Protective Equipment amid COVID-19: Supply Chains, Bottlenecks, and Policy Implications*, ASIAN DEV. BANK (Apr. 2020), https://www.adb.org/sites/default/files/publication/579121/ppe-covid-19-supply-chains-bottlenecks-policy.pdf.
[203] *Trump administration tries to narrow stockpile's role for states*, ASSOC. PRESS (Apr. 3, 2020), https://www.latimes.com/world-nation/story/2020-04-03/trump-admin-tries-to-narrow-stockpiles-role-for-states.

Federal and New York State government responses were intended to help and did provide some relief during the winter and spring of 2020. For example, the federal medical assistance percentage ("FMAP") of state assistance expenditures was boosted due to increased operating costs; however, that increase was terminated in mid-2020.[204] The imposition and enforcement of New York's 60-day required PPE reserve for nursing homes, meant to prevent a second scramble for PPE, was mistimed and added local stress to the situation. Many New York providers were suddenly competing for huge amounts of the same supplies when PPE was in extremely short supply. Once providers met the required standard, they were required to maintain that level of PPE reserves, although the period of greatest need may have passed.[205]

What was most devastating for nursing homes was asymptomatic spread. In March 2020, asymptomatic transmission was not yet well-recognized. It was because asymptomatic spread was not recognized that the public authorities had believed the virus could be controlled.[206] Instead, the virus had spread through the New York metropolitan area and was present in its nursing homes. Staff was infected. Residents were infected.

At least through New York's first surge, the greatest determinant of COVID-19 results spread appears to have been location. A nursing home located in a

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[204] On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA provided a temporary 6.2 percentage point increase.

[205] *See* Note 59, s*upra.*

[206] *See* Daniel Jernigan, *Update: Public Health Response to the Coronavirus Disease 2019 Outbreak – United States, February 24, 2020*, CDC (Feb. 24, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6908e1-H.pdf; Andrew Romano, *Fauci Once Dismissed Concerns About 'Silent Carriers' of Coronavirus. Not Anymore.*, YAHOO!NEWS (Apr. 7, 2020), https://news.yahoo.com/fauci-once-dismissed-concerns-about-silent-carriers-of-coronavirus-not-anymore-161718057.html; *see also Older Adults*, CDC (April 16, 2021), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/older-adults.html.

neighborhood with a high number of COVID-19 cases was much more likely to have a COVID-19 outbreak than a nursing home in a neighborhood with a lower level of cases.[207] That is not surprising. The largest proportion of a nursing home's staff are low-paid direct care aides, food service workers and custodian staff. These workers are typically drawn from areas in close proximity to the nursing home. Thus, especially in the early days of the epidemic in New York, when asymptomatic spread was not yet recognized, there was a close correlation between nursing home location and COVID-19 cases.

Nursing home residents were in harm's way. The CDC posted guidance on March 5th advising people over 60 to take special precautions.[208] The first recognized outbreak in the United States occurred at a nursing home in Washington State. Experience with the virus thus far has shown that virus has been most dangerous for older individuals. Almost 96% of deaths have occurred in individuals over the age of 50, with over 88% in those over 60, and over 70% in those over 70.[209] The comorbidities are also striking, as are their relationships to age. Of those who have passed away due to the virus in New York State, 92% have had at least one known comorbidity, and these are comorbidities typically associated with aging including hypertension, diabetes, dementia, coronary artery disease, and Chronic Obstructive Pulmonary Disorder.[210]

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[207] Margaret Sugg et al., *Mapping Community-Level Determinants of COVID-19 Transmission in Nursing Homes: A Multi-Scale Approach*, NAT'L INST. OF HEALTH (Aug. 25, 2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7446707/.

[208] Elizabeth Cohen, *New CDC guidance says older adults should 'stay at home as much as possible' due to coronavirus*, CNN POLITICS (Mar. 6, 2020), https://www.cnn.com/2020/03/06/health/coronavirus-older-people-social-distancing/index.html.

[209] *COVID-19 Fatality Tracker*, N.Y. ST. DEP'T OF HEALTH, https://covid19tracker.health.ny.gov/views/NYS-COVID19-Tracker/NYSDOHCOVID-19Tracker-Fatalities?%3Aembed=yes&%3Atoolbar=no&%3Atabs=n (last visited Apr. 28, 2021).

[210] *Id.*

The virus had an immediate impact on nursing home staffing. Nursing homes, which were already leanly staffed, found themselves with missing staff. Staff became ill. Staff stayed away from work to care for their own families. And some staff simply became afraid. This is not a criticism. Health care workers, including nursing home staff, have performed heroically through the epidemic. Nevertheless, there were staffing shortages. Operators reacted with forced overtime, hazard pay and bonuses.[211]

Into this toxic mix came the March 25th Department of Health directive that required nursing homes to accept COVID-19-positive returning and prospective residents, and specifically barred testing of those individuals. As will be discussed further in this report, how many individuals were admitted into nursing homes as a result of this directive is not yet clear.

The Governor and the State Department of Health were focused on readying the State's hospitals. The same focus was not placed on preparing the State's nursing homes for the onslaught of the virus. It is also not clear to the Task Force that the State's nursing homes took sufficient meaningful steps to prepare for the arrival of the virus. The Task Force saw no evidence that the State's nursing homes prepared for the virus by increasing staffing, or providing staff training that had any meaningful impact, or stocking up on PPE. After the virus arrived, there were nursing homes that created COVID-19-only floors or wings. There was also hazard pay.

There is one other event to mention. In March of 2020, the Governor, via Executive Order, granted immunity against ordinary negligence to health care

[211] Noelle Denny-Brown, Denise Stone, Burke Hays, and Dayna Gallagher, *COVID-19 Intensifies Nursing Home Workforce Challenges*, U.S. DEP'T OF HEALTH & HUMAN SERVS., OFF. OF THE ASST. SEC. FOR PLANNING & EVAL. (Oct. 19, 2020), https://aspe.hhs.gov/basic-report/covid-19-intensifies-nursing-home-workforce-challenges.

professionals, and certain health care entities, including nursing homes.[212] That immunity was codified a short time later.[213]

The grant of immunity was controversial from the start. Immunity stripped the protections provisions under the New York State Public Health Law that protected nursing home residents from abuse and neglect. The argument for immunity was that it shielded health care workers from the uncertainty of an overwhelmed system facing an unknown disease with to-be-discovered treatments. In nursing homes, the principal beneficiaries of the grant of immunity were operators. The principal argument against immunity was that it would allow nursing home operators to inadequately staff, or otherwise fail to meet their obligations with impunity.

The immunity grant was partially repealed in August.[214] As modified, any health care facility or health care professional was shielded from any liability, civil or criminal, for any harm or damages, so long as the following conditions were met:

- The health care facility or health care professional is providing health care services in accordance with applicable law, or where appropriate pursuant to a COVID-19 emergency rule;

- The act or omission occurs in the course of providing health care services and the treatment of the individual is impacted by the health care facility's or health care professional's decisions or activities in response to or as a result of the COVID-19 outbreak and in support of the state's directives; and

- The health care facility or health care professional is providing health care services in good faith.

[212] Executive Order 202.10 (Mar. 23, 2020).
[213] 2020 N.Y. Laws ch..56, part GGG (April 3, 2020).
[214] 2020 N.Y. Laws ch. 134 (Aug. 3, 2020).

The immunities did not apply if the harm or damages were caused by an act or omission that was willful or arose out of intentional criminal misconduct, gross negligence, reckless misconduct, or intentional infliction of harm by the health care facility or health care professional providing health care services. However, decisions resulting from a resource or staffing shortage would not be considered to be willful or intentional and thus, could not fall within the exceptions (i.e., immunity applied to decisions resulting from resource or staffing shortages).

The immunity provision has now been repealed.[215]

There are those who argue that the grant of immunity caused nursing home operators to act recklessly. This is not a theory that the Task Force was able to examine. There is not yet any data or reports on whether nursing homes behaved differently because of the grant of immunity. With vaccines and the reopening of nursing homes to visitations, we may soon have a real sense of how nursing home residents fared regarding their other care needs. We do know that there were some nursing home operators who more readily accepted COVID-19 patients. A large part of the reason for the grant of immunity was to encourage just that, the acceptance of COVID-19 individuals. During the six-plus weeks that the March 25th directive was in place, no encouragement should have been needed as a mandate to accept those patients was in place. As the Task Force learned, though, there were nursing homes that refused to accept COVID-19 patients before and even while the directive was in place. As New York moved past the first surge, and nursing home occupancies dropped, immunity may have been a boon to operators anxious to fill empty beds. The

[215] 2021 N.Y. Laws ch. 96.

directive may also have encouraged operators to continue short staffing while it was in place. Immunity may also have provided a level of comfort to the professional staff, encouraging them to remain in place.

One would think that staffing shortages resulted in worse outcomes for nursing home residents. The Task Force would not dispute that insufficient numbers of staff does result in a diminution of care and jeopardizes residents. Insufficient numbers of staff can also make infection control more difficult. As staff move quickly, more quickly than they should, from one resident to another, corners can be cut, and those corners can include steps critical to infection control, such as hand-washing or changing of gloves.

Nevertheless, the research available to the Task Force at this time is inconclusive regarding whether better-staffed nursing homes had better outcomes regarding COVID-19 than poorly staffed nursing homes. There is a report that found that residents of unionized nursing homes suffered fewer deaths than nursing homes where unions were not present.[216] According to that report, unionized nursing homes had more staff, better trained staff, and more PPE. Other reports have not found a clear correlation between COVID-19 deaths and staffing levels.[217] As discussed above, the federal Center for Medicare and Medicaid Services utilizes a five-star system for rating nursing home quality. These reports have found no different COVID-19 outcomes between one and five star rated nursing homes.

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[216] Adam Dean et al., *Mortality Rates For COVID-19 Are Lower in Unionized Nursing Homes*, 39 HEALTH AFFAIRS 1993 (2020), https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2020.01011.

[217] Rebecca J. Gorges & R. Tamara Konetzka, *Staffing Levels and COVID-19 Cases and Outbreaks in U.S. Nursing Homes*, 68 JAGS 2462 (2020), https://agsjournals.onlinelibrary.wiley.com/doi/10.1111/jgs.16787.

The Task Force also looked at whether a nursing home's for-profit or not-for-profit status was a determinant of COVID-19 results. The published reports, thus far, have not shown that for- or not-for-profit status was a COVID-19 determinant.[218]

Once New York was past the first surge, and asymptomatic spread was understood, COVID-19 outbreaks continued to occur throughout the State.[219] As discussed above, beginning in May, nursing homes were required to routinely test their staffs. Nursing homes were also closed to visitors. The mandate to accept COVID-19 residents had also been rescinded. Adequate supplies of PPE became available. Nevertheless, virus outbreaks continued to occur in nursing homes throughout the State, and continued until the wide-spread vaccination of the State's nursing home residents. COVID-19 spreads through the air. An aerosol disease in a facility filled with individuals particularly vulnerable to the disease is simply a recipe for disaster.[220] Even with widespread testing, due to asymptomatic spread, an individual can be COVID-19 positive, and an unknown carrier for a period of time.

1. The Impact of the March 25th Directive

The March 25th directive to New York's nursing homes regarding the admission of COVID-19-positive residents has become so central to the public narrative of New York's first surge experience that it must be discussed separately. "No resident shall be

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[218] Attached as an Appendix to this Report is a Table identifying New York's nursing homes, their bed capacity, number of COVID-19 deaths among residents, not- or for-profit status and their CMS star staffing rating.

[219] M. Hill, *Some NY nursing homes proved helpless in face of virus surge*, ASSOC. PRESS (Mar. 20, 2021), https://apnews.com/article/us-news-new-york-coronavirus-pandemic-nursing-homes-08cd2ed9c308d30f7de28b9f5ae7a83b; L Brody, T. McGinty, *N.Y. Nursing Homes See Surge in COVID-19 Deaths as Officials Hope Vaccinations Will Curb Spread*, WALL STREET JOURNAL (Jan. 13, 2021), https://www.wsj.com/articles/new-york-nursing-homes-see-surge-in-covid-19-deaths-as-officials-hope-vaccinations-will-curb-spread-11610573476.

[220] To a certain extent, nursing home representatives have argued that containing COVID-19 in nursing homes was simply beyond their abilities. *See* NYS Health Facilities Association: 'Outbreaks of COVID-19 are not the result of inattentiveness or shortcomings in our facilities' (wnypapers.com).

denied re-admission or admission to the NH solely based on a confirmed or suspected diagnosis of COVID-19. NHs are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or readmission." (underlining in original). The Advisory drew almost immediate criticism,[221] caused the Governor to lash out at nursing homes, spurred a congressional inquiry, and, ultimately, an investigation of the Governor himself. What the directive did not do, as is often claimed, is cause 15,000 deaths. The 15,000 number that has been bandied about is the approximate total number of New York long-term care facility residents who have succumbed to the virus. This figure includes nursing home residents who passed away long after the directive had been rescinded. It includes residents who were unaffected by the order.

This is not to say that the directive did not result in any additional deaths. Although a determination of the number of additional nursing home deaths is beyond the capacity of the Task Force, there are credible reviews that suggest that the directive, for the approximately six weeks that it was in effect, did lead to some number of additional deaths. The Department of Health issued a report in 2020 in which it argued unconvincingly that the admission of 6,326 COVID-positive residents during the period the Health directive was in effect had no impact. That cannot be the case, and has now been shown not to be the case.[222] As we have seen, once the virus came into

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[221] *See* Associated Press, *More Than 1,700 New, Unreported Deaths at Nursing Homes in NY*, FOX5 N.Y. (May 5, 2020), https://www.fox5ny.com/news/more-than-1700-new-unreported-deaths-at-nursing-homes-in-ny; *see also* Luis Ferré-Sadurní & Amy Julia Harris, *Does Cuomo Share Blame for 6,200 Virus Deaths in N.Y. Nursing Homes?*, N.Y. TIMES (July 8, 2020), https://www.nytimes.com/2020/07/08/nyregion/nursing-homes-deaths-coronavirus.html.

[222] The Empire Center, in its report dated February 18, 2021, specifically disputes the Department's contention, but agrees that the Department's advisory was not the sole or primary cause of most nursing home deaths. Bill Hammond & Ian Kingsbury, *COVID-positive Admissions Were Correlated with Higher*

a nursing home, it was hard to control. The Department of Health's report, however, does correctly state that on March 25th the virus was already in many of metropolitan New York's nursing homes, and that the COVID-19 fuse had been lit.

That there were additional deaths does not mean the Department of Health directive was issued in error. The emergency circumstances of March 25th must be remembered. On March 25th, the State believed that it was in need of thousands more hospital beds. ICUs were filling up. The hospital system appeared to be fully overwhelmed and in danger of collapse. Difficult decisions were being made.

The State was also burdened with the insufficiencies of the federal response. The federal response was hopelessly politicized. What can kindly be called mixed messages and stops and starts were coming from the federal government. Then-President Donald Trump repeatedly down-played the scope of the problem.[223] President Trump ordered, but ultimately retreated from firing a CDC official who, in late February, had stated that a COVID-19 epidemic in the United States was inevitable.[224]

There were federal policy failures. The federal government had been unsuccessful in getting complete information from China about the virus. The federal government failed to marshal sufficient supplies of PPE. PPE shortages caused the

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Death Rates in New York Nursing Homes, EMPIRE CTR. FOR PUB. POL. (Feb. 18, 2021), https://www.empirecenter.org/publications/covid-positive-admissions-higher-death-rates/.

[223] D. Wolfe, D. Dale, *"It's Going to Disappear:" A Timeline of Trump's Claims That COVID-19 Will Vanish*, CNN, Oct. 31, 2020, https://www.cnn.com/interactive/2020/10/politics/covid-disappearing-trump-comment-tracker/.

[224] Grace Panetta, *Trump reportedly threatened to fire a top doctor at the CDC for sounding the alarm about the coronavirus in February*, BUSINESS INSIDER (Apr. 22, 2020), https://www.businessinsider.com/trump-wanted-to-fire-cdc-doctor-for-raising-alarm-on-coronavirus-wsj-2020-4.

discouragement of mask-wearing. Finally, testing was almost completely unavailable. By the end of March, testing was still limited to symptomatic individuals.[225]

At least facially, nursing homes should have been able to meet the needs of stable COVID-19 residents just as they are expected to be able to meet the needs of other residents with communicable diseases. Nursing homes are required to 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.[226] Nursing homes also must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.[227] Given the overwhelming dimensions of the epidemic – that the virus is spread through the air, asymptomatic spread, and the vulnerability of the elderly – expecting nursing homes to have been able to shield all their residents from the virus was probably too much to ask. But at the time, seeing nursing home beds as hospital extender beds when hospital beds were not expected to be available was not an unreasonable decision.

What was unreasonable was the failure to recognize that nursing homes were just as much in need of substantial help as general hospitals. Nursing homes were given little help with securing PPE. In fact, in at least one press conference, Governor

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[225] C. Johnson, L.Sun, L. McGinley, *In Hard-Hit Areas, Testing Restricted to Health Care Workers, Hospital Patients*, WASH. POST (Mar. 21, 2020), https://www.washingtonpost.com/health/2020/03/21/coronavirus-testing-strategyshift/; *see also* R. Patel, *et al., Report from the American Society of Microbiology COVID-19 International Summit* (Mar 23, 2020), https://mbio.asm.org/content/11/2/e00722-20.

[226] 42 C.F.R. § 483.80; 10 N.Y.C.R.R. § 415.19.

[227] 42 C.F.R. § 483.90; 10 N.Y.C.R.R. § 415.29.

Cuomo roundly criticized suggestions that nursing homes should have been aided.[228] Nursing homes also could have used assistance in putting together infection control sufficient to meet the virus, if that were even possible in late March 2020.

Also unreasonable was the absoluteness of the directive. Under the applicable regulations, a nursing home is to accept only individuals the nursing home is able to care for properly.[229] That, in essence, is the promise every nursing home makes to residents and their families – we admit you because we can properly care for you. The directive did not explicitly override the regulation, but it was commonly read as though it did. The directive came at a time when regulations were routinely being overridden. Providers were told to follow the Department of Health's instructions. The language of the directive was absolute: "No resident shall be denied admission . . . ." The language should be compared with a similar directive that was issued to adult care facilities two weeks later. That directive told adult care facilities that they could not deny admission to COVID-positive individuals, but expressly restated the exception for those individuals for whom the facility could not provide appropriate care.[230] The March 25th directive placed nursing homes on the wrong footing.

Finally, it was unreasonable to leave the directive in place for so long after it was necessary. Hospitalizations peaked on April 14th.[231]. The hospital beds at the Javits Center were barely used, and the USNS Comfort sat empty in the Hudson River. The

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[228] Bernadette Hogan and Bruce Golding, *Nursing homes have 'no right' to reject coronavirus patients, Cuomo says*, N.Y. POST (Apr. 23, 2020), https://nypost.com/2020/04/23/nursing-homes-cant-reject-coronavirus-patients-cuomo-says/.
[229] 10 N.Y.C.R.R. § 415.1.
[230] *See* 18 N.Y.C.R.R. § 487.5(a)(3)(xii).
[231] *Tracking Coronavirus in New York: Latest Map and Case Count*, N.Y. TIMES, https://www.nytimes.com/interactive/2021/us/new-york-covid-cases.html (accessed Apr. 28, 2020).

Comfort set sail from New York City on April 23rd. The March 25th directive could have been rescinded on or about the date the Comfort set sail, if not sooner.

VI. Impact of COVID-19 in Other Long-Term Care Settings

A. Adult Care Facilities

1. Regulatory Structure

Adult homes and enriched housing programs are residential facilities designed to meet the needs of persons with physical or mental impairments who do not require the higher level of care associated with nursing homes.[232] Adult homes and enriched housing programs are sometimes referred to collectively as adult care facilities, or ACFs. An assisted living program (ALP) is an adult home or enriched housing program with an associated licensed home care services agency (LHCSA) that can provide nursing and other ancillary health care services.[233] Adult homes or enriched housing programs may be licensed as assisted living residences (ALRs), with or without enhanced or special needs certification.

The Department of Health licenses and governs adult care facilities under a detailed regulatory scheme that covers all aspects of their operations, from food service[234] and medication distribution[235] to resident recreational activities.[236] The standards for adult homes and enriched housing programs are found in 18 N.Y.C.R.R.

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[232] N.Y. Soc. Servs. Law § 2(21)–2(28).
[233] *See* 18 N.Y.C.R.R. § 494.5.
[234] *See* 18 N.Y.C.R.R. §§ 487.8, 488.8.
[235] *See* 18 N.Y.C.R.R. §§ 487.7(f), 488.7(d).
[236] *See* 18 N.Y.C.R.R. § 487.7(h) (requiring a diversified program of at least 10 hours per week of cultural, spiritual, diversional, physical, political, social and intellectual activities, including all of the following: (i) individual, small group and large group activities; (ii) facility-based and community activities; (iii) physical exercise or other physical activities; (iv) intellectual activities; (v) social interaction; and (vi) opportunities for both active and passive resident involvement, offered during evenings and weekends as well as during the weekday); *see also* 18 N.Y.C.R.R. § 488.7(f).

Parts 487 and 488. These standards, among other things, include detailed admission standards, including that ACFs may not admit anyone with a medical condition which requires continual skilled observation[237] or who suffers from a communicable disease.[238]

The Department's regulations also protect the rights of residents, including, among others, their absolute right to leave and return to the facility at any reasonable time,[239] and their right to invite guests into the facility without restriction,[240] and the right not to be restrained or locked in a room at any time.[241] Residents also must be encouraged to collectively organize.[242]

Admission standards for assisted living programs allow for the admission of persons who need more care and services than in an adult home, but still prohibit the admission of anyone who requires continual nursing or medical care, or whose medical impairment endangers the safety of other residents.[243]

The Department enforces these regulations through on-site inspections.[244] Any regulatory violations can result in fines and the potential of license revocation.[245] The Department's inspectors protect resident rights.

Significantly, adult homes and enriched housing programs are residential, not medical or nursing facilities. They do not provide medical or nursing care directly. Rather, all medical and nursing care, including both routine appointments and treatment

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[237] 18 N.Y.C.R.R. §§ 487.4(c)(6), 488.4(c)(6).
[238] 18 N.Y.C.R.R. §§ 487.4(c)(12), 488.4(c)(12).
[239] 18 N.Y.CR.R. § 487.5(a)(3)(xii)
[240] 18 N.Y.C.R.R. § 485.14(b)(1).
[241] 18 N.Y.C.R.R. § 487.5(a)(3)(x).
[242] 18 N.Y.C.R.R. § 487.5(b).
[243] *See* 18 N.Y.C.R.R. Part 494.
[244] *See* 18 N.Y.C.R.R § 486.2.
[245] *See* 18 N.Y.C.R.R. § 486.4.

for acute conditions, is performed by outside providers, either through on-site appointments or at a hospital or other outside medical facility. As this regulatory structure implies, the residents are typically healthier and more independent than nursing home residents.

Prior to the coronavirus pandemic, ACFs had no history of dealing with infection control and were in fact prohibited from admitting or retaining residents with communicable diseases. 18 N.Y.C.R.R. §§ 487.4(c)(12), 488.4(c)(12). The only PPE requirement applied during flu season; licensed home care personnel without a current flu shot were required to wear masks when treating residents.[246] ACFs were not required to maintain any inventory of PPE, and at the start of the pandemic, most had only a very small number of masks on hand.

2. The Coronavirus Pandemic and the Experience of Adult Care Facilities[247]

Because adult care facilities are confined spaces with numerous persons living and working in close proximity, including many who are particularly vulnerable due to age or medical condition, when the coronavirus pandemic emerged as a significant threat, preventing the introduction of the virus into adult care facilities should have been a top priority. The existing regulatory structure governing ACFs created obstacles to limiting two potential routes by which the coronavirus might enter the facilities: visitors and staff carrying the virus into the facilities and residents themselves bringing the virus into the facilities after becoming infected outside.

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[246] *See* 10 N.Y.C.R.R. § 2.59.

[247] The narrative is based on the Executive Orders, Dear Administrator Letters, and other written communications with adult care facilities, as well as interviews with the operators of adult care facilities about their experience, particularly during the early months of the pandemic.

When adult care facilities, in response to the virus' threat, sought to restrict or temporarily bar visitors from their facilities, the State's initial response was to leave existing regulations in place, including the residents' right to entertain visitors. 18 N.Y.C.R.R. § 485.14(b)(1). In a March 11, 2020 Dear Administrator Letter, the Department of Health instructed adult care facilities to screen all visitors for symptoms of COVID-19. Although the memorandum suggested that adult care facilities should consider modifying visiting hours, it implicitly discouraged such modifications by advising that any limitations on visiting hours would need to be immediately reported to the Department.[248] Two days later, in a Health Advisory issued on March 13, 2020,[249] the Department abruptly reversed course, effectively barring all visitors from the facilities. This was one day after visitors were barred from nursing homes.

Although visitors were barred and then heavily restricted,[250] throughout the entirety of the pandemic, residents have remained free to leave the facilities at will. Once residents leave the building, the facility has no ability to control where they go or with whom they come into contact. Although the Department advised adult care facilities to discourage residents from going outside,[251] facilities remained legally obligated to

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[248] N.Y. ST. DEP'T OF HEALTH, DEAR ADMINISTRATOR LETTER 20-10 (Mar 11, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/03/adult_care_guidance.pdf [hereinafter DAL 20-10].

[249] N.Y. ST. DEP'T OF HEALTH BUREAU OF HEALTHCARE ASSOCIATED INFECTIONS ("BHAI"), HEALTH ADVISORY TO NURSING HOMES AND ADULT CARE FACILITIES (Mar. 13, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/07/revised-march-13-guidance-07.10.2020-final.pdf.

[250] *See* N.Y. ST. DEP'T OF HEALTH, *Health Advisory: Visitation in Adult Care Facilities* (Sept. 9, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/09/health-advisory_adult-care-facilities-visitation-9-9-2020.pdf; *see also* N.Y. ST. DEP'T OF HEALTH, *Health Advisory: Revised Adult Care Facilities Visitation* (Mar. 25, 2021), https://coronavirus.health.ny.gov/system/files/documents/2021/03/updated_adult_care_facility_visitation.pdf.

[251] *See* DAL 20-10, *supra* note 248.

allow residents to come and go as they please.[252] Even during the height of the lockdown in New York City, adult homes had no ability to limit residents' right to leave the facilities at will. This is in contrast to nursing home residents, who have been prohibited from leaving their facilities.

By late March 2020, adult care facility operators had become concerned that they were being asked to readmit residents who had been hospitalized for COVID despite the fact that these individuals may still have been COVID positive and presumably highly contagious. Adult care facilities informed the Department of these concerns and noted that they had no practical ability to quarantine residents effectively. This occurred during a time when adult care facilities were still suffering from serious PPE shortages and were being advised to conserve and reuse PPE.[253] As it had done with nursing homes, the Department informed the adult homes that they were prohibited from refusing readmission on the basis of a COVID infection. This was confirmed in an Advisory to adult care facilities on April 7, 2020, which not only stated that adult homes could not refuse readmission on the basis of COVID, but also expressly prohibited adult homes from requiring a COVID test of any returning resident.[254] Unlike the nursing home advisory, the advisory to adult care facilities did advise adult care facilities that they were not to accept residents for whom they could not provide appropriate care.

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[252] 18 N.Y.C.R.R. § 487.5(a)(3)(xii).
[253] N.Y. ST. DEP'T OF HEALTH BHAI, *Health Advisory: Options when Personal Protective Equipment (PPE) is in Short Supply or Not Available* (Apr. 2, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19-_ppeshortages_040220.pdf [hereinafter PPE SHORT SUPPLY]..
[254] N.Y. ST. DEP'T OF HEALTH, *Advisory: Hospital Discharges and Admissions to ACFs* (Apr. 7, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh_covid19_acfreturnofpositiveresidents_040720.pdf.

Even with that proviso, the advisory stymied efforts adult care facilities were making through screening and entry restrictions to keep the coronavirus out of their facilities.

As noted above, ACFs had no experience with infection control and lacked the appropriate equipment and personnel to contain contagious disease. Until the April 7th advisory, ACFs had been prohibited by regulation from admitting or retaining any person who "suffers from a communicable disease or health condition which constitutes a danger to other residents and staff."[255] Although this regulation exists for the express purpose of protecting adult home residents from communicable disease, the Department chose to interpret the regulation to apply only to symptomatic individuals,[256] contrary to CDC guidance about the transmission of the novel coronavirus.[257]

This mandate to readmit COVID-positive residents and prohibition on testing remained in place until the Governor issued Executive Order 202.30 on May 10, 2020. This order prohibited hospitals from discharging a patient to a nursing home unless that patient first tested negative for COVID and the nursing home certified that it was capable of properly caring for that individual. Although the Executive Order applied only to nursing homes, the Department applied an identical standard to adult care facilities.[258]

In a sharp change of course from the earlier directive to admit COVID-19 positive residents, in response to concerns that residents of adult care facilities might carry the

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[255] 18 N.Y.C.R.R. §§ 487.4(c)(12), 488.4(c)(12).
[256] *See* Appendix E; *see also, supra* note 254, April 7, 2020 Advisory.
[257] *Discontinuation of Transmission-Based Precautions and Disposition of Patients with SARS-CoV-2 Infection in Healthcare Settings*, CDC (Feb. 16, 2021), https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html.
[258] *See* N.Y. ST. DEP'T OF HEALTH, DEAR ADMINISTRATOR LETTER 20-14 (May 11, 2020), https://www.health.ny.gov/professionals/hospital_administrator/letters/2020/docs/dal_20-14_covid_required_testing.pdf [hereinafter DAL 20-14].

coronavirus into the facilities after spending holidays with family members outside, the Governor imposed a requirement by Executive Order in early May 2020 that any resident who leaves his/her facility must be quarantined for 14 days.[259] Although many nursing homes responded to this requirement by restricting or eliminating passes for residents to leave the premises, adult care facilities, which have no legal authority to prevent residents from leaving at will, were left with a mandate instructing them to quarantine every resident who set foot outside the facility, but without legal means to effectuate quarantine, other than to report violators.[260]

Early in the pandemic, the Department did not answer requests from adult care facilities for assistance in procuring PPE. Adult care facilities were first instructed to obtain PPE through their normal sourcing process. This presented two problems. First, non-ALP facilities, which do not provide on-site nursing services, did not have any established sourcing for medical products. Second, there were nationwide PPE shortages.

The Department instructed adult care facilities that, should they be unable to obtain PPE on their own, they should inform the local Office of Emergency Management of their PPE needs.[261] This instruction, however, did little or nothing to alleviate the problem. The New York City Office of Emergency Management, for example, expressly informed adult homes that they were not considered high priority facilities, and therefore

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[259] *See* N.Y. Exec. Order 202.77 (Nov. 23, 2020); N.Y. ST. DEP'T OF HEALTH, *Health Advisory: Universal Use of Eye Protection* (Nov. 24, 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/11/hcp_eye_protection_guidance_112520.pdf.

[260] *See* 18 N.Y.C.R.R. § 487.5(a)(3)(x) ("A resident shall not be restrained nor locked in a room at any time.").

[261] N.Y. ST. DEP'T OF HEALTH, *Guidance Regarding ACF Operations during COVID-19 Outbreak* (Mar. 22, 2020) [hereinafter ACF OPERATIONS].

would not be provided with any PPE. In early April 2020, the Department provided facilities with guidance on calculating future PPE needs.[262] At the time the calculation was an academic exercise due to the severe, ongoing nationwide PPE shortages.

It was not until mid-April 2020 that the Department began to provide PPE to adult care facilities. Only in May 2020, when PPE began to be provided to adult care facilities along with regular COVID tests, did the severe shortages begin to be alleviated.

The Department also displayed inflexibility with respect to other preexisting regulatory requirements. For example, the Department required facilities to maintain a full resident activity calendar,[263] even as the Department was instructing adult care facilities to advise their residents to stay in their rooms. This did not change throughout the course of the pandemic.[264]

Adult care facilities were required to report to the Department of Health on the COVID status of all of their residents. Executive Order 202.18, issued on April 16, 2020, also required adult care facilities to "notify family members or next of kin if any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such positive test result or death." Executive Order 202.19, issued the following day, imposed a $2,000 per day fine for noncompliance with this reporting requirement. These Orders were of limited effectiveness due to delays in the reporting of results.[265]

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[262] PPE SHORT SUPPLY, *supra* note 253.
[263] *See* 18 N.Y.C.R.R. § 487.7(h).
[264] *See* ACF OPERATIONS, *supra* note 261.
[265] *See* N.Y. ST. DEP'T OF HEALTH, DEAR ADMINISTRATOR LETTER C20-01 (Apr. 19 2020), https://coronavirus.health.ny.gov/system/files/documents/2020/04/doh-_covid_acf-nh_communicationpractices_041920.pdf.

Just as it had with nursing homes, as the order regarding the admission of COVID-positive individuals drew public scrutiny, the Governor issued orders that seemed to be intended to shift attention from the admission orders to the performance of long-term care facilities. Executive Order 202.23, issued on April 24, 2020, authorized the Commissioner of Health to suspend or revoke the operating certificate of any nursing home or adult care facility on 24 hours' notice "if it is determined that such facility has not adhered to any regulations or directives issued by the Commissioner of Health." This was followed by a May 11, 2020 Dear Administrator Letter requiring the operator or administrator of each facility to certify, subject to criminal penalties, that the facility was in compliance with all applicable Executive Orders and directives of the Commissioner of Health.[266]

The new mandates on adult care facilities, including the regular testing of employees and residents, increased staffing needs due to in-room meal and medication delivery, and PPE requirements, but were not accompanied by increased financial support. Executive Order 202.30, issued on May 10, 2020, required adult care facilities to arrange for all personnel to be tested for COVID-19 twice per week.[267] These tests alone imposed thousands of dollars per week in unreimbursed costs on adult homes.

Many states publicly report COVID-19 surveillance data across various types of facilities. An article available on the CMS website relied on data systematically retrieved from health department websites to characterize COVID-19 cases and deaths

[266] *See* DAL 20-14, *supra* note 258.
[267] *See id.*; *see also* N.Y. Exec. Order 202.40 (June 10, 2020) (reducing testing to once weekly).

in and among assisted living residents and residents and staff members.[268] Limited data was available for 39 states. By October 15, 2020, among 28,623 assisted living facilities in those 39 states, 6,440 (22%) had at least one COVID-19 case among residents or staff members. Among the states with available data, the proportion of COVID-19 cases that were fatal was 21.2% for residents, 0.3% for staff members, and 2.5% overall for the general population of these states.[269] As of October 15, 2020, an average of one death occurred among every five assisted living residents with COVID-19, compared with one death among every 40 persons in the general population with COVID-19 in states with available data. The disproportionate share of deaths among assisted living facility residents underscores the need for ongoing surveillance of nationwide COVID-19 data and more robust infection prevention and control activities to protect this population, according to the authors of the study.

The Department of Health, reports that, as of May 3, 2021, 989 residents of adult care facilities had died from COVID-19.[270] Those numbers reflect the typically lower age and better health of adult care facility residents vis-à-vis nursing home residents.

The authors of the recent study mentioned above concluded that to prevent the introduction and spread of virus that causes COVID-19, assisted living facilities should: (1) identify a point of contact at the local health department; (2) educate residents, families, and staff members about COVID-19; (3) have a plan for visitor and staff member restrictions; (4) encourage social (physical) distancing and the use of masks,

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[268] *See* Sarah Yi et al., *Characterization of COVID-19 in Assisted Living Facilities — 39 States, October 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1730 (2020), https://www.cdc.gov/mmwr/volumes/69/wr/pdfs/mm6946a3-H.pdf.

[269] *Id.*

[270] *Other Adult Care Facility COVID Related Deaths Statewide*, N.Y. ST. DEP'T OF HEALTH, https://www.health.ny.gov/statistics/diseases/covid-19/fatalities_other_acf.pdf (last visited May 4, 2021).

as appropriate; (5) implement recommended infection prevention; (6) rapidly identify and properly respond to residents and staff members with suspected or confirmed COVID-19; and (7) conduct surveillance of COVID-19 cases and deaths, facility staffing, and supply information.

B. Home Care

1. Regulatory Structure

Home care has enabled many individuals who are otherwise eligible for nursing home services to remain in their homes.[271] More New Yorkers receive home care than reside in nursing homes. According to a report published by the Home Care Association of New York State, approximately 500,000 New Yorkers were receiving home care in 2019.[272] The greatest limiting factor to receive home care is not eligibility, but workforce availability. Personal care aides are in such short supply that home care agencies frequently turn away prospective patients because they lack the aides to serve them.[273] These workforce challenges preceded the pandemic.

Home care takes many forms. It is delivered through Certified Home Health Agencies and Licensed Home Care Services Agencies, both licensed under Article 36 of the Public Health Law,[274] and under the Consumer Directed Personal Assistance Program organized under the Social Services Law.[275] The Office for People with

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[271] *See* Joanne Lynn, *The Challenges of Caring for the Growing Elderly Population*, 41 BIFOCAL 225, 228, (2020).
[272] *State of the Industry 2019*, HOME CARE ASS'N OF N.Y. ST. (Feb. 2019), https://hca-nys.org/wp-content/uploads/2019/02/HCA-Financial-Condition-Report-2019.pdf [hereinafter *Home Care Report*].
[273] *Id.*
[274] *See* Pub. Health Law §§ 3605, 3606.
[275] The Consumer Directed Personal Assistance Program ("CDPAP") has been less affected by staffing issues than other types of home care. Unlike other forms of home care, individuals receiving CDPAP services may hire most family members as personal assistants. *See* Social Services Law § 365-f(3).

Developmental Disabilities also has a small but growing program of home care called Consumer Self-Direction.[276] Home care is authorized under federal Medicaid rules under the Medicaid home and community-based ("HCBS") waiver.

Home care may be paid for by individuals out-of-pocket, through health insurance, and under Medicare and Medicaid.[277] Medicare, as in a nursing home, pays for a limited amount of home care.[278] Medicaid, as in a nursing home, will pay for a temporally extended period of home care, which is commonly regarded as custodial care.[279]

Home care is popular. As the name implies, individuals receiving home care receive care in their homes.[280] Although some recipients of home care eventually are admitted to nursing homes, many are not. Conversely, some nursing home residents, usually rehabilitation patients, receive home care after their nursing home stay.

The COVID-19 pandemic affected home care in ways similar to nursing homes, and differently. Especially in the devastating first months of the pandemic in New York City, home care was disrupted. Many individuals receiving home care declined services, at least for a time, in order to minimize their risk of infection. Others were unable to receive services because home care workers, either due to their own illness or the illness of a family member, kept them away from work. And others, just as in

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[276] *Self-Direction Guidance for Providers*, N.Y. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES ("OPWDD") (Apr. 6, 2020), https://opwdd.ny.gov/system/files/documents/2020/04/sd_guidance_040620.pdf.

[277] According to the Home Care Association report, 87% of home care in New York is paid for under the State Medicaid program. *Home Care Report*, *supra* note 272.

[278] *Home Health Services Coverage*, Medicare.gov, https://www.medicare.gov/coverage/home-health-services.

[279] *See, e.g.*, 18 N.Y.C.R.R. §§ 505.14, 505.28,

[280] Individuals in adult care facilities may receive home care. Individuals in nursing homes may not, nor may individuals residing in OPWDD-operated or certified residences.

nursing homes, stopped working out of fear that they would become ill themselves or bring the illness to their families.

In terms of State assistance, home health care was treated as a lower priority than hospitals or nursing homes for the receipt of PPE. Within home care, the Consumer Directed Personal Assistance Program came behind Certified Home Health Agencies and Licensed Home Care Services Agencies. All were left to fend for themselves in finding gloves, masks, shields and gowns in the opening months of the pandemic.[281]

COVID-19 deaths and illnesses among home care patients have not been separately reported. What we do know, though, is that without the concentration of individuals, home care was not the vector for contagion that institutionalized care was. A positive home care worker or home care patient simply was not exposed to or could expose the number of individuals who would be present in institutionalized care.[282]

According to a recent study completed in Connecticut, people receiving community-based long-term care had better COVID-19 outcomes than residents of skilled nursing facilities.[283] As noted by the authors of the study (which compared data acquired from March to July in 2020), home care recipients have comparable medical

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[281] The pandemic exacerbated fears among CDPAP participants that they were at risk of being institutionalized, they faced challenges obtaining PPE, and there was a dramatic impact on the ability of recipients to staff their services. *See The Impact of COVID-19 on Consumer Direction in New York State*, CONSUMER DIRECTED PERSONAL ASSISTANCE ASS'N OF N.Y. ST., http://cdpaanys.org/wp-content/uploads/2020/06/CDPAANYS-COVID-19-Impact-Survey.pdf (last visited Apr. 28, 2021).

[282] Although not much has yet been published about the impact of COVID-19 on those receiving home care, there is at least one peer reviewed study published on the impact of COVID-19 on the home care work force. *See* Madeline Sterling *et al*., *Experiences of Home Health Care Workers in New York City during the Coronavirus Disease 2019 Pandemic*, 180 JAMA INTERNAL MEDICINE 1453 (2020), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2769096.

[283] Julie Robinson et al., *Community-Based Long-Term Care has Lower COVID-19 Rates and Improved Outcomes Compared to Residential Settings*, 22 JAMDA 256 (2020), https://www.jamda.com/action/showPdf?pii=S1525-8610%2820%2931050-1.

vulnerability to nursing home residents and perhaps more than some assisted living residents. Nevertheless, their COVID-19 positivity rate during the first five months of the pandemic in Connecticut was considerably lower than residents of either congregate setting.[284]

From the other side, according to a report by the Visiting Nurse Society of New York, only 11% of hospitalized COVID-19 patients were discharged to home care.[285] That may have been a lost opportunity as the outcomes for those discharged patients were generally positive.[286]

COVID-19 has also significantly impacted those people with developmental disabilities living independently or with family care givers. Although no studies are available, factors that have been cited anecdotally by advocates include illness and death from exposure to the virus; difficult or nonexistent access to services; closed day programs and job sites; ill-equipped families responsible for more daily care and supervision; and the withholding of funds in anticipation of budget cuts.

The CDC has a webpage devoted to COVID as it relates to disability. The agency identifies the following three groups at greatest risk of infection: people who have limited mobility or who cannot avoid coming into close contact with others who may be infected, such as direct support providers and family members; people who have trouble understanding information or practicing preventive measures, such as

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[284] *Id.*

[285] *See* Robert Holly, *COVID-19 Patients Discharged from Home Health Care Often Have 'Excellent' Symptom Improvement, Functional Outcomes*, HOME HEALTH CARE NEWS (Nov. 23, 2020), https://homehealthcarenews.com/2020/11/covid-19-patients-discharged-from-home-health-care-often-have-excellent-symptom-improvement-functional-outcomes/; *see also* Kahryn Bowles *et al.*, Surviving COVID-19 After Hospital Discharge: Symptom, Functional, and Adverse Outcomes of Home Health Recipients, 174 ANNALS OF INTERNAL MEDICINE 316 (2021), https://www.acpjournals.org/doi/10.7326/M20-5206.

[286] *Id.*

hand washing and social distancing; and people who may not be able to communicate symptoms of illness.[287]

a. Special Considerations for Palliative Care

Hospice and palliative care have much in common. Both are for people with serious illnesses. Both follow treatment goals that aim to relieve pain, increase comfort, and improve quality of life for patients and their families. Both are sensitive to a patient's personal, cultural and religious values, beliefs, practices, and preferences. Palliative care and hospice, however, are offered to different types of patients. Palliative care relieves pain from serious illness and alleviates the side effects of treatments. Palliative care physicians and nurses work with patients to identify their goals, including symptom relief, counseling, spiritual comfort, or whatever a patient believes will enhance their quality of life. Compared to palliative care, the primary difference in hospice care is that hospice is for patients with a limited lifespan. Hospice care is a ***type*** of palliative care – given to address the unique needs of people with a terminal illness and their families.

Surges in demand for healthcare, including end-of-life care, during the pandemic have exposed and exacerbated underlying gaps in access to specialty-trained physicians and teams, palliative care medications, and bereavement support for patients and families. These gaps jeopardize the quality of care for seriously ill and at-risk patients, including those whose prognosis is uncertain and those with diseases other than COVID-19.[288] The pandemic reduced patients' contact with their families,

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[287] *People with Disabilities*, CDC (Mar. 16, 2021), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-disabilities.html (last visited Apr. 28, 2021).
[288] Moira McCarthy, *No Hugs: How the COVID-19 Pandemic Has Impacted Palliative, Hospice Care*, HEALTHLINE (Oct. 1, 2020), https://www.healthline.com/health-news/no-hugs-how-the-covid-19-pandemic-has-impacted-palliative-hospice-care.

directly or by phone, increasing the need for care that goes beyond symptom relief. Family is also important to setting care goals, encouraging their loved ones, and providing support to care staff. Also, studies show that Medicaid enrollees, an important patient population, underutilize hospice leading to unnecessary suffering at the end of life. Patients who die in inpatient settings have greater distress and poorer quality of life than those who die at home, and their bereaved caregivers have worse mental health throughout their loved ones' dying process. Hospice use, particularly in-home, is associated with better symptom control and quality of life near death.[289]

C. Office for Mental Health–Operated and Licensed Facilities

The Office for Mental Health (OMH) provides individuals with mental illness supports and services in a wide range of contexts, both in facilities and the community. The public mental health system in New York State is vast and estimated to reach over 775,000 people.[290] Males and females are served at approximately the same rate (39.0–39.1 per 1,000 males/females in the population). The highest annualized service utilization by age falls within the 25-4 age group (42.3 per 1,000). For people over the age of 65, service utilization is 19.6 per 1,000.[291] Service utilization rates by race and

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[289] *See* Jean Abbott, et al., *Ensuring Adequate Palliative and Hospice Care During COVID-19 Surges*, 324 JAMA 1393 (2020), https://jamanetwork.com/journals/jama/fullarticle/2771025?guestAccessKey=dca5fc8d-1f4e-49d3-8e36-92e7413c1857; *see also* Jennifer W. Mack, et al., *Underuse of Hospice Care by Medicaid-Insured Patients With Stage IV Lung Cancer in New York and California*, 31 J. OF CLINICAL ONCOLOGY 2569 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3699723/; Gail Gazelle, *Understanding Hospice-An Underutilized Option for Life's Final Chapter*, 357 NEW ENGLAND J. OF MEDICINE 321 (2007), https://www.nejm.org/doi/full/10.1056/NEJMp078067.

[290] The demographic characteristics of people served in the public mental health system is from data derived from the OMH Patient Characteristics Survey (PCS). The survey encompasses people who receive services from programs the agency operates, funds or licenses. Data is captured during a one-week period on a biennial basis. To annualize the data, OMH employs an algorithm developed at the Nathan Kline Institute.

[291] *Id*. By race and ethnicity, African Americans have the highest annualized service utilization (52.8 per 1,000) as compared to other racial and ethnic groups.

ethnicity show the highest annual service utilization rates among Black/African Americans (52.8 per 1,000), Pacific Islanders (51.6), Hispanic/Latino (47.8), and Multi-Racial (36.0), as compared to lower utilization rates for Whites (29.5), Native American/Alaskan (22.2), and Asians (9.1).[292]

As a provider of service, OMH operates 24 inpatient facilities for civil, forensic and research purposes.[293] There are approximately 3,000 adult and children's beds in the OMH system and 700 forensic beds for people referred for admission from the criminal justice system.[294] In addition, OMH licenses over 100 acute care psychiatric units in general hospitals that have an aggregate capacity of 5,000 beds.[295] In 2019, there were 120,830 admissions to hospitals licensed or operated by OMH.[296] Under the model of care developed by OMH, acute inpatient admissions are directed to the article 28 hospitals with psychiatric units. Longer term care is delivered by OMH state hospitals. Lengths of stay in OMH hospitals can be years in duration, particularly when a patient is referred from the criminal justice system.[297] Overall, OMH reports that nearly

[292] OMH states that its rate of service utilization data by race and ethnicity should be read with caution because of the small size of some racial groups in the general population and fluctuation in the analyses of past PCS data.
[293] N.Y. Mental Hyg. Law § 7.15; Statewide Comprehensive Plan, at 10, https://omh.ny.gov/omhweb/planning/docs/507-plan.pdf.
[294] Statewide Comprehensive Planat 10.
[295] *Id*. at 12.
[296] As reported to the Mental Hygiene Legal Service ("MHLS"). MHLS is an auxiliary agency of the Appellate Divisions of State Supreme Court that provides legal services and assistance to patients and residents of mental hygiene facilities pursuant to article 47 of the Mental Hygiene Law. *See* N.Y. Mental Hyg. Law § 9.11.
[297] *See* N.Y. Crim. Pro. Law ("CPL") art. 730; N.Y. CPL § 330.20. An article that analyzes length of stay for individuals found not responsible by reason of mental disease or defect is found at: Richard Mirgalia & Donna Hall, *The Effect of Length of Hospitalization on Re-arrest among Insanity Plea Acquittees,* 39 J. AM. ACAD. PSYCHIATRY & LAW 524 (2011).

half of the patients on its inpatient census have been hospitalized for over one year and a large percentage for more than several years.[298]

As its inpatient census ages, OMH, effective April 1, 2016, instituted a SNF project designed to expand and intensify OMH's ongoing efforts to refer and place long stay patients in skilled nursing facilities.[299]

There are also over 600 residential programs in the community serving 40,000 people with mental illness in New York State. [300] Included in this category of service are supported housing beds (46% of the total) and community residences (14% of the total).[301] A community residence is defined as: "any facility operated by or subject to licensure by the office of mental health [or the office for people with developmental disabilities] which provides a supervised residence or residential respite services for individuals with mental disabilities and a homelike environment and room, board and responsible supervision for the habilitation or rehabilitation of individuals with mental disabilities as part of an overall service delivery system."[302]

OMH also serves people with forensic involvement and renders long-term care in institutional and secure facilities. People served include those committed to hospitals under article 730 and section 330.20 of the Criminal Procedure Law. In addition, OMH operates a hospital for sentence serving inmates at the Central New York Psychiatric Center. Admission to this facility is pursuant to Correction Law § 402. OMH and the Department of Corrections and Community Supervision also jointly operate and serve

[298] Statewide Comprehensive Planat 49.
[299] Statewide Comprehensive Plan at 54.
[300] Statewide Comprehensive Plan at13.
[301] The remaining beds are classified as Apartment/Treatment; Community Residence/Single Room Occupancy; Supported Single Room Occupancy. Statewide Comprehensive Plan at 13.
[302] N.Y. Mental Hyg. Law § 1.03(28).

approximately 10,000 people serving sentences in 29 satellite mental health units located within prisons. [303]

In addition, OMH houses people convicted of sex offenses who are judicially adjudicated as having a "mental abnormality" and committed pursuant to article 10 of the MHL.[304] The commitment authorized by Article 10 is indefinite, so people committed could potentially remain in these facilities for the balance of their lives, subject to periodic judicial review.[305]

1. Regulatory Structure

Facilities operated or licensed by OMH are subject to extensive oversight and regulation. As a foundational principle, the New York State Constitution provides: "The care and treatment of persons suffering from mental disorder or defect and the protection of the mental health of the inhabitants of the state may be provided by state and local authorities and in such manner as the legislature may from time to time determine."[306]

Significantly, OMH has the responsibility for seeing that mentally ill persons are provided with care and treatment, that such care, treatment, and rehabilitation is of high

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[303] Li-Wen Lee, *Forensic Mental Health Services*, N.Y. ST. OFF. OF MENTAL HEALTH, https://omh.ny.gov/omhweb/forensic (last visited Apr. 29, 2021).
[304] The statutory predicate for these programs is found at Mental Hygiene Law § 7.18. The law provides: (a) "There shall be in the office secure treatment facilities, as defined in subdivision (o) of section 10.03 of this title, as designated by the commissioner for the care and treatment of dangerous sex offenders requiring confinement, as described in article ten of this title." Such secure treatment facilities may be created on the former grounds of hospitals operated by OMH, but shall be considered separate and distinct facilities and shall not be considered or defined as hospitals.
[305] N.Y. Mental Hyg. Law § 10.09. The media reported on COVID-19 outbreaks on at the Central New York Psychiatric Center SOTP in April of 2020. Rick Karlin, *Residents, Guards Say Marcy Psychiatric Center is Coronavirus Hothouse*, ALB. TIMES UNION (Apr. 14, 2020), https://www.timesunion.com/news/article/Residents-guards-say-Marcy-psychiatric-center-is-15200056.php.
[306] N.Y. Const., Art 17, § 4.

quality and effectiveness, and that the personal and civil rights of persons receiving care, treatment, and rehabilitation are adequately protected.[307]

OMH regulations are found at title 14 of the New York Code of Rules and Regulations. OMH regulations cover the spectrum of services rendered by the agency and its oversight activities. Regulations that govern residential services are found in the following parts: Part 580 – Operation of Psychiatric Inpatient Units of General Hospitals; Part 582 – Operation of Hospitals for Persons with Mental Illness; and Part 595 – Operation of Residential Programs for Adults. As a general rule and across service settings, OMH regulations governing residential services provide for a description of the program mission, the population to be served; admission and discharge criteria; a description of the specific service needs of the defined target population; a description of the goals and anticipated outcomes of the program, including the anticipated average length of stay for residents, resident rights, governance, and quality assurance.

Prior to the COVID-19 public health crisis, OMH also had in place regulations governing the use of telemental health. Originally adopted in 2016, the regulations are found at part 596 and define telemental health as "the use of two-way real-time interactive audio and video equipment to provide and support mental health services at a distance."[308]

The rights of people receiving services from the facilities licensed or operated by OMH, OPWDD and OASAS are protected by statutes and regulations. Article 33 of the MHL is entitled "rights of patients" and each agency under the Department of Mental

[307] N.Y. Mental Hyg. Law § 7.07(c).
[308] 14 N.Y.C.R.R. § 596.1(a).

Hygiene has implementing regulations. OMH's regulations provide each person residing in a hospital or community-based residential program has the following rights, among others, to:

- a safe and sanitary environment;
- freedom from abuse and mistreatment by employees or other residents of the facility;
- receive visitors at reasonable times, to authorize those family members and other adults who will be given priority to visit, to have privacy when visited, and to communicate freely with persons within or outside the facility;
- appropriate medical and dental care for residents of hospitals;
- an individualized plan of treatment or services and to participate in the development of that plan including the opportunity for a person, 16 years of age or older, to request a significant individual to himself or herself, including any relative, close friend or individual otherwise concerned with such person's welfare, to participate in the development of such plan; and
- bring any questions or complaints, including complaints regarding any orders limiting such persons' rights, to the facility director, the Mental Hygiene Legal Service, the board of visitors if applicable, and the Commission on Quality of Care and Advocacy for Persons with Disabilities.[309]

a. Oversight

OMH's Office of Quality Improvement (OQI) oversees the development of an incident management system that is designed to protect the health and safety of consumers and enhance the quality of care provided.[310]

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[309] 14 N.Y.C.R.R. § 527.5. The Commission of Quality of Care and Advocacy for Persons with Developmental Disabilities was subsumed in the Justice Center for the Protection of People with Special Needs. Specifically, in 2012, the Legislature enacted the Protection of People with Special Needs Act, N.Y. Exec. Law § 550, et seq., to protect individuals "who are vulnerable because of their reliance on professional caregivers to help them overcome physical, cognitive and other challenges," 2012 N.Y. Laws ch. 501, §§ 1, 2, by creating a new state agency, the Justice Center for the Protection of People with Special Needs.

[310] *The Division of Quality Management (DQM)*, N.Y. ST. OFF. OF MENTAL HEALTH, https://omh.ny.gov/omhweb/dqm/ (last visited Apr. 29, 2021). The Justice Center and the National

External oversight and advocacy for patients within the OMH system is provided by the Justice Center for the Protection of People with Special Needs,[311] the Board of Visitors,[312] the Mental Hygiene Legal Service,[313] and the federally funded protection and advocacy agency, Disability Rights New York.[314]

OMH has few specific regulations governing infection control. One regulation, Part 509, is entitled "Prevention of Influenza Transmission", and was adopted "in response to [the] increased public health threat . . . of seasonal influenza."[315] The OMH Policy Manual also has policies governing the employee vaccination program for Hepatitis B (Policy OM-400) and a policy governing occupational exposure to bloodborne pathogens (Policy OMH-403). [316] However, TJC has developed extensive materials on infection control and prevention.[317]

2. The Coronavirus Pandemic

Individuals who live in OMH congregate care residential settings are – like those who live in nursing homes – subject to risk of being infected with COVID-19, a risk generally perceived to be higher than the rest of the population. However, there has

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Association of Psychiatric Health Systems (NAPHS), the National Association of State Mental Health Program Directors (NASMHPD) and the NASMHPD Research Institute, Inc. (NRI) collaborated on the development of a set of core performance measures for Hospital-Based Inpatient Psychiatric Services (HBIPS). Measures in the HBIPS set were re-endorsed by the National Quality Forum (NQF) on February 18, 2014. *See Hospital-Based Inpatient Psychiatric,* JOINT COMM'N, https://www.jointcommission.org/measurement/measures/hospital-based-inpatient-psychiatric/ (last visited Apr. 29, 2021).

[311] N.Y. Exec. Law § 550 et seq.

[312] N.Y. Mental Hyg. Law § 7.33.

[313] N.Y. Mental Hyg. Law §§ 47.01, 47.03.

[314] Disability Rights New York is the designated federal Protection and Advocacy System ("P&A") for individuals with disabilities in New York State. The Protection and Advocacy Act for Individuals with Mental Illness is codified at 42 U.S.C. § 10801 *et. seq*.

[315] *See OMH Official Policy Manual*, N.Y. ST. OFF. OF MENTAL HEALTH, https://omh.ny.gov/omhweb/policymanual/contents.htm (last visited Apr. 29, 2021).

[316] *Id.*

[317] *Infection Prevention and Control*, JOINT COMM'N, https://www.jointcommission.org/resources/patient-safety-topics/infection-prevention-and-control/ (last visited Apr. 29, 2021).

been no public reporting of COVID -19 infection and death rates by OMH facilities. According to media reports, however, as of February 10, 2021, 846 patients in State hospitals contracted the virus and 58 patients died. [318] Age was a salient factor contributing to COVID deaths in State hospitals as 41 of the 58 patients who perished from the virus were over 65. [319] Patients at State mental hygiene facilities may not always be able to wear or tolerate a mask or adhere to safety protocols.[320] Impeding a further examination of the impact of the virus among people living in OMH congregate care settings, such as community residences, is a lack of reporting. OMH does not require certified residential programs or not-for-profit providers to track COVID infection.[321]

OMH maintains a COVID page on its website devoted to guidance issued during the pandemic.[322] Generally, the COVID policies are grouped into the following sections: FAQs for program providers; Program Guidance; Infection Control; Fiscal/Contract Guidance and State Hospital Guidance. On November 12, 2020, New York State also published an Infection Control Manual for Public Mental Health Programs that is available on the OMH website. In addition, federal guidelines on infection control were issued during the public health crisis. For instance, the federal Substance Abuse and

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[318] Ethan Geringer-Sameth, *Covid Toll at State Psychiatric Facilities Has Remained Disproportionately High*, GOTHAM GAZETTE (Feb. 26, 2021), https://www.gothamgazette.com/state/10207-covid-new-york-state-psychiatric-facilities-disproportionately-high?mc_cid=7b4e367861&mc_eid=1a5d3a1f3d.

[319] *Id.*

[320] *Id.*

[321] *See* N.Y. ST. OFF. OF MENTAL HEALTH, INCIDENT REPORTING AND NIMRS UPDATE, Apr. 21, 2020, https://omh.ny.gov/omhweb/guidance/covid-19-guidance-nimrs-incident-reporting-updates.pdf. NIMRS is an acronym for the Incident Management and Reporting System utilized by state hospitals, article 28 hospitals and licensed provider agencies. This guidance instructed hospitals and providers that they were not required to track COVID infections. *Id.* Deaths attributed to COVID were to be reported using a new subtype COVID-12 related. *Id.*

[322] *COVID-19 Resources*, N.Y. ST. OFF. OF MENTAL HEALTH, https://omh.ny.gov/omhweb/covid-19-resources.html (last visited Apr. 29, 2021); https://omh.ny.gov/omhweb/guidance/covid-19-guidance-infection-control-public-mh-system-sites.pdf.

Mental Health Services Administration (SAMHSA) issued a report on May 8, 2020 entitled: *COVID19: Interim Consideration for State Psychiatric Hospitals*.

An analysis of COVID-19 impact upon the OMH population should also include responses by the Office of Court Administration (OCA) because many people in the OMH system are subject to involuntary commitment and treatment. A detailed statutory framework for the admission and retention of patients is codified at article 9 of the MHL and provides largely for a medical model of admission subject to judicial review.[323] OCA issued a series of Administrative Orders during the public health crisis, closing courtrooms and instituting virtual hearings.[324] Mental hygiene proceedings were considered "essential proceedings" and continued throughout the pandemic, through the present time, largely in virtual environments.[325] Threats to liberty and due process should be recognized as having significant (if not immediately quantifiable impact) upon a substantial population of people already marginalized and at risk of infection and death from the spread of the virus in institutions where they lived or in the communities they came from.

Nine months into the pandemic, on December 8, 2020, OMH conducted a virtual town hall meeting to discuss its response to the public health crisis. OMH identified its priorities as maintaining access to clinics and ambulatory care with a major shift to telehealth and telephonic services; ensuring safety of people in residential services by using best practice infection control practices, enabling mental health beds to be

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[323] *See* N.Y. Mental Hyg. Law § 9.01–9.58; *see also Project Release v. Prevost*, 722 F. 2d, 960 (2d Cir. 1983); *Rivers v. Katz,* 67 N.Y.2d 485 (1986).
[324] *See Latest STATEWIDE Administrative Orders*, N.Y. ST. UNIFIED COURT SYS., https://www.nycourts.gov/latest-Ao.shtml (last visited Apr. 29, 2021).
[325] Admin. Order of Chief Admin. Judge of Cts. AO/78/20.

repurposed for a COVID surge; and making approximately 280 beds available on State hospital campuses receive patients upon discharge or transfer from general hospitals. [326] For infection control measures, there was daily screening of employees, required mask wearing for all employees in common areas and when rendering direct patient services and developing an inventory and stockpile of PPE.

OMH issued various guidance and directives to its own providers and the providers it regulates in relation to COVID-19. This included guidance on infection control, telehealth and regulatory changes made in response to COVID. [327] OMH also issued written guidance addressing a range of topics including: testing of patients and staff, restrictions on visitation, patient education, PPE protocols, discontinuation of congregate meals and group meals, and expansion of telehealth tools in efforts to quell the spread of the virus in OMH operated facilities.[328] With the advent of vaccines, OMH maintained that it had been successful in vaccinating 2,757 patients in facilities operated by the agency.[329] Thus, OMH patients – just as nursing home residents – with the loss of congregate meals and visitation were subjected to isolation, and all the impacts that entails, in order to be protected from the virus.

Public Health Law article 28 acute care psychiatric units similarly must follow DOH infection control guidelines when delivering mental health services in their

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[326] *OHM Statewide Virtual Town Hall*, N.Y. ST. OFF. OF MENTAL HEALTH, Dec. 8, 2020, https://omh.ny.gov/omhweb/planning/507/.
[327] Dr. Sullivan's written budget testimony is included in the appendix to this report.
[328] *COVID-19 Resources*, N.Y. ST. OFF. OF MENTAL HEALTH, https://omh.ny.gov/omhweb/covid-19-resources.html (last visited Apr. 29, 2021).
[329] Amanda Fries, *State to Vaccine Older Inmates*, ALB. TIMES UNION (Feb. 5, 2021), https://www.pressreader.com/usa/albany-times-union/20210205/281530818707928. OMH officials also reported to the press that 908 patients had refused the vaccine. *Id*.

facilities.[330] OMH operated and licensed inpatient facilities adopted policies to isolate patients with COVID and prevent further spread of the virus. For example, Northwell Health, a large health care system which includes several article 28 hospitals with inpatient psychiatric units in the New York City and on Long Island, decided to transfer all of its COVID-positive patients to a single unit as an infection control response. In the hardest hit areas of New York City certain hospitals, such as Bellevue and Bronx Care, devoted entire units to patients who had tested positive. Facilities also had to adapt to the public health crisis by canceling therapeutic group activities while offering programming in smaller, more private settings. Columbia Presbyterian Hospital provided isolated patients with tablets and internet connections to allow them to videoconference with their families.[331]

Early media reports explained the impact of the virus on State hospitals, particularly the Rockland Psychiatric Center in Orange County.[332] As the public health crisis continued unabated and community infection spread, OMH State hospitals faced challenges to their efforts to protect their patients from infection and death. Inpatient beds were closed in psychiatric hospitals licensed by OMH and operated by Public Health Law article 28 hospitals in order to create additional beds for a potential COVID

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[330] *Key Infection Control Practices in Inpatient and Outpatient Medical Care Settings*, N.Y. ST. DEP'T OF HEALTH, https://www.health.ny.gov/professionals/diseases/reporting/communicable/infection/key_infection_control_practices.htm (last visited Apr. 29, 2021).

[331] The narrative offered is from staff of the Mental Hygiene Legal Service describing their experiences during the public health crisis. Other evidence of how the pandemic impacted providers can be found in a survey conducted by The Justice Center. *See* Katie Bronk, *Joint Commission Questionnaire Identifies COVID-19 Impact, Challenges and Needs Among Health Care Organizations*, JOINT COMM'N (Dec. 17, 2020), https://www.jointcommission.org/resources/news-and-multimedia/news/2020/12/joint-commission-questionnaire-identifies-covid-19-impact/.

[332] *See* Danny Hakim, *'They Want to Forget Us': Psychiatric Hospital Workers Feel Exposed*, N.Y. TIMES (Apr. 24, 2020), https://www.nytimes.com/2020/04/24/nyregion/coronavirus-new-york-psychiatric-hospitals.html?action=click&module=Top%20Stories&pgtype=Homepage.

surge.[333] For example, the Health Alliance campus in Ulster County closed its entire inpatient psychiatric unit during the crisis.[334] The New York State Nurses Association, among other organizations, has criticized closure of inpatient psychiatric beds.[335] There is no guarantee that these beds will return post-COVID-19 and this, in turn, adversely impacts people and communities that depend on essential acute care psychiatric services.[336]

Well before COVID-19, community-based mental health and substance abuse disorder/addiction agencies have struggled for years to address increasing rates of overdose and suicides in communities across New York State. A now familiar and distressing refrain is that the public health crisis exposed and exacerbated existing problems in the mental health arena.[337]

The stresses of the pandemic have compounded the need for mental health services. Elevated levels of adverse mental health conditions, substance use, and

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[333] *See* Bethany Bump, *Albany Psychiatric Unit Under Quarantine After Coronavirus Outbreak*, ALB. TIMES UNION (Dec. 9, 2020), https://www.timesunion.com/news/article/Quarantines-ordered-at-Albany-psychiatric-center-15787982.php.

[334] *See* William J. Kemble, *Lawmakers Push for Return of Inpatient Mental Health Services for Ulster County*, KINGSTON DAILY FREEMAN (Jun. 20, 2020), https://www.dailyfreeman.com/news/local-news/lawmakers-push-for-return-of-inpatient-mental-health-services-to-ulster-county/article_f7954ac8-b31a-11ea-b080-6b51947f8e2f.html?utm_medium=social&utm_source=email&utm_campaign=user-share.

[335] *See Closures Are Causing a Full-Blown Mental Health Emergency in New York*, N.Y. ST. NURSES ASS'N (Aug. 20, 2020), https://www.nysna.org/blog/2020/08/20/closures-are-causing-full-blown-mental-health-emergency-new-york#.YANKmLNOnD4.

[336] *A Crisis in Inpatient Psychiatric Services in NYS Hospitals.* N.Y. ST. NURSES ASS'N (2020), https://www.nysna.org/sites/default/files/attach/ajax/2020/08/Psych%20Whitepaper%20NYSNA.pdf. The report notes that the median number of psychiatric beds per 100,000 people in 2014 was 68. *Id.* at 6. Factors that effect this range include the percentage of the population with serious mental illness, the availability of alternative treatment modalities such as assisted outpatient treatment, the overall length of stay in psychiatric hospitals and the flexibility in financing inpatient beds. *Id.* According to the National Association of State Mental Health Program Directors, New York State only had 55.3 beds per 100,000 people in 2014 and the situation only appears to be growing worse. *Id*.

[337] *See Behavioral Health Advocates Raise Grave Concerns on Proposed Cuts in Today's Budget Hearing*, MHANYS (Feb. 5, 2021), https://mhanys.org/mh-update-2-5-21-behavioral-health-advocates-raise-grave-concerns-on-proposed-cuts-in-todays-budget-hearing/.

suicidal ideation were reported by adults in the United States in June 2020. The prevalence of symptoms of anxiety disorder was approximately three times those reported in the second quarter of 2019 (25.5% versus 8.1%), and prevalence of depressive disorder was approximately four times that reported in the second quarter of 2019 (24.3% versus 6.5%).[338] Mental health conditions are disproportionately affecting specific populations, especially young adults, Hispanic persons, Black persons, essential workers, unpaid caregivers for adults, and those receiving treatment for preexisting psychiatric conditions. [339] It has been long understood that people living with mental illness often face substantial obstacles to improving their mental health and participating fully in their communities and societies.[340] They have been subjected to discrimination, stigmatization, and other indignities, as well as social and economic barriers that limit their opportunities. [341] The pandemic exacerbated these pre-existing conditions for people confined in institutions and those dependent upon community based mental health services. The potential that community beds and services may be further eroded foreshadows continuing hardship for this already vulnerable population.

D. Office for People with Developmental Disabilities

The Office for People with Developmental Disabilities ("OPWDD") is responsible for ensuring that New Yorkers with developmental disabilities "are provided with

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[338] Mark Czeisler et al., *Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic — United States, June 24–30, 2020*, 69 MORBIDITY & MORTALITY WKLY. REP. 1049 (2020), http://dx.doi.org/10.15585/mmwr.mm6932a1external icon.

[339] *Id*.

[340] Lance Gable & Lawrence Gostin, *Mental Health as a Human Right*, 3 SWISS HUMAN RIGHTS BOOK 249 (2009), https://ssrn.com/abstract=1421901.

[341] *Id*. As noted by the authors, the closure of large psychiatric institutions and the promise of deinstitutionalization was undercut by ineffective planning and meager economic support. *Id.* (citing Robert Burt, *Promises to Keep, Miles to Go: Mental Health Law Since 1972*, *in* THE EVOLUTION OF MENTAL HEALTH LAW 11 (Lynda Frost & Richard Bonnie eds., 2001).

services including care and treatment, that such services are of high quality and effectiveness, and that the personal and civil rights of persons receiving such services are protected."[342] The services provided by OPWDD are designed to promote and attain independence, inclusion, individuality and productivity for persons with developmental disabilities.[343] The agency describes itself as being responsible for coordinating services for New Yorkers with developmental disabilities, including intellectual disabilities, cerebral palsy, Down syndrome, autism spectrum disorders, Prader-Willi syndrome and other neurological impairments.[344] OPWDD provides services directly and through a network of approximately 500 not-for-profit service providing agencies, with about 80% of services provided by the private nonprofits and twenty percent provided by state-run services.[345] Ninety-five percent of the people accessing OPWDD services and supports have Medicaid provided under the Home and Community Based Services ("HCBS") waiver.[346] In 2019, nearly 120,000 people received OPWDD Medicaid services and supports.[347] The OPWDD system is largely community-based.[348] Over one-half of Medicaid enrollees from the OPWDD system live

[342] N.Y. Mental Hyg. Law § 13.07(c).
[343] *Id.*
[344] *See* OPWDD, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, https://opwdd.ny.gov/ (last visited Apr. 29, 2021).
[345] *Id.*
[346] *Home and Community Based Services Waiver*, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, https://opwdd.ny.gov/providers/home-and-community-based-services-waiver (last visited Apr. 29, 2021).
[347] *By the Numbers*, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, https://opwdd.ny.gov/data (last visited Apr. 29, 2021).
[348] OPWDD still operates two developmental centers located in Franklin County and Chenango County. They are the Sunmount Developmental Center and the Valley Ridge Center for Intensive Treatment. Identified as "schools" by definition, *see* N.Y. Mental Hyg. Law § 1.03(11), OPWDD now refers to these inpatient centers as "Intensive Treatment Options" in its continuum of care. People are admitted on an inpatient status pursuant to article 15 of the Mental Hygiene Law or article 730 and section 330.20 of the Criminal Procedure Law. Capacity at these two facilities combined is approximately 200 beds.

at home or with family care givers.[349] Those people needing residential placement live in community residences licensed or operated by OPWDD. [350] There are approximately 6,100 community residences operated or certified by OPWDD.[351] These include Individualized Residential Alternatives ("IRAs") which may have up to 14 residents and provide room, board and individualized service options.[352] Approximately 54% of these IRAs are designed to serve more than four residents and near 11% are designed to serve 10 or more residents. In 2019, approximately 33,000 individuals resided in IRAs. Community residences also include Intermediate Care Facilities, a residential option for individuals with specific medical or behavioral needs whose disabilities severely limit their ability to live independently. In 2019, OPWDD served 4,553 individuals in ICFs, 30,530 individuals in supervised IRAs and 2,276 individuals in supportive IRAs.[353]

1. Regulatory Structure

Facilities operated or licensed by OPWDD are subject to extensive oversight and regulation. OPWDD regulations are found at title 14 of the New York Code of Rules and Regulations. Regulations that govern residential services include: Part 636-Services and Supports for Individuals with Developmental Disabilities; Part 681 –

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[349] *By the Numbers*, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, https://opwdd.ny.gov/data (last visited Apr. 29, 2021).
[350] *See* N.Y. Mental Hyg. Law § 1.03(28) (definition of community residence); *see also Facts about OPWDD*, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (2020), https://opwdd.ny.gov/system/files/documents/2020/03/002_facts_about_opwdd_342020.pdf. Agencies licensed by OPWDD to provide services are referred to as "voluntary providers." There are over 500 non-profit OPWDD providers in New York State. *Id.*
[351] *New York State HCBS Settings Transition Plan Executive Summary*, N.Y. ST. DEP'T OF HEALTH 100-01 (2018), https://www.health.ny.gov/health_care/medicaid/redesign/hcbs/docs/2018-11-07_hcbs_final_rule.pdf; *Understanding Primary Diagnosis*, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, https://opwdd.ny.gov/understanding-primary-diagnosis (last visited Apr. 29, 2021).
[352] 14 N.Y.C.R.R. § 686.16; *Facts about OPWDD*, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (2020), https://opwdd.ny.gov/system/files/documents/2020/03/002_facts_about_opwdd_342020.pdf.
[353] *Id.*

Intermediate Care Facilities; Part 686 – Operation of Community Residences and Part 687 – Operation of Family Care Homes. The rights of individuals receiving services are protected by federal and state law. The federal Developmental Disabilities Assistance and Bill of Rights is codified at 42 U.S.C. § 15001. Congress found, among other things, that people with developmental disabilities are at greater risk than the general population for abuse, neglect, financial and sexual exploitation, and the violation of legal and human rights.[354] The federal bill of rights provides among other things that federal and state governments are obligated to ensure that public funds are provided to programs that meet minimum standards relating to the provision of care that is free from abuse and neglect and that individuals receive appropriate medical care.[355]

OPWDD's implementing regulations provide that people receiving services have a right to, among other things:

- a safe and sanitary environment;
- freedom from physical or psychological abuse:
- written individualized plan of services (see glossary) which has as its goal the maximization of a person's abilities to cope with his or her environment, fosters social competency (which includes meaningful recreation and community programs and contact others who do not have disabilities), and which enables him or her to live as independently as possible.
- the opportunity to object to any provision within an individualized plan of services, and the opportunity to appeal any decision with which the person disagrees, made in relation to his or her objection to the plan;
- the opportunity to receive visitors at reasonable times; to have privacy when visited, provided such visits avoid infringement on the

[354] 42 U.S.C. § 15001 (a)(4-5).
[355] 42 U.S.C. § 15009(a)(3)(B)(i); 42 U.S.C. 15009.

rights of others, and to communicate freely with anyone within or outside the facility.[356]

OPWDD certifies more than 7,500 sites and programs (operated by more than 500 not-for-profit and state providers) and conducts on-site visits to ensure the provision of quality services and compliance with applicable regulatory requirements. If OPWDD identifies deficient practices, providers are expected to remedy the concerns and submit plans of corrective action.[357] In addition, those programs certified as ICFs are subject to oversight by CMS which contracts with DOH to survey OPWDD licensed and operated ICFs, including the remaining State-operated developmental centers.[358] This is similar to the nursing home survey process. External oversight and advocacy for patients within the OPWDD system is provided by the Justice Center for the Protection of People with Special Needs,[359] the Board of Visitors,[360] the Mental Hygiene Legal Service[361] and the federally funded protection and advocacy agency, Disability Rights New York ("DRNY").[362] Pursuant to the Permanent Injunction to settle the Willowbrook litigation, Willowbrook Class Members enjoy advocacy and assistance from the Consumer Advisory Board ("CAB") and representation by Class Counsel, the New York Civil Liberties Union and New York Lawyers for the Public Interest ("NYLPI").[363]

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[356] *See* 14 N.Y.C.R.R. § 633.4 (a)(4).
[357] *See Provider Stability and Performance*, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES, https://opwdd.ny.gov/providers/provider-stability-and-performance (last visited Apr. 29, 2021).
[358] *See Methodology and Source*, N.Y. ST. DEP'T OF HEALTH, https://profiles.health.ny.gov/nursing_home/pages/methodology (last visited Apr. 29, 2021).
[359] *See* 14 N.Y.C.R.R. Part 700.
[360] N.Y. Mental Hyg. Law § 13.33
[361] N.Y. Mental Hyg. Law §§ 47.01, 47.03
[362] The federal Developmental Disabilities Assistance and Bill of Rights Act ("DD Act") requires states to establish P&A systems in order to receive federal funding. 42 U.S.C. § 15041.
[363] The Willowbrook case, bearing the caption *New York State Assoc. for Retarded Children v. Cuomo*, 393 F. Supp. 715 (E.D.N.Y. 1975) (the "Willowbrook Litigation"), is still pending in the United States District Court before the Hon. Raymond J. Dearie. The goals of the litigation were then virtually unheard of – deinstitutionalization, normalization, and community integration – but they have been effectuated through a series of orders entered in the Willowbrook Litigation, culminating in a March 1993 Permanent

According to guidance issued by OPWDD on March 11, 2020, staff at OPWDD-licensed congregate settings were, prior to COVID-19, required to receive training on infection control, use of PPE, cleaning, activity restrictions and isolation, and symptom identification. There is a regulatory foundation for the guidance, as section 633.4(a)(4)(i) of the OPWDD regulations requires that people receiving services for a developmental disability shall not be denied a safe and sanitary environment. Most of the pre-COVID guidance was directed at environmental/facility standards like maintenance and general cleanliness provisions and were not geared towards identification and prevention of infectious disease.[364] Importantly, section 690.5(b)(2)(vi) of the OPWDD regulations, governing day treatment services, required (and still requires) day treatment facilities to ensure that "there is a standing committee, or comparable mechanism, to address the issue of infection control."

2. The Impact of the Coronavirus Pandemic

Individuals served by the OPWDD-operated or regulated system faced hardships akin to those suffered by the State's nursing home residents. Between March 17 and 19, 2020, OPWDD closed day programs and suspended visitation at OPWDD operated and certified congregate care facilities, including community residences. These were essentially preemptive quarantines to prevent the introduction of the virus. Just as in nursing homes, this effectively cut off the individuals residing in these residences from their families, from their communities, and from their usual activities. OPWDD also

Injunction. The NYCLU continues to monitor the State's compliance with that 1993 injunction on behalf of over 2,600 individuals with intellectual and/or developmental disabilities living all across New York State.

364 *See Agency Protocol Manual*, N.Y. ST. OFF. FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES (2019), https://opwdd.ny.gov/system/files/documents/2019/11/agency_protocol_manual_provider_copy_2-2019.pdf.

ordered the shut-down of off-site day habilitation programs. The disruption of usual activities and the lock down of community residences caused many individuals to regress. These programs supported their well-being. Families, and the staff within community residences, could not duplicate fully the lost activities that are so crucial for these individuals' developmental and mental support. According to research conducted during the pandemic, restrictions on usual activities are likely to induce mental stress, especially among those who are autistic, leading to an escalation in challenging behaviors, risk of placement breakdown and increased the use of psychotropic medication.[365]

As will be discussed below, the lockdown of community residences and shut down of day habilitation programs was overall successful in preventing the spread of the virus, but at terrible cost. And even with that cost, the virus came.

OPWDD took certain steps in response to pandemic.[366] OPWDD created COVID-19-specific data reporting that was later expanded to include mandatory reporting through a 24-hour hotline.[367] OPWDD also assigned 100 staff in the OPWDD system to contact tracing efforts. Over 80 guidance documents were issued by OPWDD for providers and mitigation and containment efforts resulted in visitation restrictions and program suspensions. OPWDD also convened regular "stakeholder" meetings with selected OPWDD providers, family groups and advocates to provide them with information about OPWDD efforts to manage the public health crisis and

[365] K. Courtenay & B. Perera, *COVID-19 and People with Intellectual Disabilities: Impacts of a Pandemic*, 37 IRISH J. OF PSY. MEDICINE 231 (2020).
[366] *Joint Legislative Public Hearing on 2021 Executive Budget Proposal: Topic Mental Hygiene*, 2021 Leg. (NY 2021) (testimony of Dr. Theodor Kastner, Commissioner of OPWDD). Dr. Kastner's budget testimony is included in the appendix to this report.
[367] OPWDD's data reporting mandates are in contrast to those of OMH which did not require providers to track COVID infections.

safeguard its population. There are 36,256 OPWDD-certified residential beds and 42,956 total community beds.[368] As of February 10th, 2021, there had been 9,267 cases of COVID-19 among individuals receiving OPWDD services. 6,698 cases occurred in residential settings. 618 residents had died from the virus by that date. There were also 12,414 confirmed cases among staff.[369] As in nursing homes, residents in the New York metropolitan area were most affected in the initial surge. Since that time, residents and staff have been affected throughout the State, largely tracking the rise and fall of infection rates regionally throughout the State.

Studies demonstrate that individuals with developmental disabilities have a higher incidence of co-occurring medical conditions than the general population that put them at greater risk of death should they contract COVID-19.[370] In addition to the heightened risk of serious medical outcomes, residing in congregate care settings puts residents at higher risk of contracting COVID-19 for several reasons.[371] These include the extreme difficulty of social distancing in a congregate care setting where individuals are sharing bathrooms, bedrooms, and other living spaces. In addition, many people with developmental disabilities receive high levels of personal care assistance from direct support personnel, who may come in and out of the residence or work at multiple

[368] Individuals with developmental disabilities may reside in certified or non-certified beds.
[369] This data has been collected and provided to the Task Force by the New York Alliance for Inclusion and Innovation. *See also COVID-19 Data Project*, N.Y. ALLIANCE FOR INCLUSION & INNOVATION, https://nyalliance.org/COVID-19_Data_Project (last accessed Apr. 29, 2021).
[370] See Margaret Turk et al., *Intellectual and Developmental Disability and COVID-19 Case-Fatality Trends: TriNetX Analysis*, DISABILITY & HEALTH J. (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7245650/pdf/main.pdf (using database of medical records to compare COVID-19 death rates and comorbidities between individuals with and without IDD, and confirming that people with I/DD have higher prevalence of comorbid risk factors (i.e., hypertension, heart disease, respiratory disease, and diabetes) which are often associated with poorer COVID-19 outcomes).
[371] *See* Scott Landes et al., *COVID-19 Outcomes Among People with Intellectual and Developmental Disability Living in Residential Group Homes in New York State*, DISABILITY & HEALTH J. (2020), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7311922/pdf/main.pdf.

program sites. Many individuals with developmental disabilities may also be unable to wear face coverings, or adhere to other infection control protocols.

OPWDD providers were under great fiscal strain during the pandemic due to loss of revenue and enormous and unexpected expenditures required to maintain the safety or residents and staff. Perhaps the greatest challenge encountered by providers was that OPWDD-licensed and operated community residences were not afforded the same priority as skilled nursing facilities and other congregate care settings for allocations of PPE.[372] Further, the State Department of Health, as the State Medicaid agency, initially set COVID policies for people residing in OPWDD-certified settings. Thus, OPWDD did not establish the priorities for their constituents despite having greater knowledge and expertise about the needs of people with developmental disabilities. For example, visitation at hospitals was suspended by DOH without considering how this suspension impacted people with disabilities who must rely upon family and staff support when they are hospitalized. Considerable advocacy was required for DOH to address this need and amend its visitation policies.[373]

Furthermore, while some data have been collected and released to the public about the rate of infection and fatalities among staff and residents in skilled nursing facilities, data have not been publicly released concerning the rate of infections and

[372] Statement of J.R. Drexelius, Governmental Affairs Counsel, Developmental Disability Alliance for Western New York, to the Task Force.

[373] OPWDD has substantially altered and adapted its service delivery system during the pandemic as reflected in the State's Medicaid HCBS Appendix K emergency funding application. See https://www.health.ny.gov/docs/2020-04-07_appendix_K. Thus, for example, OPWDD sought and obtained approval from the federal government to permit day services and residential habilitation services to be delivered at alternative sites. Telehealth services were also expanded and DQI reviews were postponed. However, unlike some other states, DOH and OPWDD did not seek to amend Appendix K so that reimbursement could be awarded under Medicaid to cover staff who accompanied persons with developmental disabilities to hospitals.

fatalities among staff and residents in OPWDD-operated or certified settings. The lack of data transparency impedes an objective assessment of the impact of the pandemic upon a very vulnerable population and the people who provide services and supports to them. This, in turn, obstructs informed discussions toward mitigating the potentially devastating impacts of future infectious disease outbreaks. Part of the gap in data collection is now filled following the March 2021 release of an investigatory report by DRNY, the New York Civil Liberties Union, and New York Lawyers for the Public Interest, entitled *New York State's Response to the Protect People with Intellectual and Developmental Disabilities in Group Homes During the COVID-19 Pandemic*.[374] To determine how many people with developmental disabilities were exposed to infection and death, the report relied on data received from the Justice Center for the Protection of People with Special Needs[375] and OPWDD reports relayed on periodic telephone conference calls with selected stakeholders.

According to the investigative report, as of November 4, 2020, 3,906 New Yorkers with developmental disabilities had a confirmed COVID-19 diagnosis. Of those individuals, 3,107 resided in OPWDD-certified beds. 477 deaths attributable to confirmed COVID-19 occurred. Of the staff working in OPWDD-certified programs, 4,911 had tested positive for COVID-19 through November 4, 2020.[376] Individuals with developmental disabilities residing in OPWDD-certified group homes were three times more likely to contract COVID-19 than members of the general population in New York

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[374] *New York State's Response to Protect People with Intellectual and Developmental Disabilities in Group Homes during the COVID-19 Pandemic*, DISABILITY RIGHTS N.Y. (2021), https://www.dropbox.com/s/e4ym4d1s2zwmbf2/2021.03.05%20Investigatory%20Report%20on%20State%27s%20Response%20to%20People%20with%20IDD.pdf?dl=0.
[375] *Id*. at 8.
[376] *Id*.

State and nearly three times as likely to perish if they contracted the virus.[377] The data trended worse through the balance of the calendar year 2020 through to February of 2021. According to an OPWDD provider association that participates in periodic OPWDD stakeholder meetings, through March 24, 2021, there were 10,113 confirmed COVID-19 positive cases reported to OPWDD statewide. Of those people that tested positive, approximately three-quarters resided in OPWDD-certified residential programs. A total of 642 individuals statewide who tested positive died. In addition, 12,414 staff were reported as confirmed COVID-19-positive. There is greater geographic impact in the OPWDD system, as well, with the downstate region accounting for 76% of the total COVID cases.[378]

While the hardships endured by people with developmental disabilities and their families during this public health crisis has been devastating, deaths and rates of infection on the scale seen in nursing facilities were likely avoided because of the model of service delivery. That is, people with developmental disabilities who reside in OPWDD certified settings generally live in family settings and in small residences, not in large institutions.

[377] *Id*. Beyond quantitative analysis the investigative report published by the three attorney advocacy agencies found, among things that, OPWDD group homes did not have timely access to PPE, testing should have been mandatory for staff supporting residents in group homes and clearer guidance and greater coordination was required retarding quarantines in group homes. Other compelling topics addressed by the report are staffing challenges during the pandemic, issues that arose when people with developmental disabilities were hospitalized during the pandemic and the lack of transparency related to the release of data and essential information to service recipients and stakeholders.

[378] The DRNY/NYCLU/NYLPI investigative report indicates that one-half of the total COVID fatalities in the OPWDD system occurred in the five boroughs of New York City and that New York City and Long Island accounted for 70% of the fatalities in group homes. *Id.*

VII. Conclusion

The Task Force's review of the impact of COVID-19 on nursing homes and long-term care, including in OMH and OPWDD providers, reveals that COVID-19 has been most dangerous for residents of nursing homes, and others in congregate care settings. In this regard, we cannot say that New York's experience has varied in a meaningful way from that of other states. COVID-19 has been most dangerous for the aged and those with certain comorbidities, most prominently cardiovascular and pulmonary conditions, and individuals with disabilities. To be a nursing home resident is to be an individual with comorbidities.

Given the nature of COVID-19, the physical condition of individuals residing in congregate settings, and their close living conditions, some level of death was inevitable. This is especially true in nursing homes, due to their size and configuration, the level of close contact, and the age and comorbidities of their residents. The sheer number of deaths was not. At-risk nursing home residents were compromised by a number of factors: community spread, insufficient staffing – pre-existing and/or exacerbated by the pandemic, insufficient training, insufficient PPE, insufficient State support, and insufficient preparation. We think there was another factor, especially applicable to the early days of the pandemic, when COVID-19 seemingly appeared overnight in metropolitan New York. There was a lack of foresight; really, a lack of imagination.

We usually think of imagination as the conception of an idea, as conceiving something better. Imagination is also necessary to conceive of risk and response. In the late winter of 2020, New York and the United States had no experience with COVID-

19. We had seen Wuhan, China, and its lockdown. We had seen the building there of rows of hospitals, seemingly overnight. But that was far away. It was not us. Our experience had been that new viruses may develop overseas, but they will be largely contained overseas. That had been our collective experience with SARS, with MERS, with Zika, and even with Ebola. What seemed terrifying was less so when it reached our shores, if it even reached our shores.

COVID-19 was different. Despite the obvious scope of the problem in China there was disbelief that the epidemic could be that bad. This was for three reasons. To borrow the phrasing of former Secretary of Defense Donald Rumsfeld, there were unknown unknowns. China wasn't sharing what it had learned regarding the virus. The President had been briefed, but he chose to downplay the danger. The virus was known to be highly contagious, but that it spread asymptomatically was unknown. Then, there was a certain pridefulness. There was a belief that America and New Yorkers could handle it. This wasn't our first rodeo, in the words of Governor Cuomo. Finally, there was a lack of imagination, not just about how bad the virus could be, but how quickly it could be upon us. As the warnings came – China, Kirkland, Washington, Italy – and as the directives came from the CDC and State Department of Health, there was a failure to recognize just how bad things could be, and how quickly that could happen. By the time public health professionals were warning of impending, overwhelming danger, the danger had arrived. Collectively, New York's health care institutions, including nursing homes in metropolitan New York, were not ready. The warnings had come too late, and the expectations regarding what we faced had been too small. The CDC issued a directive on February 26th for nursing homes to prepare.

The Governor declared a State of Emergency on March 7th. The State Department of Health issued nursing home directives on March 12th.

Yet, by March 25th, the State's hospitals were so overwhelmed that the Department of Health issued its now infamous directive that nursing homes must accept stable COVID-19 patients, and were barred from testing for COVID-19. By the time the directives came, could anyone say that there was enough time to find and hire sufficient staff, to train sufficient staff, to corral sufficient PPE?

In the best of circumstances, time was short. But the State's nursing homes were not in the best of circumstances. COVID-19 exposed that. This Task Force does not aim to resolve whether the funding of nursing homes has been inadequate, or whether for-profit-operators are better or worse than not-for-profit providers. The important points for the Task Force's work are that the system in which nursing homes were operating did not adequately account for a pandemic of the magnitude of COVID-19 – staffing was too lean to accept any stress to the system, too little PPE was on hand, and the infection control procedures in place were too weak to meet the virus. And, because of a lack of recognition of what was at hand – a lack of imagination about how bad the pandemic could be – there was a lack of preparation, if preparation had even begun. We saw no evidence that the State's nursing homes, overall, had done additional hiring in anticipation of COVID' s arrival, no evidence that the State's nursing homes had undertaken needed staff training, no evidence that the State's nursing homes had begun purchasing PPE. We also cannot say that the guidance to nursing homes or other long-term care providers from public health authorities was sufficient.

What is worse, all that happened in New York's nursing homes happened after the nation's first COVID-19 outbreak occurred – in a Washington State nursing home. That should have set off alarm bells that nursing home residents were at high risk. If the bells were ringing, they went unheard.

Perhaps worst of all has been the experience in the State's nursing homes since the initial outbreak. Even after the initial impact, many months into the epidemic, COVID-19 continued to ravage nursing homes across the State until effective vaccines were administered. A high percentage of the State's deaths continued to occur in the State's nursing homes. The nursing home proportion of the State's deaths has been about 30%. In this, the State's experience has varied little from the rest of the nation. The proportion of COVID-19 deaths in the State's nursing homes is not meaningfully different than the proportion in nursing homes in other states. This suggests that New York's nursing homes are no better and no worse than the nation at large. More importantly, this suggests that nursing homes are not well-suited to manage an airborne, highly infectious disease.

The experience in nursing homes has been different than that experienced by other long-term care providers. Individuals receiving Medicaid-funded home care must be eligible for nursing home level care. Many individuals in OPWDD-certified community residences have exceedingly complex health care needs. Residents of these facilities suffered during the pandemic and experienced infection and death at rates much higher than the general population. Nevertheless, the incidence of death and disease from COVID-19 has not been as devastating for those served by other long-term care providers. Some of that difference may reflect differences in age, some

of it may reflect differences in comorbidities. But the primary difference appears to be place. Nursing homes are institutional by design. Nursing homes are larger. Nursing homes bring large numbers of susceptible individuals together.

There are no quick fixes. But there can be improvements. Our recommendations are both short-term and long-term. Some may be implemented quickly, some will require a process, and some are long-term solutions for long-term improvement.

We must also recognize the dynamic nature of the epidemic and the response to it. We are fortunate that as our Task Force has undertaken its work and this Report is being written highly effective vaccines have become available. More vaccines are expected to be available in the next few months. These vaccines are changing the impact of COVID-19 on long-term care. Vaccines are being administered to nursing home residents as this is being written, and are available to other long term care recipients. As these vaccines are administered, the danger to nursing home and other long term care recipients thankfully is diminishing, though the high percentage of staff members yet to be vaccinated presents a risk of the virus' return. The imminent end of the epidemic in long-term care may be near, but that does not diminish the need for reforms. Communicable diseases will continue to be a threat in long term care, especially in nursing homes. The flu is an annual danger, and new contagious diseases – SARS, MERS and now COVID-19 – continue to emerge.

VIII. Recommendations

Government at the federal, state and local levels have various responsibilities to the public, especially the most vulnerable, during emergencies. Application of these

responsibilities to the pandemic response in nursing homes and other long-term care settings may offer some context to explain why the situation became so dire and to hopefully prevent future occurrences.

A. Protect Public Health

1. Rethink the Delivery of Long-Term Care

One of the most basic responsibilities of government is to protect public health. The experience with COVID-19 compels a rethinking of the delivery of long-term care. Through the course of the COVID-19 epidemic, nursing homes have been dangerous places for their residents. That statement is not intended as an indictment of nursing homes. It is simply a reflection of the overwhelming impact COVID-19 has had in nursing homes. Nursing homes, as a whole, have had difficulty in containing an aerosol-based virus. COVID-19 has been a challenge for congregate care providers, but nursing homes have faced the most challenges.

State and federal regulations recognize that, for many, nursing homes will be their final home. That is unacceptable. Nursing homes are institutional care. Human beings do not want to end their days in institutions. There must be a lessened dependence on nursing homes. Individuals being discharged from hospitals in need of further care must be offered home care options just as they are offered nursing home options. Individuals finishing their rehabilitation time in nursing homes in need of further care must be offered other long-term care as well as continued nursing home placement. Those individuals should be offered the full range of services that may meet their needs, whether institutional or community based. Home care, in its several forms, must be available to the same extent as nursing home care.

There will be a continued need for nursing home services. There will be those in need of inpatient rehabilitation. There will also be those in need of care that simply cannot be offered at home. But, as we have seen, in many instances nursing homes became hothouses for COVID-19. And, as studies from this pandemic are beginning to reveal a connection between the impact of COVID-19 in nursing homes based on race and ethnicity of patients, nursing homes serving these populations were disproportionately impacted. Not everyone in need of care needs to end their days in a hospital extender. Serious consideration must be given to whether the physical structure of nursing homes themselves can change. A systemic preference for institutionalized care should not be in place when there is agreement, and, under *Olmstead*, a requirement, that individuals should live in the community when that is their preference

Before nursing homes developed in their current form, convalescent care, old-age care, was often provided in small settings, including caregiver's homes. As people aged and their health care needs became more complex, that informal model became obsolete, succeeded by the institutional model dominant today. Consideration should be given to the whether the non-institutional, smaller-sized model of times past could be replicated today and altered to meet individuals' needs. There is such a model, though not perfectly equivalent. Services for people with developmental disabilities were once highly institutionalized. That system, despite the complex needs of many service recipients, has long since moved to a community-based system. That system dispenses medication, arranges medical care, and otherwise is responsible for meeting residents' needs, all in home-like settings. In addition, because its residences are so

much smaller, contagion can be more easily contained. A serious examination should be made to determine how much of the nursing home system can be transformed into a community-based system. Further, consideration should be given to whether current nursing home facilities can be transformed from hospital-like wards to something more akin to home-like apartments.

As consideration is given to transformation of the system of long-term care, there is a need to improve the delivery of care while nursing homes remain the dominant long-term care providers. To that end, more immediate reforms are needed to protect residents in long term care.

2. Meaningful Agency Enforcement

Meaningful enforcement of nursing home and adult care facility regulations can play an important role in limiting the further spread of this coronavirus, and the possibility of future emerging pandemics. Toward that end, however, we recommend certain changes in DOH enforcement policies and practices.

a. Review Regulatory Standards

The regulation of nursing homes and adult care facilities by DOH is characterized by hundreds to thousands of standards that regulate the minutiae, and which have little to no impact on residents' quality of life or protection from contagion. Too often, however, the focus of DOH surveyors is on this minutiae rather than on the big picture – the quality of life and protection of resident safety and rights. Required rigid adherence to less-important regulatory standards can not only take the focus of surveyors away from the bigger picture, but also stifle initiative from operators when they are having to deal with emerging threats like COVID-19. DOH is also seen in the industry as having moved away from an advisory and supportive role to one much more prosecutorial in

nature. This has inhibited the open dialogue that may prove critical in dealing with and containing emerging outbreaks. Contagious diseases and pandemics are not spread in long-term care facilities by the failure to adhere perfectly to the minutiae, but rather by failure to focus on what is needed to enhance infection control, to increase and train staffing, to supply PPE, and to empower operators to make timely and critical decisions based on their immediate needs and situations.

b. Survey Process

The survey process must be reformed to better measure intended outcomes. Too often, the survey process becomes the application of a checklist that does little to measure actual quality and real risks to residents. Infection control must be a central part of the survey process. So, too, should staffing levels. The survey process should include a review of whether nursing facilities meet whatever the pre-determined staffing standard has established.

c. Address Under-Performers

The State's nursing homes have usually operated at very high occupancies. Overall occupancy rates usually exceeded 95%. There was no excess capacity. Since COVID-19, overall occupancy rates have fallen significantly, to below 85%. When the system was performing at capacity, the State's nursing home regulator – the State Department of Health – could find its options constrained in dealing with the worst performers. Excess capacity provides the Department of Health an opportunity to deal with operators who have a history of failing to meet their residents' needs, whose performance jeopardizes the health of their residents. The Department should use it.

B. Prepare for Emergencies

The COVID-19 epidemic is a once-in-a-hundred-year event. Preparation for such an event is difficult. Communicable disease outbreaks, however, are not unusual. Proper planning for those outbreaks would meet many of the issues that have emerged in this epidemic. As noted above, a properly trained, properly empowered infection control officer developing and implementing an infection control plan would be a key to proper preparation.

Preparation is also necessary on the macro level. The pandemic has revealed that the federal and state public health support structures were not what they should be. National stockpiles of equipment, for example, had withered. More importantly, human capital, especially at the federal level had withered. The CDC's international reach had lessened. The National Security Council no longer had a position dedicated to health issues. Public health requires attention and capabilities, as much as any other element of national defense.

1. Support for Staffing

Another key to preparation is adequate staff, adequately trained. Staff members stretched beyond their capabilities inevitably will have to cut corners. Proper care of residents takes time. Following infection control procedures takes time. Properly donning PPE takes times. Proper hand sanitation takes time. There must be enough staff. Minimum staffing standards are highly controversial. Adequate staffing, though, could be addressed in other ways. Nursing homes could be required to disclose their staffing ratings at the time of each resident's admission. The prominent posting of staffing ratings could be required. DOH regulations could require a monthly certification of adequate staffing, including a statement of how the determination of adequate

staffing was reached. Those statements could be publicly available on the Department's web site.

Even when fully staffed, staff members must be properly trained so that they have a full understanding and commitment to infection control, including the basics of hand-washing, PPE wear, and disinfection techniques.

There may be some disagreement about what is an appropriate funding level for long-term care providers, but there can be no dispute that direct care staff are low-paid. This is true in nursing homes, in OPWDD-certified group homes, and in home care. There also can be no dispute that most funding for long-term care comes from government, principally Medicaid. Those Medicaid funding rates presume (or drive) wage rates for direct care workers to or near minimum wage standards, even if those wage standards are described as "living wages". Low wages correlate with high staff turnover. High staff turnover increases training needs and costs. High staff turnover leads to less familiarity with residents. High staff turnover correlates to lower quality care. Means must be established to increase direct staff wage rates.

Infection control also requires that contagious staff not be at the worksite. New York has addressed this problem in regard to COVID-19 by requiring paid leave to those subject to quarantine or isolation orders. Paid staff sick leave must become a permanent fixture in long-term care. Medicaid funding levels must be adjusted to fully support the costs of that sick leave.

2. Visitation and Home Visits

One of the most unfortunate effects of the COVID-19 epidemic has been the severe restrictions that have been placed upon visitation and home visits. Those restrictions have caused depression and regression for residents of nursing and group

homes. When the only effective means to stop the spread is to isolate, those restrictions are understandable. The immense collateral damage they cause, however, must be recognized, constantly monitored, and minimized, if possible. Means of contact must be established. Video-conferencing works for business. It can help in congregate care. Whether the use of PPE can adequately minimize the risk of visits must also be considered. Finally, the restrictions themselves must be continuously reviewed for continued necessity, and altered as appropriate.

C. Clear Guidance

During an emergency, clear and consistent guidance from the various levels of government is important to ensure the safety of the public. The guidance should be understandable to the intended audience and should not conflict with other government requirements. When the Governor issued the March 25th directive, many nursing homes believed this meant they could not deny admittance or readmittance of a COVID-19-positive patient. Additionally, at this time the CDC guidance was different from the March 25th directive which put nursing homes in the untenable position of attempting to determine what they were supposed to do in order to be in compliance.

D. Prevent the Spread of Communicable Diseases

1. Empowered Infection Control Officers

Under current regulations, every nursing home must have an infection control plan. An employee must be responsible for the plan. Given the primacy of infection control, we think the position must be upgraded. Nursing homes must have a designated infection control officer reporting directly to the governing body. Subject to the governing body, the infection control officer must be responsible for development, implementation, and oversight of an infection control plan. The infection control officer

also must be responsible for identifying emergent infection risks and adapting the infection control plan as needed, especially in light of the lessons learned from COVID-19.

2. COVID-19 Nursing Homes and Wards

In some states, COVID-only nursing homes were established. In New York, some nursing homes established COVID-only floors or wards. These COVID-only solutions are disruptive to residents, but seem to have been effective in limiting the spread of COVID-19. State regulations should permit their further use if necessary, and require their use if necessary to control other serious epidemics.

E. Collect and Disseminate Information

The controversy over the reporting of COVID-related deaths in skilled nursing facilities is well known. There was also a complete lack of public reporting of COVID-19-related infection and deaths in facilities licensed or operated by OMH and OPWDD. Data transparency, in particular demographic data with respect to individuals living in long term care settings and the staff employed in these settings, is essential for syndemic analysis on public health and must be assured by New York State agencies going forward.

F. Allocate Resources

Plans must be made in advance for the identification, acquisition, and allocation of resources necessary to meet the needs of the health care delivery system. There must be a willingness to use already granted statutory authority, such as the Defense Production Act, in order to produce and allocate necessary supplies.

Funding is always an issue. In a nation that spends 17.7% of its gross domestic product on health care, an average of $11,852 per person,[379] it is difficult to say that more should be spent. There is, nevertheless, a lack of investment in certain areas of the healthcare system over decades that has caused significant misallocation compared to the need, and that must be addressed. The pandemic has exposed underinvestment, and the devastating impact on poor communities, which, in New York, are primarily communities of color. Funding must go where it is most needed, through structures that allow that funding to be used appropriately and efficiently. The pandemic has also exposed underinvestment and under-attention to public health. These must be corrected.

G. Long-Term Care Needs as a Priority

One of the public policy shortcomings that occurred as COVID-19 exploded in the dark days of March and April was the near absolute focus on the needs of hospitals, to the near exclusion to all other levels of care. This shortcoming was most glaring in the allocation of PPE. We recognize that PPE was in short supply in the early days of the epidemic, but there does not appear to have been a convincing reason to place the need for PPE in hospitals over the need in nursing homes. It was no answer to say that nursing homes should have had an adequate stock of PPE in place. The same was equally true of hospitals.

The health care system is a system of interlocking parts. Hospitals are the center of the system, attracting the most attention and money. But they do not stand

[379] *National Health Expenditure Data*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical#:~:text=The%20data%20are%20presented%20by,spending%20accounted%20for%2017.7%20percent (last visited Apr. 29, 2021).

alone. Nursing homes act as hospital extenders. Many nursing home residents are indistinguishable from hospital patients, but for the fact that for many nursing home residents, their respective conditions will not improve. And, as we have seen, nursing home residents were highly susceptible to the virus. That does not mean in all circumstances that the need in nursing homes is the same as in hospitals. It does mean that policymakers must take a broader view, especially when dealing with shortages. Like must be treated as like, and there must be consideration of what is alike.

Other long-term care providers faced even greater difficulties in securing PPE, and less help from State government in accessing PPE. In an instance of extreme shortage, priorities must be established. Nevertheless, in establishing priorities, some recognition must be made of other long-term care providers, including a recognition of the risk that the failure to address their needs portends.

H. Remove Politics from the Equation

Neither COVID-19 nor communicable or infectious diseases discriminate on the basis of political affiliation. These viruses do not care who is elected President, Governor, Mayor, or federal or state legislators. Politics, however, appears to have played an overly large and counterproductive role in dealing with this pandemic, especially on the federal level. Whether to mandate or advocate testing, vaccinations, mask-wearing and social distancing became political footballs, and not doing so became rallying cries, although largely after the first surge in New York. This led, at a minimum, to lack of acceptance among many about the virus and how to slow its spread, and this did impact the subsequent surges. Accurate data were not reported or

were presented in misleading fashion at the federal and state levels. Political rivalry between the Governor and the NYC Mayor created tensions and delays in efforts to halt the spread. In the end, the best advice of our public health experts was not timely followed. Effectively dealing with pandemics and major health crises requires putting political differences and ambitions aside, and relying upon the advice of experts who have been put in the positions they hold to prepare for and give that advice. .

Appendices

Appendix I: Executive Orders relating to Nursing Homes and Adult Homes

EO No.	Applicability
EO 202 **Issued:** 03/07/2020	**ALL; Hospitals and NHs**: suspends certain transfer and affiliation agreement requirements to permit rapid discharge, transfer and receipt of patients.
EO 202.5 **Issued:** 03/18/2020	**NHs**: suspends or modifies regulations relating to resident assessment and care planning; physician approvals for admission; admission policies and practices to facilitate resident transfer.
EO 202.5 **Issued:** 03/18/2020	**NHs**: suspends or modifies regulations relating to resident assessment and care planning; physician approvals for admission; admission policies and practices to facilitate resident transfer.
EO 202.10 **Issued:** 03/23/2020	**All healthcare providers**: relief from recordkeeping requirements and immunity relating to same.
EO 202.18 **Issued:** 04/16/2020	**Hospital or Nursing Home**: temporarily suspends licensure requirements to permit recent nurse practitioner graduates to practice in a hospital or nursing home. **SNF, NH, and ACFs**: Directs notification to family members or next of kin within 24 hours if any resident tests positive for COVID-19 or suffers a COVID-19 related death
EO 202.19 **Issued:** 04/17/2020	**SNF, NH or ACF**: Directs the imposition of penalty for non-compliance with EO 202.18 of $2,000 per violation per day.
EO 202.23 **Issued:** 04/24/2020	**SNF or ACF**: authorizes the Health Commissioner to suspend or revoke SNF or ACF operating certificate for failure to adhere to Commissioner's regulations or directives and to appoint a receiver to continue operations on 24 hours' notice
EO 202.30 **Issued:** 05/10/2020	NHs and ACFs: requires nursing homes and adult care facilities to test or make arrangements for the testing of all personnel twice per week pursuant to a plan [to be] developed by the facility administrator and filed with the Department of Health by 05/13/2020 and to report positive test results by

	5:00 pm on the day following receipt of the test results; authorizes the Commissioner to suspend or revoke the operating certificate of a nursing home or adult care facility for noncompliance with EO 202.30 or any regulations or directives issued by the Commissioner and to appoint a receiver to continue operations on 24 hours' notice; makes a false statement in the attestation punishable under Penal Code 210.45; subjects nursing home or adult care facility to a penalty for non-compliance of $2,000 per violation per day for noncompliance.
EO 202.32 **Issued:** 05/21/2020	**Clinical Labs, NHs and ACFs**: allows clinical laboratories to accept and examine specimens and test for COVID-19 specimens for NH and ACF personnel without a prescription and to report the results to operators and administrators; and facility administrators to contact the local health department for follow up for all facility personnel who test positive.
EO 202.40 **Issued:** 06/10/2020	**NHs and ACFs**: continues the testing requirements in EO 202.30 and amends it to require nursing homes and adult care facilities in Phase Two reopening regions to test or make arrangements to test all personnel for COVID-19 once per week.
EO 202.44 **Issued:** 06/21/2020	**Clinical Labs, NHs and ACFs:** allows clinical laboratories to accept specimens and test for COVID-19 for NH and ACF personnel without a prescription and to report the results to operators and administrators and requires facilities to report positives to the local health department for follow up for treatment and isolation orders; authorizes the Commissioner to suspend or revoke the operating certificate of a skilled nursing facility or adult care facility for noncompliance with any regulations or directives issued by the Commissioner and to appoint a receiver to continue the operations on 24 hours' notice.

EO 202.60 **Issued:** 09/04/2020	**Coroner, NHs, Hospitals, Hospice Agencies:** Directs the coroner or medical examiner to administer a COVID-19 and influenza test to a deceased person upon a reasonable suspicion that COVID-19 or influenza was a cause of death, where no such tests were performed within 14 days prior to death in a nursing home or hospital or by the hospice agency and to report the cause of death only after receiving the test results.
EO 202.73 **Issued:** 11/09/2020	**NHs (does not refer to ACFs):** Extends and modifies EO 202.30 and 202.40 to require nursing homes in red, orange, or yellow zones (under EO 202.68) to test or make arrangements for testing for COVID for all personnel.
EO 202.77 **Issued:** 11/23/2020	**NHs or ACFs:** Requires nursing homes and adult car facilities to comply with guidance for patients released for a leave of absence to visit friends or relatives (i.e., for the Thanksgiving holiday) upon the resident's return.
EO 202.88 **Issued:** 01/04/2021	**NHs:** Modifies EO 202.73, which modified EO 202.30, and 202.40, to require nursing homes to test all personnel at the facility in any area of the state irrespective of location in a micro-cluster zone as provided in EO 202.68.

Appendix II: New York State Regulatory Activity relating to Nursing Homes and COVID

Notice No./ Regulation	Issued	Subject of proposed rule
HLT-08-20-00001	02/26/2020 Emergency/ Proposed 05/27/2020 Emergency 07/01/2020 Finalized	Communicable Diseases Reporting and Control - Adding Severe or Novel Coronavirus: To require physicians, hospitals, nursing homes, D&TCs and clinical laboratories to report instances of severe or novel coronavirus
HLT-12-20-00004	03/25/2020 Emergency	Investigation of Communicable Disease; Isolation and Quarantine: Control of communicable disease.
HLT-17-20-00004	04/29/2020 Emergency	Immunizations and Communicable Diseases: To control and promote the control of communicable diseases to reduce their spread.
HLT-25-20-00002	06/24/2020 Emergency	Investigation of Communicable Disease; Isolation and Quarantine: Control of communicable disease.
HLT-30-20-00001	07/29/2020 Emergency	Enforcement of Social Distancing Measures: To control and promote the control of communicable diseases to reduce their spread.
HLT-31-20-00013	08/05/2020 Emergency 02/03/2021 Emergency	Hospital Personal Protective Equipment (PPE) Requirements: To ensure that all general hospitals maintain a 90-day supply of PPE during the COVID-19 emergency.
HLT-32-20-00001	08/12/2020 Emergency 02/03/2021 Emergency	Nursing Home Personal Protective Equipment (PPE) Requirements: To ensure that all nursing homes maintain a 90-day supply of PPE during the COVID-19 emergency.
HLT-34-20-00002	08/26/2020 Emergency	Surge and Flex Health Coordination System: Provides authority to the Commissioner to direct certain actions and waive certain regulations in an emergency. (**Full text is posted at the following State website: www.health.ny.gov/Laws&Regulations/Emergency**

		Regulations): Although the Governor retains authority to issue Executive Orders to temporarily suspend or modify regulations and issue directives pursuant to the Executive Law, these proposed regulatory amendments would provide an expedient and coherent plan to implement quickly the relevant temporary suspensions, modifications, and directives. The proposed regulatory amendments would permit the State Commissioner of Health or designee to take specific actions, as well as to temporarily suspend or modify certain regulatory provisions (or parts thereof) in Titles 10 and 18 of the NYCRR during a state disaster emergency, where such provisions are not required by statute or federal law. These proposed amendments would also permit the Commissioner to take certain actions, where consistent with any Executive Order (EO) issued by the Governor during a declared state disaster emergency. Examples include issuing directives to authorize and require clinical laboratories or hospitals to take certain actions consistent with any such EOs, as well as the temporary suspension or modification of additional regulatory provisions when the Governor temporarily suspends or modifies a controlling state statute. The proposed regulatory amendments would also require hospitals to: develop disaster emergency response plans; maintain a 90-day supply of personal protective equipment (PPE); ensure that staff capable of working remotely are equipped and trained to do so; and report data as requested by the Commissioner.
HLT-37-20-00007	09/16/2020 Emergency	Confirmatory COVID-19 and Influenza Testing: To require confirmatory COVID-19 and influenza testing in several settings to improve case statistics and contact tracing.
HLT-38-20-00001	09/23/2020 Emergency	Investigation of Communicable Disease; Isolation and Quarantine: Control of communicable disease. These regulations clarify the authority and duty of the New York State Department of Health ("Department") and local health departments to protect the public in the event of an outbreak of communicable disease, through appropriate public health orders issued to persons diagnosed with or exposed to a communicable disease. These regulations also require hospitals to report syndromic surveillance

		data to the Department upon direction from the Commissioner and clarify reporting requirements for clinical laboratories with respect to communicable diseases. **Full text is posted at: https://regs.health.ny.gov/regulations/emergency.**
HLT-43-20-00001	10/28/2020 Emergency	Enforcement of Social Distancing Measures: To control and promote the control of communicable diseases to reduce their spread.
HLT-44-20-0000	11/04/2020 Emergency	Hospital Personal Protective Equipment (PPE) Requirements: To ensure that all general hospitals maintain a 90-day supply of PPE during the COVID-19 emergency.
HLT-44-20-00011	11/04/2020 Emergency	Nursing Home Personal Protective Equipment (PPE) Requirements: To ensure that all nursing homes maintain a 90-day supply of PPE during the COVID-19 emergency.
HLT-47-20-00001	11/25/2020 Emergency	Surge and Flex Health Coordination System: Provides authority to the Commissioner to direct certain actions and waive certain regulations in an emergency. **(Full text is posted at the following State website: www.health.ny.gov/Laws&Regulations/Emergency Regulations):** Although the Governor retains authority to issue Executive Orders to temporarily suspend or modify regulations and issue directives pursuant to the Executive Law, these proposed regulatory amendments would provide an expedient and coherent plan to implement quickly the relevant temporary suspensions, modifications, and directives. The proposed regulatory amendments would permit the State Commissioner of Health or designee to take specific actions, as well as to temporarily suspend or modify certain regulatory provisions (or parts thereof) in Titles 10 and 18 of the NYCRR during a state disaster emergency, where such provisions are not required by statute or federal law. These proposed amendments would also permit the Commissioner to take certain actions, where consistent with any Executive Order (EO) issued by the Governor during a declared state disaster emergency. Examples include issuing directives to authorize and require clinical laboratories or hospitals to take certain actions consistent with any such EOs, as well as the temporary suspension or modification of additional regulatory provisions when the Governor temporarily suspends or modifies a controlling state statute. The

		proposed regulatory amendments would also require hospitals to: develop disaster emergency response plans; maintain a 90-day supply of personal protective equipment (PPE); ensure that staff capable of working remotely are equipped and trained to do so; and report data as requested by the Commissioner.
HLT-50-20-00001:	12/16/2020 Emergency	Enforcement of Social Distancing Measures: To control and promote the control of communicable diseases to reduce their spread.
HLT-50-20-00003	12/16/2020 Emergency	Confirmatory COVID-19 and Influenza Testing: To require confirmatory COVID-19 and influenza testing in several settings to improve case statistics and contact tracing.
HLT-51-20-00001	12/23/2020 Emergency	Investigation of Communicable Disease; Isolation and Quarantine: Control of communicable disease. These regulations clarify the authority and duty of the New York State Department of Health ("Department") and local health departments to protect the public in the event of an outbreak of communicable disease, through appropriate public health orders issued to persons diagnosed with or exposed to a communicable disease. These regulations also require hospitals to report syndromic surveillance data to the Department upon direction from the Commissioner and clarify reporting requirements for clinical laboratories with respect to communicable diseases. **(Full text is posted at: https://regs.health.ny.gov/regulations/emergency)**

Appendix III: COVID-Era Sub-Regulatory Guidance

A. Federal Nursing Home Guidance

Date	Title	
02/06/2020	CMS QSO 20-09-ALL, re Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV)	For 2019 novel coronavirus, CDC is currently advising adherence to Standard, Contact, and Airborne Precautions, including the use of eye protection (for more information, see CDC's Interim Infection Control Recommendations for 2019-nCoV). In addition to the review of CDC information by healthcare facilities, we encourage the review of appropriate personal protective equipment (PPE) use and availability, such as gloves, gowns, respirators, and eye protection. Medicare participating healthcare facilities should also have PPE measures and protocols within their emergency plans, especially in the event of potential surge situations.
03/04/2020	CMS QSO-20-12-All, re "Suspension of Survey Activities"	Effective immediately, survey activity is limited to the following (in Priority Order): all immediate jeopardy complaints and allegations of abuse and neglect; complaints alleging infection control concerns, including facilities with potential COVID-19 or other respiratory illnesses; statutorily required recertification surveys (Nursing Home, Home Health, Hospice, and ICF/IID facilities); any re-visits necessary to resolve current enforcement actions; initial certifications; surveys of facilities/hospitals that have a history of infection control deficiencies at the immediate jeopardy level in the last three years; surveys of facilities/ hospitals/ dialysis centers that have a history of infection control deficiencies at lower levels than immediate jeopardy.
03/04/2020	CMS QSO-20-14-NH, re "Guidance for Infection Control and	Per CDC, prompt detection, triage and isolation of potentially infectious patients are essential to prevent unnecessary exposures

	Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes"	among patients, healthcare personnel, and visitors at the facility. Therefore, facilities should continue to be vigilant in identifying any possible infected individuals. Facilities should consider frequent monitoring for potential symptoms of respiratory infection as needed throughout the day. A nursing home can accept a patient diagnosed with COVID-19 and still under Transmission-based Precautions for COVID-19 as long as it can follow CDC guidance for transmission-based precautions. If a nursing home cannot, it must wait until these precautions are discontinued.
03/13/2020	CMS QSO-20-14-NH REVISED, re "Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes (REVISED)"	CMS is providing additional guidance to nursing homes to help them improve their infection control and prevention practices to prevent the transmission of COVID-19, including revised guidance for visitation.
03/23/2020	CMS QSO-20-20-All, "Prioritization of Survey Activities:"	During this three-week timeframe [from the declaration of the PHE on 3/13/2020], only the following types of surveys will be prioritized and conducted: complaint/facility-reported incident surveys, triaged at the immediate jeopardy level; Targeted infection control surveys (using a streamlined review checklist).
04/02/2020	CMS and CDC COVID-19 Long-Term Care Facility Guidance	Nursing Homes should immediately ensure that they are complying with all CMS and CDC guidance related to infection control. • In particular, facilities should focus on adherence to appropriate hand hygiene as set forth by CDC. CMS has also recently issued extensive infection control guidance, including a self-assessment checklist that long-term care

		facilities can use to determine their compliance with these crucial infection control actions. • Facilities should also refer to CDC's guidance to long-term care facilities on COVID-19 and also use guidance on conservation of personal protective equipment (PPE) when unable to follow the long-term care facility guidance. 2. As long-term care facilities are a critical part of the healthcare system, and because of the ease of spread in long-term care facilities and the severity of illness that occurs in residents with COVID-19, CMS urges State and local leaders to consider the needs of long-term care facilities with respect to supplies of PPE and COVID-19 tests. State and local health departments should work together with long-term care facilities in their communities to determine and help address long-term care facility needs for PPE and/or COVID-19 tests. • Medicare is now covering COVID-19 testing when furnished to eligible beneficiaries by certified laboratories. These laboratories may also choose to enter facilities to conduct COVID-19 testing.
04/13/2020	CMS QSO-20-25-NH, re 2019 Novel Coronavirus (COVID-19) Long-Term Care Facility Transfer Scenarios	CMS is waiving requirements in 42 CFR 483.10(c)(5); 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), (c)(9), and (d); and § 483.21(a)(1)(i), (a)(2)(i), and (b) (2)(i) (with some exceptions) to allow a long term care (LTC) facility to transfer or discharge residents to another LTC facility solely for the cohorting purposes: transferring residents with symptoms of a respiratory infection or confirmed diagnosis of COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents; transferring residents without symptoms of a respiratory infection or confirmed to not have COVID-19 to another facility that agrees to accept each specific resident, and is dedicated to the care of such residents to

		prevent them from acquiring COVID-19; or transferring residents without symptoms of a respiratory infection to another facility that agrees to accept each specific resident to observe for any signs or symptoms of a respiratory infection over 14 days.
04/19/2020	CMS QSO-20-26-NH, re “Upcoming Requirements for Notification of Confirmed COVID-19 (or COVID-19 Persons under Investigation) Among Residents and Staff in Nursing Homes”	Facility Reporting Current requirements at 42 CFR 483.80 and CDC guidance specify that nursing homes notify State or Local health department about residents or staff with suspected or confirmed COVID-19, residents with severe respiratory infection resulting in hospitalization or death, or ≥ 3 residents or staff with new-onset respiratory symptoms within 72 hours of each other. At present, these data are not collected by CMS, CDC, or the Federal Emergency Management Agency (FEMA). CMS and CDC will soon provide nursing homes with specific direction on standard formatting and frequency for reporting this information through the CDC’s National Health Safety Network (NHSN) system. Currently, this information is provided optionally by nursing homes. The required collection of this information will be used to support surveillance of COVID-19 locally and nationally, monitor trends in infection rates, and inform public health policies and actions. This information may be retained and publicly reported in accordance with law. Resident and Resident Representative Reporting In addition to requiring reporting to CDC, *in rulemaking that will follow*, we will also be requiring that facilities notify its residents and their representatives to keep them informed of the conditions inside the facility. In *rulemaking that will follow this memorandum*, failure to report resident or

		staff incidences of communicable disease or infection, including confirmed COVID-19 cases (or Persons Under Investigation for COVID-19), or provide timely notification to residents and their representatives of these incidences, as required, could result in an enforcement action against the nursing home by CMS.
04/24/2020	CMS QSO-20-28-NH, re "Nursing Home Five Star Quality Rating System updates, Nursing Home Staff Counts, and Frequently Asked Questions"	Is a negative test for COVID-19 (SARS-CoV-2) required before a hospitalized patient can be discharged to a nursing home? A: No. For patients hospitalized with COVID-19, decisions about discharge from the hospital should be based on their clinical status, the ability of the accepting facility to meet their care needs and the infection control requirements specified below. Decisions about hospital discharge are distinct from decisions about discontinuation of Transmission-Based Precautions. (Additional guidance follows.)
05/06/2020	CMS QSO-20-29-NH, re "Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes"	On May 8, 2020, CMS will publish an interim final rule with comment period: COVID-19 Reporting Requirements: CMS is requiring nursing homes to report COVID-19 facility data to the Centers for Disease Control and Prevention (CDC) and to residents, their representatives, and families of residents in facilities.
05/18/2020	CMS CMS QSO-20-30-NH, "Nursing Home Reopening Recommendations for State and Local Officials"	Recommendations for State and Local Officials: CMS is providing recommendations to help determine the level of mitigation needed to prevent the transmission of COVID-19 in nursing homes. The recommendations cover the following items: o Criteria for relaxing certain restrictions and mitigating the risk of resurgence: Factors to inform decisions for relaxing nursing home restrictions through a phased approach. o

		Visitation and Service Considerations: Considerations allowing visitation and services in each phase. o Restoration of Survey Activities: Recommendations for restarting certain surveys in each phase.
06/01/2020	CMS QSO-20-31-All REVISED re "COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes"	• CMS has implemented a new COVID-19 reporting requirement for nursing homes, and is partnering with CDC's robust federal disease surveillance system to quickly identify problem areas and inform future infection control actions. • Following the March 6, 2020 survey prioritization, CMS has relied on State Survey Agencies to perform Focused Infection Control surveys of nursing homes across the country. We are now initiating a performance-based funding requirement tied to the Coronavirus Aid, Relief and Economic Security (CARES) Act supplemental grants for State Survey Agencies. Further, we are providing guidance for the limited resumption of routine survey activities. CMS has revised the criteria requiring states to conduct focused infection control surveys due to the increased availability of resources for the testing of residents and staff and factors related to the quality of care. CMS is providing Frequently Asked Questions related to health, emergency preparedness and life-safety code surveys. CMS is also enhancing the penalties for noncompliance with infection control to provide greater accountability and consequence for failures to meet these basic requirements.
06/04/2020	CMS QSO 20-32-NH, re "Release of COVID-19 Nursing Home Data"	Nursing Home COVID-19 Information: CMS will post COVID-19 data submitted by facilities via the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN). The information will

		also be available at https://data.cms.gov/Covid19-nursing-home-data.
06/04/2020	CMS QSO 20-33-NH, dated "Posting of Nursing Home Inspections"	Nursing Home Inspections: CMS will post health inspection (i.e., surveys) results that were conducted on or after March 4th, 2020, which is the first date that CMS altered the way that inspections are scheduled and conducted. This includes inspections related to complaints and facility-reported incidents (FRIs) that were triaged at the Immediate Jeopardy (IJ) level, and the streamlined Infection Control inspection process that was developed based on the guidance for preventing the spread of COVID-19. • The information will be available in the "Spotlight" section of the Nursing Home Compare home page on June 4th, 2020.
06/25/2020	CMS QSO 20-34-NH, "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"	Changes to the Nursing Home Compare Website and Five Star Quality Rating System: • Staffing Measures and Ratings Domain: On July 29, 2020, Staffing measures and star ratings will be held constant, and based on data submitted for Calendar Quarter 4 2019. o Also, CMS is ending the waiver of the requirement for nursing homes to submit staffing data through the Payroll-Based Journal System. Nursing homes must submit data for Calendar Quarter 2 by August 14, 2020. • Quality Measures: On July 29, 2020, quality measures based on a data collection period ending December 31, 2019 will be held constant.
07/09/2020	CMS QSO-20-28-NH REVISED re: "Nursing Home Five Star Quality Rating System updates, Nursing Home Staff Counts,	• Nursing Home Compare website & Nursing Home Five Star Quality Rating System: We are announcing that the inspection domain will be held constant temporarily due to the prioritization and suspension of certain surveys, to ensure the rating system reflects fair information for consumers. • Posting of

	Frequently Asked Questions, and Access to Ombudsman (REVISED)"	surveys: CMS will post a list of the surveys conducted after the prioritization of certain surveys, and their findings, through a link on the Nursing Home Compare website. • Nursing Home Staff: CMS is publishing a list of the average number of nursing and total staff that work onsite in each nursing home, each day. This information can be used to help direct adequate personal protective equipment (PPE) and testing to nursing homes. • Access to Ombudsman: We are reminding facilities that providing ombudsman access to residents is required per 42 CFR § 483.10(f)(4)(i) and per the Coronavirus Aid, Relief, and Economic Security Act (CARES Act). • Frequently Asked Questions (FAQ): We are releasing a list of FAQs to clarify certain actions we have taken related to visitation, surveys, waivers, and other guidance.
08/17/2020	CMS QSO-20-35-ALL, dated "Enforcement Cases Held during the Prioritization Period and Revised Survey Prioritization"	• CMS is revising guidance on the expansion of survey activities to authorize onsite revisits and other survey types. • CMS is providing guidance to State Survey Agencies (SAs) on resolving enforcement cases: CMS is providing guidance on resolving enforcement cases that were previously directed to be held, and providing guidance on Civil Money Penalty (CMP) collection. • Expanded Desk Review Authority: CMS is temporarily expanding the desk review policy to include review of continuing noncompliance following removal of Immediate Jeopardy (IJ), which would otherwise have required an onsite revisit from March 23, 2020, through May 31, 2020. • CMS is also issuing updated guidance for the re-prioritization of routine SA Clinical Laboratory Improvement Amendments (CLIA) survey activities, subject to the SA's discretion, in addition to lifting the restriction on processing CLIA enforcement actions, and issuing the

		Statement of Deficiencies and Plan of Correction (Form CMS-2567).
08/26/2020	CMS QSO-20-38-NH re "Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements and Revised COVID-19 Focused Survey Tool"	• On August 25, 2020, CMS published an interim final rule with comment period (IFC). This rule establishes Long-Term Care (LTC) Facility Testing Requirements for Staff and Residents. Specifically, facilities are required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the HHS Secretary. This memorandum provides guidance for facilities to meet the new requirements. • Revised COVID-19 Focused Survey Tool -To assess compliance with the new testing requirements, CMS has revised the survey tool for surveyors. We are also adding to the survey process the assessment of compliance with the requirements for facilities to designate one or more individual(s) as the infection preventionist(s) (IPs) who are responsible for the facility's infection prevention and control program (IPCP) at 42 CFR § 483.80(b). In addition, we are making a number of revisions to the survey tool to reflect other COVID-19 guidance updates.
08/26/2020	CMS QSO-20-37-CLIA,NH re "Interim Final Rule (IFC), CMS-3401-IFC, Updating Requirements for Reporting of SARS-CoV-2 Test Results by (CLIA) of 1988 Laboratories, and Additional Policy and Regulatory Revisions in Response to the	• On August 25, 2020, an interim final rule with comment period (IFC) went on display at the Federal Register. • CLIA regulations have been updated to require all laboratories to report SARS-CoV-2 test results in a standardized format and at a frequency specified by the Secretary. • Failure to report SARS-CoV-2 test results will result in a condition level violation of the CLIA regulation and may result the imposition of a Civil Money Penalty (CMP) as required under §§ 493.1804 and 493.1834. • Long-Term Care (LTC) Enforcement requirements at 42 CFR part 488 have been revised to include requirements specific to the imposition of a

	COVID-19 Public Health Emergency"	CMP for nursing homes that fail to report requisite COVID-19 related data to the Centers for Disease Control and Prevention (CDC) National Healthcare Safety Network (NHSN) per §483.80(g)(1) and (2). • LTC Facility Testing Requirements for Staff and Residents- Facilities are required to test staff and to offer testing to all nursing home residents.
09/17/2020	CMS QSO-20-39, re "Nursing Home Visitation - COVID-19"	• Visitation Guidance: CMS is issuing new guidance for visitation in nursing homes during the COVID-19 PHE. The guidance below provides reasonable ways a nursing home can safely facilitate in-person visitation to address the psychosocial needs of residents. • Use of Civil Money Penalty (CMP) Funds: CMS will now approve the use of CMP funds to purchase tents for outdoor visitation and/or clear dividers (e.g., Plexiglas or similar products) to create physical barriers to reduce the risk of transmission during in-person visits.
10/05/2020	CMS QSO-21-02-NH re "Compliance with Residents' Rights Requirement related to Nursing Home Residents' Right to Vote"	• The Centers for Medicare & Medicaid Services (CMS) is affirming the continued right of nursing home residents to exercise their right to vote. • While the COVID-19 Public Health Emergency has resulted in limitations for visitors to enter the facility to assist residents, nursing homes must still ensure residents are able to exercise their Constitutional right to vote. • States, localities, and nursing home owners and administrators are encouraged to collaborate to ensure a resident's right to vote is not impeded.

Appendix III: COVID-Era Sub-Regulatory Guidance (cont'd)

B. New York State Department of Health

03/6/2020	"Visitor Signage for Posting at Nursing Homes"	Sign states, "ATTENTION ALL VISITORS DO NOT VISIT if you have fever, shortness of breath, cough, nasal congestion, runny nose, sore throat, nausea, vomiting and/or diarrhea."
03/8/2020	"Notification Regarding Visitor Restrictions for New Rochelle-Area Nursing Homes and ACFs"	Many asymptomatic individuals can carry COVID-19 ("coronavirus"), and there have been confirmed coronavirus cases in your local community. Effective immediately, to minimize resident exposure, all nursing homes and adult care facilities (ACFs) in the New Rochelle area must suspend all visitation, including by family and other resident guests. Only staff, residents, and staff of the local and State Health Departments should be permitted access to your facility, except in an emergency, through March 22, 2020.
03/11/2020	"Revised COVID-19 Guidance for Nursing Homes"	Provides guidance on preventing exposure to and spread of illness at the nursing home; requires screening, signage addressing visitation restrictions; precautionary or mandatory quarantine, based on symptoms, for staff who have been potentially exposed to someone with confirmed COVID-19, or to someone who is a person under investigation (PUI) for COVID-19 and furlough for 14 days following the exposure; provides guidance for Standard, Droplet and Contact precautions (applicable for the care of all residents) at: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/prevent-spreadin-long-term-care-facilities.html and procedures for donning/ doffing PPE at: https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf; hand hygiene practices and respiratory hygiene/cough etiquette; daily; frequent cleaning and disinfection of

		commonly touched environmental surfaces; conservation of PPE, including "administrative controls on the availability of masks by centrally holding and allocating masks to staff as necessary."
03/13/2020	COVID-19 Cases in Nursing Homes and ACFs	Provides guidance to prevent the introduction of COVID-19 into NHs and ACFs, including the immediate suspension of all visitation except when medically necessary (i.e. visitor is essential to the care of the patient or is providing support in imminent end-of-life situations) or for family members of residents in imminent end-of-life situations, and those providing hospice care; the provision of other methods to meet the social and emotional needs of residents, such as video calls; signage notifying the public of the suspension of visitation and proactively notify resident family members; health checks for all healthcare personnel and other facility staff at the beginning of each shift; use of a facemask while within 6 feet of residents. Extended wear of facemasks is allowed; facemasks should be changed when soiled or wet and when HCP go on breaks. Facilities should bundle care and minimize the number of HCP and other staff who enter rooms to reduce the number of personnel requiring facemasks.
03/20/2020	Recommendations to Protect Nursing Home Residents	Recommendations to support resident physical health, including cancellation of communal dining and group activities; restriction of visitors and non-essential health care personnel, except for certain compassionate care situations, such as imminent end-of life situation; allow all provisional employees of nursing homes to work with supervision; implement active health screening every shift, at least every eight hours or as needed of residents and staff for fever and respiratory symptoms; implement health care worker daily alerts;

		review and revision of processes for interacting with vendors and others; creating/increasing listserv communication to update families, with staff to serve as the primary contact to families for inbound calls and conducting regular outbound calls to keep families up to date; advising visitors and others entering the nursing home to monitor for signs and symptoms of respiratory infection for at least 14 days after exiting the facility.
03/21/2020	Respiratory Illness in Nursing Homes and ACFs in Areas of Sustained Community Transmission of COVID-19	Recent testing of residents and healthcare workers (HCWs) of nursing home and adult care facilities in New York City, Long Island, Westchester and Rockland counties has revealed that symptoms of influenza-like illness are very often determined to be COVID-19 in facilities located in areas with sustained community transmission. As a result, ANY febrile acute respiratory illness or clusters of acute respiratory illness (whether febrile or not) in NHs and ACFs in New York City, Long Island, Westchester County, or Rockland County should be presumed to be COVID-19 unless diagnostic testing reveals otherwise. Testing of residents and HCWs with suspect COVID-19 is no longer necessary and should not delay additional infection control actions. All facilities in areas of the state with sustained community transmission of COVID-19 including New York City, Long Island, Westchester and Rockland with residents who have febrile acute respiratory illness or with clusters of acute respiratory illness should follow the guidance from the NYSDOH advisory issued on March 13, 2020 for COVID-19 Cases in Nursing Homes and Adult Care Facilities in the section entitled “If there are confirmed cases of COVID-19 in a NH or ACF”.

		NHs and ACFs outside of these areas should continue to pursue testing of residents and HCWs with suspect COVID-19 to inform control strategies.
03/25/2020	Hospital Discharges and Admissions to Nursing Homes	COVID-19 has been detected in multiple communities throughout New York State. There is an urgent need to expand hospital capacity in New York State to be able to meet the demand for patients with COVID-19 requiring acute care. As a result, this directive is being issued to clarify expectations for nursing homes (NHs) receiving residents returning from hospitalization and for NHs accepting new admissions. Hospital discharge planning staff and NHs should carefully review this guidance with all staff directly involved in resident admission, transfer, and discharges. During this global health emergency, all NHs must comply with the expedited receipt of residents returning from hospitals to NHs. Residents are deemed appropriate for return to a NH upon a determination by the hospital physician or designee that the resident is medically stable for return. Hospital discharge planners must confirm to the NH, by telephone, that the resident is medically stable for discharge. Comprehensive discharge instructions must be provided by the hospital prior to the transport of a resident to the NH. No resident shall be denied re-admission or admission to the NH solely based on a confirmed or suspected diagnosis of COVID-19. NHs are prohibited from requiring a hospitalized resident who is determined medically stable to be tested for COVID-19 prior to admission or readmission.

03/26/2020	March 26th COVID-19 Infection Control Guidance for Nursing Homes and ACFs Webinar Slides	Powerpoint presentation.
03/31/2020	Updated Protocols for Personnel in Healthcare and Other Direct Care Settings to Return to Work Following COVID-19 Exposure or Infection (Nursing Homes Only – Superseded by July 24th Guidance for Other Settings/Services)	This advisory supersedes guidance from the New York State Department of Health to Hospitals, Nursing Homes (NHs) and Adult Care Facilities (ACFs) pertaining to the COVID-19 outbreak, released on March 16, 2020, and further clarifies the updated guidance issued on March 28, 2020. Provides guidance to circumstances under which entities may allow healthcare personnel (HCP) to work after exposure to confirmed or suspected case of COVID-19, or who have traveled internationally in the past 14 days, whether healthcare providers or other facility staff.
04/03/2020	COVID-19 Guidance for Inpatient, Rehabilitation, and Skilled Nursing Facilities and Other Health Care Providers on Suspension of Health Plan Utilization Review Requirements	
04/04/2020	"Guidance for Resident and Family Communication in ACFs and Nursing Homes"	Strongly encourages the implementation of a communication protocol for both residents and their families, loved ones, and guardians unable to visit the resident during the COVID-19 pandemic and offers best practices to consider.
04/04/2020	"In Response to COVID-19, CMS Has Released 1135 Waivers to Address an Adequate Supply	Provides guidance and recommendations relating to CMS's temporary waiver of nurse aide training and certification requirements to assist with potential staffing challenges during the COVID-19 pandemic.

	of Workforce Staff and Facilities”	
04/11/2020	“Nursing Home COVID-19 Preparedness Self-Assessment Checklist”	
04/19/2020	DAL: BFD 20-04, Updated COVID-19 Guidance for Health Care Facilities Regarding Management of Decedent Personal Effects	In response to multiple inquiries regarding the management of decedent personal effects during the COVID-19 public health emergency, the NYS Department of Health (the Department) Bureau of Funeral Directing is distributing the following guidance from the Office of the Chief Medical Examiner’s (OCME) Biological Incident Fatality Surge Plan for Managing In- and Out-of-Hospital Deaths, to assist health care facilities in New York City (NYC).
04/19/2020	“Discontinuation of Isolation for Patients with COVID-19 Who Are Hospitalized or in Nursing Homes, Adult Care Homes, or Other Congregate Settings with Vulnerable Residents”	Provides guidance on the discontinuation of isolation for patients with COVID-19 when they meet the specified conditions. •
04/19/2020,	CPSO DAL 20-01 “Guidance for Nursing Homes on Managing Resident Deaths During the COVID-19 Outbreak”	Due to the COVID-19 public health emergency, the New York State Department of Health (DOH) is distributing the following guidance to assist nursing homes in processing the removal of decedents. This guidance is intended for nursing homes that may be experiencing an increase in resident deaths, as well as nursing homes that may be relying upon new staff to perform this sensitive responsibility.
04/19/2020,	DAL 20-01, Guidance for Resident and Family	Provides guidance and offers “best practices” on innovative ways to keep residents connected to their families and communities.

	Communication in ACFs and Nursing Homes	
04/29/2020	Infection Control and Cohorting Requirements	This letter is intended to serve as a reminder of facility obligations under the Public Health Law and regulations to ensure that all residents receive the care they need. Specifically, pursuant to 10 NYCRR section 415.26, nursing homes must only accept and retain those residents for whom the facility can provide adequate care.
04/29/2020	Extension of COVID-Related Work Exclusion Period for Nursing Home Staff	On March 16, 2020, the Centers for Disease Control and Prevention (CDC) issued guidance to address employees of healthcare facilities, including nursing homes, suspected of or confirmed to be positive for the COVID-19 virus (Criteria for Return to Work for Healthcare Personnel with Confirmed or Suspected COVID-19 (Interim Guidance)). Under the CDC guidance workers could return to work at a nursing home: “At least 3 days (72 hours) have passed since recovery defined as resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath); and, At least 7 days have passed since symptoms first appeared.” The CDC updated their guidance to address asymptomatic workers thereafter. New York State Department of Health’s guidance mirrored the CDC’s position – however, going forward we will no longer adhere to CDC’s standard on this issue, and will instead require that nursing home employees who test positive for COVID-19 but remained asymptomatic are not eligible to return to work for 14 days from first positive test date in any situation and will no longer adhere to the shorter CDC timeframe. Symptomatic nursing home employees may

		not return to work until 14 days after the onset of symptoms, provided at least 3 days (72 hours) have passed since resolution of fever without the use of fever-reducing medications and respiratory symptoms are improving. For those nursing homes facing staffing difficulties the State of New York has established an online portal that currently includes more than 95,000 healthcare workers across New York State and nation. Four hundred nursing homes have been invited to access the portal, and more than 200 have used the portal to date. Many nursing homes are also working with partner organizations, like SEIU-1199, to recruit staff from the portal. We have also provided 400 nursing homes the opportunity to access for free the full recruiting tools of Indeed, the world's largest job search engine, which has identified 1,500 nurses who immediately available to work in New York State. If your nursing home needs additional assistance, please contact CovidStaffingPortal@exec.ny.gov or call 518-474-2012.
05/06/2020	"Pediatric Multi-System Inflammatory Syndrome Potentially Associated with COVID-19 in Children"	The purpose of this health advisory is to (1) ensure providers are aware of the pediatric multi-system inflammatory syndrome potentially associated with COVID-19 and (2) provide guidance on reporting of cases to NYS DOH and testing of patients who present with this disease.
05/11/2020	"Hospital Discharges and Admissions to Nursing Homes and ACFs (Addendum to May 11th DAL - Required COVID-19 Testing for All Nursing	This Directive supplements the prior Department of Health Advisory concerning hospital discharges to nursing homes (NHs) and adult care facilities (ACFs), as well as the DAL sent on April 29, 2020. To this end, hospital discharge planners must confirm to the facility to which the patient is being discharged (whether NH or

Home and ACF Personnel)"

ACF), by telephone, that the resident is medically stable for discharge. Comprehensive discharge instructions must be provided by the hospital prior to the transport of a resident to the NH or ACF, and all discharge planning requirements must be followed.

In accordance with 10 NYCRR 415.26, NHs must only accept and retain those residents for whom the facility can provide adequate care. ACFs have an obligation to provide care to residents and ensure their life, health, safety and welfare are protected, pursuant to Social Services Law § 461-c(2-a) and 18 NYCRR 487.7 and 488.7. Therefore, no hospital shall discharge a patient to a NH or ACF unless the facility administrator has first certified that they are able to provide that patient with adequate care. In addition, hospitals must test any patient who may be discharged to a NH or ACF for COVID-19, using a molecular test for SARS-Cov-2 RNA. No hospital shall discharge a patient who has been diagnosed with COVID-19 to a NH or ACF, until that patient has received one negative test result using such testing method.

If a NH or ACF is not able to provide adequate care to a resident at any time during that resident's stay, the NH or ACF must call their respective regional office of the Department of Health to provide necessary information and assist with any relocation needs, including but not limited to assistance with arranging transportation to an alternate facility that can provide adequate care for the resident.

However, with the exception of patients of hospitals who have not yet tested negative, a NH or ACF cannot deny admission of a

		resident based solely on a resident's COVID-19 diagnosis.
05/11/2020	"Required COVID-19 Testing for All Nursing Home and Adult Care Facility Personnel"	Provides guidance on EO 202.30, which requires periodic COVID-19 testing of all personnel in nursing homes and adult care facilities. This DAL explains the requirements of the Executive Order and provides additional direction and guidance on how to implement its requirements.
05/12/2020	"Nursing Home and ACF Staff Testing Requirement FAQ #1 – May 12, 2020"	
05/13/2020	Nursing Home Cohorting FAQs	Provides guidance on resident cohorting.
05/19/2020	"Nursing Home and ACF Staff Testing Requirement FAQ Update – May 19, 2020 (Superseded by June 24, 2020 Update)"	
05/19/2020,	"DOH Issues FAQ on "Cohorting" of Residents"	Nursing home members encouraged to review and operationalize guidance.
06/24/2020	"Nursing Home and ACF Staff Testing Requirement FAQ Update – June 24, 2020"	
07/10/2020	"COVID-19 Cases in Nursing Homes and ACFs (Revised July 10, 2020)"	
07/17/2020	"Civil Monetary Penalty Reinvestment Funds:	

	Communication Devices”	
07/17/2020	“Notification of Non-emergent Resident Transfers to the Hospital and SNFs”	
07/20/2020	“Civil Monetary Penalty Reinvestment Funds Available to Nursing Homes”	Grant awards would aid in purchasing devices for resident communication.
07/20/2020	“DOH Issues Guidance on Resident Transfers”	DOH requires notification prior to certain nursing home transfers.
07/20/2020	“DOH Issues Guidance on Resident Transfers”	DOH requires notification prior to certain nursing home transfers.
08/20/2020,	“Required Annual Pandemic Emergency Plan for All Nursing Homes”	
09/01/2020	“Amended PPE Requirements for Nursing Homes”	

Appendix III: COVID-Era Sub-Regulatory Guidance (cont'd)

C. Office of Mental Health

Date	Title	Addressee(s)	Summary/important points
03/10/2020	Interim Guidance for Cleaning and Disinfection of Public and Private Facilities for COVID-19 (Note: NYSDOH Guidance)	Unspecified.	How to perform cleaning and disinfection in "high risk locations," in public and private facilities.
03/11/2020	Guidance for NYS Behavioral Health Programs (funded, operated, licensed, regulated, or designated providers) (Note: This guidance was referenced in the Consolidated Telemental Health Guidance issued 3/30/2020).	Unspecified.	This guidance is based on CDC and NYSDOH guidelines for COVID-19 infection prevention and control and management of Persons Under Investigation ("PUI"). Outlines screening protocol for patients (international travel, contact with people suspected or confirmed of COVID-19, whether they are currently exhibiting COVID-19 symptoms such as cough, fever, sore throat, or shortness of breath) and what to do when patients do not clear the screening process. Outlines the visitation process for any program setting (pre-screening process and procedure for handling visitors who do not clear the screening process, unscheduled visitation procedures, etc.)
03/13/2020	Provider Memo – Maintaining Continuity of	Unspecified.	Encourage all providers to develop or revise their continuity of operations plans in light of COVID-19, particularly considering the ability of individuals to

	Operations Plans and Reporting Disruptions in Services		obtain medications, access to mental health and substance use disorder treatment, and access to other required services.
03/14/2020	COVID-19 Guidance for Health Homes (Note: NYSDOH Guidance)	Medicaid Health Homes Serving Adults and Children, Care Coordination Organization/ Health Homes and Care Management Agencies	Face-to-face requirements for Health Home providers are temporarily waived until rescinded by the NYSDOH, unless medically necessary. Instead, Health Home providers may use telehealth services. In the event of face-to-face visits, members must be screened for COVID-19 symptoms (fever, cough, shortness of breath), their travel or their close contacts' travel outside of the United States in the last 14 days, their contact within the last 14 days with people with suspected or confirmed COVID-19. If the member screens positive, they should be referred to the appropriate medical personnel. If the member screens negative, the face-to-face visit may continue. Agencies should implement policies to screen staff for COVID-19 symptoms and contacts before face-to-face visits with members. Staff who are ill upon screening should be sent home and should either contact their primary care physician or seek immediate care, if necessary. Staff with symptoms of illness should not return to work until they have completely recovered. Agencies must strictly enforce their illness and sick leave policies. Staff with suspected or confirmed COVID-19 exposure may be placed under movement restrictions by public health officials.

03/14/2020	OMH Psychiatric Center Visitor Restriction Guidance (Visitor, volunteer, and student restrictions at Psychiatric Centers)	Facility Directors, Clinical Directors, Chief Nursing Officers	Effective immediately, all visitors to adults in Psychiatric Center civil and forensic inpatient units, as well as all students and volunteers who have no clinical responsibilities, are restricted. This does not apply to children and adolescents living in Psychiatric Center inpatient units, who may have visitors who are subject to previously issued screening protocols. Staff must notify families of staff of these restrictions as soon as possible. Psychiatric Centers must identify protocols for exceptions to these restrictions. Psychiatric Centers "must ensure that patients have easily available means to stay in contact with family and others. This includes ready access to phones, either through cellular or land lines. Additionally, patients who are deemed appropriate for the use of internet social media accounts should have the means to access them as needed. Every inpatient unit must identify multiple ways for patients to communicate." These restrictions do not apply to residential care units on Psychiatric Center grounds.
03/18/2020	Addendum OMH Psychiatric Visitor Volunteer Restrictions (addendum to visitor, volunteer, and student restrictions at Psychiatric Centers with	Child and Adolescent Inpatient Program Facility Directors, Clinical Directors, Chief Nursing Officers	Limits visitors to children and adolescents on inpatient units to "only those who are essential to the care and wellbeing of the patient." Visitors who are approved must be screened, limited to no more than two at a time, and must be educated about infection control and mitigation precautions. Social distancing measures must be implemented in visiting spaces and visiting spaces must be cleaned and disinfected in between visits. As stated above, psychiatric centers must ensure multiple, easily

	focus on visitors to child and adolescent patients)		accessible methods of communication, including access to social media accounts when appropriate.
03/20/2020	Admissions and Continuity of Care Advisory	Unspecified.	The State expanded the definition of “telemental health,” allowing essentially all staff in OMH licensed, funded, and designated programs and services to provide service using telemental health. This includes a waiver of the in-person initial assessment requirement in 14 NYCRR Part 596.6(b)(1), which can now be completed via telemental health during the COVID-19 emergency. Housing providers should screen and accept new admissions where there are vacancies to support the discharge of individuals from more intensive facilities. Allowed verbal consent for admissions and treatment/service plans and waived face-to-face requirements for behavioral health services. Ability to provide face-to-face services should be maintained for when it is safe and necessary to do so.
03/20/2020	Essential Business Letter	Unspecified.	OMH authorized, operated, licensed, designated, or funded service providers are essential businesses that are exempt from the in-person workplace restrictions imposed on businesses and nonprofit entities by Governor Cuomo’s Executive Order 202.7 (effective March 21, 2020 at 8:00 p.m.), and should therefore remain operational to provide mental health services for those under its care and custody, including administrative offices and employees performing essential agency functions.

03/25/2020	Frequently Asked Questions from Supportive Housing Providers Re: COVID-19	Not-For-Profit Supportive Housing Providers	Provides answers to questions regarding: state contract requirements; resident screening protocols; quarantine protocol for single room occupancy ("SRO") residents; provision of personal protective equipment ("PPE"); screening visitors; telemental health guidance; sending clients for testing; cleaning supplies
03/30/2020	OMH COVID-19 Consolidated Telemental Health Guidance (Use of Telephone and Two-way Video Technology by OMH-Licensed, Funded or Designated Providers and Clients Affected by the COVID-19 Pandemic)	Unspecified.	Applies to OMH licensed, funded, or approved programs/agencies. Includes expanded definitions for the terms "telemental health" and "telemental health practitioner" (section 4), billing modifiers (section 5), guidance for service delivery and billing for OMH-licensed programs and OMH-designated services (section 6), OMH-licensed or funded residential programs (section 7), service delivery for OMH-funded programs (section 8), Comprehensive Psychiatric Emergency Programs ("CPEP") and Inpatient Programs (section 9), guidance for the prescription of controlled substances (section 10), and consent for treatment and client signatures on treatment plans.
03/30/2020	Self-Attestation of Compliance to Offer Telemental Health Services	Unspecified.	Must certify: "1. That the practitioner(s) will possess a current and valid license, permit, limited permit or other credential to the extent required in NYS to deliver the service. 2. That transmission linkages on which Telemental Health Services will be performed, will be dedicated, secure, and meet minimum federal and NYS requirements.

			3. That confidentiality will be maintained as required by New York State Mental Hygiene Law Section 33.13 and 45 CFR Parts 160 and 164 (HIPAA Privacy Rules). (HIPAA confidentiality requirements have been relaxed to permit service delivery via telehealth. NYS confidentiality requirements found in MHL 33.13 remain in effect and apply to all programs and services regulated by OMH, but do not prohibit service delivery via telehealth.) 4. That claim modifiers “95” or “GT” will be used on each claim line that represents a service via telemental health. 5. An understanding that this approval is time-limited and effective only during the disaster emergency, and once the disaster emergency has ended the formal approval process will go back into effect.”
04/17/2020	Interim Background Check (Guidance for Implementation of Executive Order 202.13 Provisions Regarding Background Checks)	Unspecified.	Modifies background check process for OMH licensed, funded, or approved programs. The purpose of the guidance is to respond to staff shortages, but any OMH provider can still maintain the standard background check process. <u>Staff Members Currently Employed by an OMH Provider:</u> Current OMH employees may bypass a new Criminal Background Check, Staff Exclusion Check, or Statewide Central Register Check. Authorized programs must complete the Executive Order (“EO”) 202.13 Criminal Background Check Request form for the prospective employee and send this form to OMH. OMH will then send this form to the Justice Center, who will review the

information and advise OMH (within one business day unless additional information is requested) about whether the individual may be hired under EO 202.13. If they are not hired under EO 202.13, they should be treated as a new staff member (see below). After hearing from the Justice Center, OMH must communicate the decision within 24 hours to the authorized program via phone or email. Employees who continue to work in the authorized program on a regular basis will be required to complete an updated criminal background check as soon as practicable.

Staff Members Currently Employed by a Provider of Another State Oversight Agency:

Current employees of Office of Addiction Services and Supports ("OASAS") certified, funded, or authorized programs, Office for People with Developmental Disabilities ("OPWDD") or their approved providers, or Office of Children and Family Services ("OCFS") operated, licensed, or certified programs may bypass a new Criminal Background Check, Staff Exclusion Check, or Statewide Central Register Check. These providers should follow the process outlined above, and regular employees are also subject to an updated criminal background check.

New Staff Members Not Otherwise Employed by an Approved Provider (those who have not completed a background check)

These employees may work unsupervised as long as they do not appear on the Staff Exclusion List and

			have completed the Executive Order 202.13 Criminal History Information Attestation form. Unsupervised contact should be limited as much as possible. Article 23-A of the NYS Correction Law will be considered in the hiring process. These employees are still required to complete all other pre-employment checks.
04/19/2020	Discontinuation of Isolation for Patients with COVID-19 Who Are Hospitalized or in Nursing Homes, Adult Care Homes, or Other Congregate Settings with Vulnerable Residents (Note: NYSDOH Guidance)	Hospitals, Nursing Homes, Adult Care Homes, and Other Congregate Settings Where Populations Vulnerable to COVID-19 Reside	The NYSDOH suggests two testing strategies. The Non-Test-Based Strategy: Requires individuals to meet three criteria: 1. At least 72 hours have passed since recovery (e.g., no temperature greater than or equal to 100.0 without the use of fever-reducing medication); 2. Improvement of respiratory symptoms (e.g., cough, shortness of breath); and 3. At least 14 days have passed since the onset of COVID-19 symptoms. Patients who meet these criteria but remain symptomatic should be placed in their own rooms or be cohorted with other recovering residents of confirmed COVID-19. These patients must remain in their rooms and wear a facemask when caregivers enter their rooms. The test-based strategy (recommended for severely immunocompromised people): To discontinue isolation, patients must meet three criteria: 1. They must not have a fever without the use of fever-reducing medication (time is not specified);

			2. Their respiratory symptoms must have improved; and 3. They must have two negative test results that are taken at least 24 hours apart. For patients who were asymptomatic at the time of their first positive test and continue to be asymptomatic, evaluation for discontinuation of isolation may begin 7 days after the first positive test.
04/20/2020	Effective Date of OMH COVID-19 Disaster Emergency Telemental Health and Program Guidance	Unspecified.	The effective date for COVID-19-related disaster emergency relief issued by OMH is March 7, 2020. All telemental health and program, documentation, and billing guidance discussed may be operationalized retroactive to March 7, 2020.
04/21/2020	Incident Reporting and NIMRS Updates	NYS Article 31 Mental Health Provider Agencies; NYS Article 28 Hospital Provider Facilities; OMH-Operated Psychiatric Center Executive Directors, Quality and Risk Management Directors	New York State Incident Management and Reporting System (NIMRS) has been updated to include a new subtype ("COVID-19 Related") when reporting client deaths which can be attributed to, or are suspected to be related to, COVID-19. This only applies to deaths that occurred since March 1, 2020 (this subtype cannot be used for deaths that occurred prior to March 1, 2020). Incident reports that are closed should be reopened and amended as necessary. OMH is not requiring providers to report suspected or confirmed COVID-19 cases. Providers should adhere to 14 NYCRR Part 524 regulations for all incident reporting requirements.

04/26/2020	DOH COVID-19 Revised Testing Protocol (Updated Interim Guidance: Protocol for COVID-19 Testing Applicable to All Health Care Providers and Local Health Departments)	Health Care Providers, Health Care Facilities, and Local Health Departments	Testing is authorized by a health care provider when: 1. An individual is symptomatic or has a history of symptoms of COVID-19, especially if the individual is 70 years of age or older, is immunocompromised, or has underlying health conditions; 2. An individual had close (within six feet) or proximate contact with another individual who is positive with COVID-19; 3. An individual was under precautionary or mandatory quarantine; 4. An individual is a healthcare worker, first responder, or another essential worker who has direct contact with the public while working; or 5. The facts and circumstances surrounding an individual warrant testing as determined by the treating clinician and state/local department of health officials. Testing prioritization (in accordance with Executive Order 202.19). 1. Symptomatic individuals in high-risk populations (people who are immunocompromised, people over 70 years of age, people with underlying health conditions, patients in hospitals, congregate care settings such as nursing homes and long-term care facilities, etc.). 2. Individuals who have had close (within 6 feet) or proximate contact with another individual who is COVID-19 positive. 3. Healthcare workers, first responders, or personnel in nursing

			homes, long-term care facilities, or other congregate care settings 4. Essential employees who directly interact with the public while working
05/01/2020	NYS Department of Health Essential Worker COVID-19 Testing	Unspecified.	Poster notifying essential workers to get tested. Includes health care workers, first responders, and workers in any position within a nursing home, long-term care facility, or other congregate care settings and essential employees who directly interact with the public while working.
05/14/2020	OMH PC COVID-19 Screening State PC Admissions Form	Unspecified.	Asks about: • Whether the patient was tested for COVID; • For patients with confirmed COVID: fever in the last 72 hours, improvement of respiratory symptoms, 14 days since symptoms first appeared, follow up negative test if tested; • Direct contact with a person suspected or confirmed with COVID-19; • If patient (in the last 72 hours) experienced a fever, respiratory and other symptoms (such as cough, headaches, sore throat, etc) and whether they have comorbidities; • Date(s) of COVID-19 virus diagnostic PCR test if patient was transferred from an article 28/31 hospital inpatient settings to a state psychiatric center.
06/05/2020	Temporary Amendment to OMH Part 524 Deadlines	NYS Article 31 Mental Health Provider Agencies; NYS Article	To address staffing shortages, OMH is temporarily waiving certain regulatory provisions within 14 NYCRR Section 524.

		28 Hospital Provider Facilities; OMH-Operated Psychiatric Center Executive Directors, Quality and Risk Management Directors	"Effective June 4, 2020, the 45-day deadline for submission of investigative findings for Allegations of Abuse or Neglect and Significant Incidents, as well as the holding of Incident Review Committee (IRC) meetings, will be temporarily extended to 60 days. This will allow for 15 additional days to submit final reports and organize IRC. This temporary amendment shall expire on July 31, 2020, unless extended or terminated before such date."
6/5/2020	Updated Treatment Planning and Documentation Standards for Article 28/31 Hospital Psychiatry Providers	NYS Article 28/31 Hospital Psychiatry Providers	<u>Mental Health Treatment Standards:</u> "During the COVID-19 emergency period, hospital-based mental health programs may modify their inpatient treatment programming as follows: 1. Hospital mental health programs should follow their hospital-wide policies regarding visitors. 2. Programs should cancel all therapeutic, rehabilitative, and recreational groups that do not align with physical distancing and other mitigation recommendations. 3. During individual sessions, if in-person, clinicians and patients should remain six feet apart. 4. Patients should be allowed to remain in their rooms during the day and should not be asked to remain in shared settings. Programs should maximize the space patients can occupy while on the unit. 5. Programs should continue to provide and even increase, where feasible, time for outside activities. Patients should be reminded to maintain at least six feet of

			distance from all other individuals while outside." Prior guidance regarding use of telemental health for removal and retention pursuant to Article 9 of the Mental Hygiene Law remains in effect (evaluations or examinations may be conducted using telemental health and the use of telemental health for Article 9 removals will be considered the equivalent to face-to-face evaluations or examinations for the purposes of meeting statutory requirements). Prior guidance regarding seclusion and restraint remains in effect ("the requirements in NYCRR 526.4 requiring a physician for the order and the in-person, face-to-face examination of the patient for restraint or seclusion may temporarily be fulfilled by an order and an in-person, face-to-face examination by a licensed nurse practitioner or physician assistant." Prior guidance regarding the use of video and telephone technology for treatment of patients remains in effect (telemental health should be used for routine treatment planning on hospital inpatient mental health units"). Prior guidance modifying documentation requirements and discharge planning is rescinded effective 6/8/2020.
06/25/2020	COVID-19 Infection Control in Reopening Public Mental Health System Sites	NYS Public Mental Health Programs	Aimed at helping programs assess how to resume some in-person services. Encourage providers to follow CDC guidelines on infection control and prevention and post educational materials for patients and staff about social distancing, hand and respiratory

hygiene, face coverings, cleaning and disinfection, etc.

Infection Control Practices for Outpatient, Support, and Certain Emergency Programs (see guidance for applicable programs and services)

Telemental Health: Encourages utilization of HIPAA and 14 NYCRR 596-compliant telemental health services, but urges that programs maintain capacity for in-person services for individuals who cannot utilize telemental health services or who need in person services. All individuals should be screened for COVID-19 like illnesses at every telemental health appointment and educated about infection control.

Guidance also includes general information for in-person encounters, such as information about screening prior to appointments and protocol for clinical services that are tailored to each region's phase of reopening.

For Phase 1 and 2 regions, this guidance addresses:

Telecommuting/working from home for staff; client screening protocol; whether to take clients' temperatures prior to entering the facility and what to do if a client has a fever of at least 100 degrees Fahrenheit; protocol for providing services (physical distancing, wearing a mask, meeting clients in well-ventilated spaces); face masks or face masks in the facility (all clients should wear a mask or cloth face covering and staff should provide a surgical mask to clients who do not bring a face covering); client accompaniments/escorts; administration of medications that require close

physical contact; cleaning and disinfecting of frequent-contact surfaces and office space; physical distancing in waiting rooms; provision of hand sanitizer; how to safely maintain peer socialization if necessary for clients' well-being.

For Phase 3 and 4 regions, this guidance also notes:

Groups of ten clients or fewer can meet indoors in a large, well-ventilated area for at most an hour if they maintain appropriate social distancing, wear appropriate face coverings, and no participant has COVID-19 like symptoms. Larger groups may meet outdoors if all participants wear appropriate face coverings and maintain social distancing. If COVID-19 infections rise locally, these programs shall be suspended until the number of local infections fall.

Scheduled appointments should be prioritized. Programs that continue drop-in hours should maintain screening procedures and physical distancing in the facility.

Staff who must visit clients in their homes must wear a mask or cloth face covering during the visit, and the client should be educated to wear a cloth face covering. If the client lives with individuals who are at high-risk of COVID-19, staff may consider acceptable alternatives such as taking a walk with the client or having the visit take place outside, if possible. Staff may disengage from the contact if the client or their family members refuse to physically distance.

Other recommendations are included, such as instituting occupancy and physical distancing policies for elevators, tight workspaces, public bathrooms, etc.

Infection Control Practices for Residential and Site-Based Programs (see guidance for full list of applicable programs)

1. General Guidance for mental health housing programs:

Educate residents on infection control and prevention measures such as encouraging residents to stay in the residence as much as possible, maintaining six feet of distance from others, proper hand and respiratory hygiene, and wearing appropriate masks or cloth face coverings; cancel social or recreational outings where appropriate social distancing cannot be maintained; institute medical appointments via telehealth services; limit all visitation that is not necessary “to the direct support of a resident’s health and wellness” and institute visitor screening protocol; encourage client reporting of COVID-19 like symptoms; etc.

2. Guidance on accepting new clients including screening protocol; accepting clients from Article 28 or Article 31 inpatient settings (“may require a negative COVID-19 diagnostic PCR test within 72 hours prior to transfer. Programs may require the test result to be sent prior to transfer”); how to handle clients who previously tested positive for COVID-19; what facilities may not require as a condition of admission (“programs may not require a negative test result for clients coming from non-inpatient hospital settings” and

"programs may not require results of serum antibody tests as a condition of admission"); and isolation of new clients.

3. Guidance on responding to clients who develop symptoms including isolation, meal provision, bathroom designation, staff support, notification to local health department and how to obtain testing, when to transport clients to the hospital, how to handle other clients who are high risk (older age and who have comorbidities), cleaning and disinfection, etc.

4. Guidance on responding to clients who are returning from the hospital.

5. Guidance for Scattered-Site Programs including visitation, cleaning and disinfection, physical distancing, telehealth to replace face-to-face visitation, proper staff protocol when face-to-face visits are necessary, etc.

6. Guidance for Child and Youth Serving Residential Programs for when home-time leave is appropriate.

Infection Control Practices for Programs Based in Article 28 Hospitals

Follow the policies and protocols of hospital's infection control departments.

Infection Control Practices for Article 31 Private Psychiatric Inpatient Hospitals

Contact local OMH Field Office to discuss infection control concerns.

Infection Control Best Practices During Non-Emergent Transportation (applies to all programs)

Includes appropriate face coverings for staff and clients, preference for larger vehicles to increase distance between

			staff and client, keeping windows open for ventilation purposes, cleaning and disinfection of the vehicle, provision of hand sanitizer with at least 60% alcohol, how to transport clients with confirmed or suspected COVID-19 (when it is unavoidable). Guidance for Staff (applies to all programs) Includes staying home when sick; wearing face coverings while at the facility; in the event of staffing shortages, when staff who have had direct contact with suspected or confirmed cases of COVID-19 may continue to work (lists 14 conditions); when symptomatic or COVID-19 positive staff can return to work; when to notify clients that they had prolonged contact with staff and need to be quarantined for 14 days, and providing the local health department with the names and contact information of staff who are suspected or confirmed with COVID-19.
06/30/2020	OMH-OASAS Ambulatory and Residential Program COVID-19 Testing, Record Keeping, and Notification Instructions	Unspecified.	Requirements of all OMH and OASAS Operated, Licensed, and Funded Programs: When a client is either confirmed with COVID-19 or is suspected of having a COVID-like illness (“CLI”), staff must notify the local health department (“LHD”). If feasible, newly symptomatic clients should be tested to determine whether isolation or quarantine is necessary. If a staff member has confirmed or suspected CLI, the program must notify the LHD and the staff member must be referred to their healthcare provider for evaluation and possible testing.

Guidance for OMH and OASAS Outpatient Programs

"1. Individuals who have known or suspected COVID-like illness must be reported to their LHD.

2. Notify the individual that they may be contacted by their LHD to help determine with whom they might have come into contact.

3. Notify the LHD of all individuals (staff and clients) who the agency is aware of who had a close or proximate contact with the individual within the agency setting. Agency staff are not responsible for determining any contacts outside of the agency setting and are also not responsible for calling individuals identified as having contact in the agency setting. Names of these individuals should be given to the LHD, which will conduct the formal contact investigation and tracing. Agency staff may need to help the LHD communicate with clients."

Guidance for Behavioral Health Programs based in Article 28 Hospitals

Follow the contact tracing policies and protocols of the hospital's infection control departments.

Guidance for Residential Programs (OMH/OASAS operated, licensed, and/or funded), Inpatient Programs in licensed Article 31 hospitals, Addiction Treatment Centers, and State-Operated Psychiatric Centers

1. For each person with CLI or who tests positive for COVID-19, record the following, if possible: their name; symptoms; the date their symptoms

begin; whether they were in contact with anyone who tested positive for COVID-19; whether they have traveled outside of their home/residence within the last 14 days (if yes, where); if hospitalized, what hospital was the individual in and what is the date of hospitalization; if tested, what were the results, where was the test done, what is the date the test was administered, and when were the results received; where is the individual currently located; are they currently in isolation or quarantine; whether the individual has their own room and whether they have had a roommate in the last 14 days; and name and contact of other individuals who may have come into contact with the individual over the last 14 days or who live and work in the hospital or residence.

“2. Notify the individual that they will be contacted by their LHD to help determine with whom they might have come into contact. Provide the collected information to LHD staff.

3. For individuals who are too symptomatic or cognitively impaired to report their contacts, staff should do their best to obtain as accurate information as possible or assist LHD staff in interviewing client. 4. Follow appropriate program-specific guidance for managing COVID-19 exposure in facility.

5. Program staff are not expected to identify or conduct outreach to possible exposed contacts outside the program but should help LHD staff as much as possible during LHD interviews to obtain needed information.

6. Work with the LHD to determine next steps and roles/responsibilities of the

			LHD and the Program to determine which entity will monitor clients and staff for the duration of time they are expected to remain under isolation or quarantine.”
07/07/2020	New York State Office of Mental Health COVID-19 Disaster Emergency FAQ	Unspecified.	Provides answers to questions including but not limited to: new referrals to community based behavioral providers; service provision in areas impacted by COVID-19; notification to patients in residential programs or clinics if a staff member developed COVID-19 symptoms; transporting COVID-19 patients; training new and current staff for restraint application while maintaining social distancing in resident treatment facilities (“RTFs”); housing programs/supported housing; background checks; new staff; telemental health guidance; etc.
11/12/20	NYS Infection Control Manual for Public Health System Programs	Unspecified	22 page manual with infection control recommendations for OMH operated and licensed providers.
12/08/2020	Strategy for OMH patient and staff testing In Inpatient and Residential Settings	Facility Directors, Clinical Directors, Chief Nursing Officers	Requires among other things that all psychiatric centers must immediately begin to implement rapid testing procedures.
12/10/2020	Updated Guidelines for Isolation Status, Quarantine	Facility Directors, Clinical Directors,	Memo supercedes earlier guidance. Psychiatric centers should not have policies delaying or canceling admissions or discharges based solely

	State and COVID-free units for Patients in Psychiatric Cents and Staff PPE policies	Chief Nursing Officers	upon a patient's COVID-19 status. Changes are: DOH instructions regarding prioritization of PPE in case of supply shortages: Instructions for Disinfection of face shields. Expanded requirement for universal eye protection in all patient-facing areas, including COVID-free units, residences, and outpatient settings.
12/20/2020	DOH Guidance	OPWDD, OMH & OASAS	Prioritization of Essential Health Care and Direct Support Personnel as well as High Risk Populations for COVID-19 Vaccinations.

Appendix III: COVID-Era Sub-Regulatory Guidance (cont'd)

D. Office for People with Developmental Disabilities

Date	Item	Summary
03/11/2020	OPWDD Guidelines for Implementation of Quarantine and/or Isolation Measures at State-Owned and Voluntary Providers in Congregate Settings	focuses on actions to be taken to address prevention and preparedness, recommendations for quarantine and isolation approaches per NYSDOH guidelines, and reporting and notification
03/14/2020	Health Advisory: COVID-19 Cases in Intermediate Care Facilities for Individuals with Intellectual Disabilities	Suspended all visitation except when medically necessary (i.e. visitor is essential to the care of the patient or is providing support in imminent end-of-life situations) or for family members of residents in imminent end-of-life situations, and those providing Hospice care
03/18/2020	EO 202.5	Waiver enacted to permit restriction of community outings for residents of such facilities to reduce the spread of COVID-19
03/18/2020	EO 202.5	Waiver enacted to allow for temporary deviations of/from an individual's service plan, which would otherwise outline participation in day programming and other community based served, and the temporary relocation of individuals, in order to maintain the health and safety of that individual during this emergency period and to the extent necessary
03/25/2020	Article 16 Clinic Considerations	Encouraged clinics to develop a plan on education of staff, screening, use of telehealth, and use and supply of PPE
03/25/2020	General Management of Coronavirus (COVID-19) in Facilities or Programs Operated and/or Certified by OPWDD	Explained that OPWDD would be following DOH recommendations and guidance for management of quarantine/isolation (activity restrictions) and addressed exposure mitigation and cleaning

04/10/2020	Guidance for Resident and Family Communication in Adult Care Facilities (ACFs) and Nursing Homes (NHs)	OPWDD adopted these DOH regulations for all OPWDD operated, certified, and funded residences. This required facilities, among other things, to: 1) report confirmed cases of COVID-19 in the residence; 2) send period status reports; and 3) maintain updated information on website.
04/10/2020	Advisory: Hospital Discharges and Admissions to Certified Residential Facilities	Guidance issued by OPWDD explaining that all Certified Residential Facilities must have a process in place to expedite the return of asymptomatic residents from the hospital and that "No individual shall be denied re-admission or admission to a Certified Residential Facility based solely on a confirmed or suspected diagnosis of COVID-19."
04/29/2020	COVID-19 PROCEDURES AND PRACTICES	OPWDD-issued poster identifying COVID-19 prevention and exposure mitigation strategies (hand hygiene, environmental hygiene/disinfection, and use of PPE).
06/18/2020		Revised visitation guidance to allow for additional visitation so long as specific conditions
07/10/2020	Home Visits for Individuals Residing in OPWDD Certified Residential Facilities	Allowed for additional visits to the extent that safe social distancing, masks, and "meticulous" hand washing were done.
09/15/2020	COVID-19: Interim Guidance for Non-Emergency Site Visits of Certified Facilities	Placed requirements on visits by outside employees, including use of PPE, log of all visitors and staff, social distancing, and screening.
10/28/2020	COVID -19: Interim Visitation Guidance for Certified "Supportive" Residential Facilities	Allowed for visitation in supportive residences

Appendix IV

N.Y. Nursing Homes: Facility-Specific Detail Including COVID-19 Deaths, Staffing Levels

NH Facility	NH PFI	County	COVID Confirmed Deaths at NH	COVID Confirmed Out of Facility Deaths of NH Residents (Hospital, Other)	COVID Presumed Deaths at NH	For Profit/ Not-for-profit Status	Number of Beds in the Facility	Staffing Levels
A Holly Patterson Extended Care Facility	000534	Nassau	11	32	5	Not-for-profit	589	2 stars
Aaron Manor Rehabilitation and Nursing Center	000431	Monroe	20	0	0	For-Profit	140	2 stars
Absolut Center for Nursing and Rehabilitation at	000073	Cattaraugus	3	1	0	For-Profit	37	2 stars
Absolut Center for Nursing and Rehabilitation at	000278	Erie	42	23	0	For-Profit	370	2 stars
Absolut Center for Nursing and Rehabilitation at	000056	Broome	18	1	0	For-Profit	160	3 stars
Absolut Center for Nursing and Rehabilitation at	000588	Niagara	2	0	0	For-Profit	83	3 stars
Absolut Center for Nursing and Rehabilitation at	001658	Steuben	15	4	0	For-Profit	120	2 stars
Absolut Center for Nursing and Rehabilitation at	003370	Chautauqua	7	0	0	For-Profit	120	2 stars
Acadia Center for Nursing and Rehabilitation	000941	Suffolk	19	19	1	For-Profit	181	3 stars
Achieve Rehab and Nursing Facility	000962	Sullivan	4	7	0	For-Profit	140	
Adira At Riverside	006250	Westchester	0	4	0	For-Profit	120	2 stars

Rehabilitation and Nursing								
Affinity Skilled Living and Rehabilitation Center	006460	Suffolk	10	9	6	For-Profit	280	2 stars
Alice Hyde Medical Center	000326	Franklin	3	3	0	Not-for-profit	135	
Alpine Rehabilitation and Nursing Center	000364	Herkimer	12	2	0	For-Profit	80	3 stars
Amsterdam Nursing Home Corp (1992)	001605	New York	14	18	45	Not-for-profit	409	3 stars
Andrus On Hudson	001126	Westchester	7	4	10	Not-for-profit	197	2 stars
Apex Rehabilitation and Care Center	000919	Suffolk	32	6	2	For-Profit	195	2 stars
Atrium Center for Rehabilitation and Nursing	001430	Kings	5	13	9	For-Profit	380	1 star
Auburn Rehabilitation & Nursing Center	000091	Cayuga	2	1	0	For-Profit	92	2 stars
Aurelia Osborn Fox Memorial Hospital	000740	Otsego	10	0	0	Not-for-profit	130	
Autumn View Health Care Facility, LLC	002956	Erie	41	6	0	For-profit	230	2 stars
Avon Nursing Home, LLC	000387	Livingston	5	0	1	For-Profit	40	3 stars
Bainbridge Nursing & Rehabilitation Center	001227	Bronx	3	8	8	For-Profit	200	2 stars
Baptist Health Nursing and Rehabilitation Center	000843	Schenectady	5	2	0	Not-for-profit	262	2 stars
Bayberry Nursing Home	001073	Westchester	2	0	0	For-Profit	60	4 stars
Beach Gardens Rehab and Nursing Center	003401	Queens	8	11	6	For-Profit	163	4 stars

Beach Terrace Care Center	000496	Nassau	3	2	0	For-Profit	182	
Beacon Rehabilitation and Nursing Center	001736	Queens	5	13	7	For-Profit	120	3 stars
Bedford Center for Nursing and Rehabilitation	001409	Kings	9	2	8	For-Profit	200	3 stars
Beechtree Center for Rehabilitation and Nursing	000983	Tompkins	6	1	0	For-Profit	120	
Beechwood Homes	000288	Erie	25	12	0	Not-for-profit	272	3 stars
Belair Care Center Inc.	000533	Nassau	6	1	2	For-Profit	102	5 stars
Bellhaven Center for Rehabilitation and Nursing Care	003423	Suffolk	7	15	0	For-Profit	240	2 stars
Bensonhurst Center for Rehabilitation and Healthcare	001406	Kings	10	7	27	For-Profit	200	2 stars
Berkshire Nursing & Rehabilitation Center	000877	Suffolk	2	4	1	For-Profit	175	2 stars
Beth Abraham Center for Rehabilitation and Nursing	001218	Bronx	9	29	16	For-Profit	448	1 star
Bethany Gardens Skilled Living Center	000594	Oneida	4	0	0	For-Profit	100	2 stars
Bethany Nursing Home and Health Related Facility	001255	Chemung	5	4	0	Not-for-profit	120	
Bethel Nursing & Rehabilitation Center	007278	Westchester	5	12	7	Not-for-profit	200	3 stars
Bethlehem Commons Care Center	000027	Albany	9	4	0	For-profit	120	2 stars
Bezalel Rehabilitation and Nursing Center	003156	Queens	8	11	1	Not-for-profit	120	2 stars

Bishop Rehabilitation and Nursing Center	000656	Onondaga	26	20	22	For-Profit	440	2 stars
Boro Park Center for Rehabilitation and Healthcare	001403	Kings	10	41	22	For-Profit	504	3 stars
Briarcliff Manor Center for Rehabilitation and Nursing	001128	Westchester	0	7	1	For-Profit	120	1 star
Bridge View Nursing Home	001673	Queens	9	7	12	For-Profit	200	2 stars
Bridgewater Center for Rehabilitation & Nursing, LLC	000050	Broome	26	15	0	For-Profit	356	2 stars
Brighton Manor	000446	Monroe	3	1	1	For-Profit	80	2 stars
Bronx Center for Rehabilitation and Healthcare	001251	Bronx	5	13	13	For-Profit	200	1 star
Bronx Gardens Rehabilitation and Nursing Center	004887	Bronx	6	23	14	For-Profit	199	2 stars
Bronx Park Rehabilitation & Nursing Center	001246	Bronx	7	16	14	For-Profit	240	1 star
Bronxcare Special Care Center	004501	Bronx	7	20	1	Not-for-profit	240	Not available
Brookhaven Health Care Facility, LLC	003928	Suffolk	7	10	0	For-Profit	160	5 stars
Brookhaven Rehabilitation & Health Care Center, LLC	001703	Queens	1	19	6	For-Profit	298	2 stars
Brooklyn Center for Rehabilitation And Residential	001395	Kings	4	6	11	For-Profit	281	3 stars
Brooklyn Gardens Nursing & Rehabilitation Center	007069	Kings	1	6	7	Not-for-profit	240	2 stars
Brooklyn United Methodist Church Home	001368	Kings	2	0	13	Not-for-profit	120	2 stars

Brooklyn-Queens Nursing Home	000277	Kings	3	3	5	For-Profit	140	1 star
Brookside Multicare Nursing Home	000949	Suffolk	8	4	4	For-Profit	353	Not available
Brothers of Mercy Nursing Home & Rehabilitation Center	000296	Erie	19	4	0	Not-for-profit	240	3 stars
Buena Vida Continuing Care & Rehab Center	006248	Kings	0	14	5	For-Profit	240	1 star
Buffalo Center for Rehabilitation and Nursing	003012	Erie	18	7	2	For-Profit	200	2 stars
Buffalo Community Healthcare Center	000633	Erie	2	10	0	For-Profit	95	3 stars
Bushwick Center for Rehabilitation and Health Care	004037	Kings	7	1	4	For-profit	225	2 stars
Campbell Hall Rehabilitation Center INC	002544	Orange	5	5	1	For-Profit	134	2 stars
Cantebury Woods	007789	Erie	6	8	0	Not-for-profit	50	5 stars
Capstone Center for Rehabilitation and Nursing	000488	Montgomery	15	0	0	For-Profit	120	2 stars
Carillon Nursing and Rehabilitation Center	000920	Suffolk	27	6	19	For-Profit	315	2 stars
Caring Family Nursing and Rehabilitation Center	003948	Queens	5	3	13	For-Profit	183	2 stars
Carmel Richmond Healthcare and Rehabilitation Center	001755	Richmond	61	19	2	Not-for-profit	300	2 stars
Carthage Center for Rehabilitation and Nursing	000381	Jefferson	15	1	0	For-Profit	90	2 stars
Casa Promesa	005567	Bronx	0	11	0	Not-for-profit	108	4 stars

Canton Park Rehabilitation and Nursing Center, LLC	001380	Kings	2	4	3	For-Profit	119	
Catskill Regional Medical Center	000840	Sullivan	3	0	0	Not-for-profit	64	
Cayuga Nursing and Rehabilitation Center	000984	Tompkins	2	0	0	For-Profit	144	
Cedar Manor Nursing & Rehabilitation Center	001087	Westchester	5	20	9	For-Profit	153	2 stars
Center Island Healthcare	000560	Nassau	5	5	21	For-Profit	202	2 stars
Central Park Rehabilitation and Nursing Center	000654	Onondaga	11	6	4	For-Profit	160	2 stars
Chapin Home for The Aging	001715	Queens	1	5	2	Not-for-profit	220	4 stars
Charles T Sitrin Health Center INC	000620	Oneida	1	0	0	Not-for-profit	187	4 stars
Chasehealth Rehab and Residential Care	000126	Chenango	23	2	0	Not-for-profit	80	
Chautauqua Nursing and Rehabilitation Center	000099	Chautauqua	24	0	0	For-Profit	216	2 stars
Chemung County Health Center Nursing Facility	000123	Chemung	1	0	0	Not-for-profit	200	
Church Home of The Protestant Episcopal Church	000444	Monroe	33	5	0	Not-for-profit	182	4 stars
Cliffside Rehabilitation & Residential Health Care Center	001676	Queens	22	0	0	For-Profit	218	3 stars
Clifton Springs Hospital and Clinic Extended Care	000677	Ontario	0	1	0	Not-for-profit	108	
Clove Lakes Health Care and	001750	Richmond	17	24	25	For-Profit	576	4 stars

Rehabilitation Center, IIN								
Cobble Hill Health Care, INC.	001381	Kings	6	1	50	Not-for-profit	364	2 stars
Cold Spring Hills Center for Nursing and Rehabilitation	000558	Nassau	15	13	20	For-Profit	588	2 stars
Coler Rehabilitation and Nursing Care Center	001600	New York	13	17	1	Public-Municipality	815	5 stars
Colonial Park Rehabilitation and Nursing Center	000592	Oneida	5	4	0	For-Profit	80	2 stars
Comprehensive Rehabilitation and Nursing Center at	000274	Erie	10	4	0	For-Profit	142	2 stars
Concord Nursing and Rehabilitation Center	001404	Kings	5	3	9	Not-for-profit	140	2 stars
Concourse Rehabilitation and Nursing Center, INC.	001253	Bronx	7	2	16	For-Profit	240	Not available
Conesus Lake Nursing Home	000392	Livingston	9	0	0	For-Profit	48	2 stars
Cooperstown Center for Rehabilitation and Nursing	000749	Otsego	0	2	0	For-Profit	174	
Corning Center for Rehabilitation and Healthcare	000867	Steuben	28	5	0	For-Profit	120	
Cortland Park Rehabilitation and Nursing Center	000160	Cortland	20	1	0	For-Profit	120	
Cortlandt Healthcare	001041	Westchester	13	9	0	For-Profit	120	2 stars
Creekview Nursing and Rehab Center	000470	Monroe	3	15	0	For-Profit	124	2 stars
Crest Manor Living and Rehabilitation Center	000481	Monroe	19	2	0	For-Profit	80	2 stars

Crouse Community Center INC	004494	Madison	36	7	0	Not-for-profit	120	
Crown Heights Center for Nursing and Rehabilitation	001407	Kings	1	2	6	For-Profit	295	2 stars
Crown Park Rehabilitation and Nursing Center	000161	Cortland	15	1	0	For-Profit	200	
Cypress Garden Center for Nursing and Rehabilitation	001709	Queens	5	7	5	For-Profit	268	2 stars
Daleview Care Center	000524	Nassau	1	2	3	For-Profit	142	2 stars
Daughters of Sarah Nursing Center	000022	Albany	7	2	0	Not-for-profit	210	4 stars
Degraff Memorial Hospital-Skilled Nursing Facility	000582	Niagara	4	0	0	Not-for-profit	80	
Delhi Rehabilitation and Nursing Center	010108	Delaware	1	0	0	For-Profit	176	
Diamond Hill Nursing and Rehabilitation Center	000772	Rensselaer	8	9	0	For-profit	120	3 stars
Ditmas Park Care Center	001576	Kings	3	3	11	For-Profit	220	3 stars
Downtown Brooklyn Nursing & Rehabilitation Center	001408	Kings	11	27	5	For-Profit	320	2 stars
DR Susan Smith McKinney Nursing and Rehabilitation	007279	Kings	4	15	18	Public-Municipality	320	5 stars
Dry Harbor Nursing Home	001705	Queens	14	25	20	For-Profit	360	3 stars
Dumont Center for Rehabilitation and Nursing Care	002575	Westchester	2	9	2	For-Profit	196	2 stars
East Haven Nursing and	001277	Bronx	7	15	7	For-Profit	200	2 stars

Rehabilitation Center 001277								
East Neck Nursing & Rehabilitation Center	003307	Suffolk	23	28	10	For-Profit	300	2 stars
East Side Nursing Home	001156	Wyoming	16	6	0	For-Profit	80	
Eastchester Rehabilitation and Health Care Center	001231	Bronx	0	6	2	For-Profit	200	1 star
Eddy Heritage House Nursing and Rehabilitation Center	004549	Rensselaer	7	11	0	Not-for-profit	120	4 stars
Eddy Memorial Geriatric Center	003293	Rensselaer	7	0	0	Not-for-profit	80	2 stars
Eddy Village Green	004000	Albany	7	0	0	Not-for-profit	192	4 stars
Eden Rehabilitation & Nursing Center	003910	Erie	11	1	0	For-Profit	40	3 stars
Edna Tina Wilson Living Center	004808	Monroe	14	6	29	Not-for-profit	120	3 stars
Eger Healthcare and Rehabilitation Center	001748	Richmond	27	9	29	Not-for-profit	378	4 stars
Elcor Nursing and Rehabilitation Center	000124	Chemung	37	26	0	For-Profit	305	
Elderwood At Amherst	000232	Erie	22	8	0	For-Profit	92	4 stars
Elderwood at Cheektowaga	004474	Erie	18	1	0	For-Profit	172	3 stars
Elderwood at Grand Island	000299	Erie	5	1	0	For-Profit	90	3 stars
Elderwood at Hamburg	003295	Erie	26	3	0	For-Profit	166	4 stars
Elderwood at Hornell	003902	Steuben	3	2	0	For-Profit	112	
Elderwood at Lancaster	000272	Erie	10	6	0	For-Profit	96	4 stars
Elderwood at Liverpool	003243	Onondaga	14	4	0	For-Profit	160	3 stars

Elderwood at Lockpart	000571	Niagara	4	2	0	For-Profit	126	3 stars
Elderwood at Waverly	000973	Tioga	28	4	1	For-Profit	200	
Elderwood at Wheatfield	005774	Niagara	4	0	0	For-Profit	123	4 stars
Elderwood at Williamsville	002815	Erie	3	1	0	For-Profit	200	3 stars
Elderwood of Lakeside at Brockport	000469	Monroe	9	0	0	For-Profit	120	
Elizabeth Church Manor Nursing Home	000048	Broome	28	3	0	Not-for-profit	120	4 stars
Ellicott Center for Rehabilitation and Nursing	000254	Erie	11	13	0	For-Profit	140	2 stars
Ellis Residential & Rehabilitation Center	004148	Schenectady	2	1	0	Not-for-profit	82	5 stars
Elm Manor Nursing and Rehabilitation Center	000682	Ontario	13	4	0	For-Profit	46	3 stars
Elmhurst Care Center, INC	007745	Queens	11	31	14	For-Profit	240	3 stars
Emerge Nursing and Rehabilitation at Glen Cove	000492	Nassau	8	5	1	For-Profit	102	3 stars
Epic Rehabilitation and Nursing White Plains	010353	Westchester	1	4	0	For-Profit	160	Not available
Essex Center for Rehabilitation and Healthcare	000305	Essex	11	3	0	For-Profit	100	
Evergreen Commons Rehabilitation and Nursing Center	007268	Rensselaer	1	1	0	For-Profit	240	3 stars
Excel at Woodbury foe Rehabilitation and Nursing, LLC	000559	Nassau	24	5	5	For-Profit	123	3 stars
Fairport Baptist Homes	000459	Monroe	6	1	0	Not-for-profit	142	4 stars

Fairview Nursing Care Center INC	001678	Queens	9	5	6	For-Profit	200	2 stars
Far Rockaway Center for Rehabilitation and Nursing	001679	Queens	2	6	0	For-Profit	100	Not available
Father Baker Manor	004898	Erie	81	28	0	Not-for-profit	160	4 stars
Ferncliff Nursing Home Co INC	000194	Dutchess	17	5	1	Not-for-profit	326	2 stars
Fiddlers Green Manor Rehabilitation and Nursing Center	000282	Erie	7	0	0	For-Profit	82	2 stars
Fieldston Lodge Care Center	001233	Bronx	1	0	14	For-Profit	200	3 stars
Fishkill Center for Rehabilitation and Nursing	000201	Dutchess	7	5	0	For-Profit	160	2 stars
Foltsbrook Center for Nursing and Rehabilitation	000360	Herkimer	10	0	0	For-Profit	163	2 stars
Fordham Nursing and Rehabilitation Center	001258	Bronx	3	18	0	For-Profit	240	2 stars
Forest Hills Care Center	001681	Queens	7	4	5	For-Profit	100	2 stars
Forest View Center for Rehabilitation & Nursing	001682	Queens	4	2	1	For-Profit	160	3 stars
Fort Hudson Nursing Center, INC	001018	Washington	13	0	0	Not-for-profit	196	2 stars
Fort Tryon Center for Rehabilitation and Nursing	001585	New York	13	0	7	For-Profit	205	2 stars
Four Seasons Nursing and Rehabilitation Center	003227	Kings	4	1	5	For-Profit	270	2 stars
Fox Run at Orchard Park	008555	Erie	3	0	0	Not-for-profit	60	3 stars
Franklin Center for Rehabilitation and Nursing	001708	Queens	7	2	52	For-Profit	320	2 stars

Friedwald Center for Rehabilitation and Nursing, LLC	000787	Rockland	11	22	3	For-Profit	180	2 stars
Fulton Center for Rehabilitation and Healthcare	000337	Fulton	16	21	2	For-Profit	176	2 stars
Fulton Commons Care Center INC	006312	Nassau	6	5	35	For-Profit	280	2 stars
Garden Care Center	000538	Nassau	16	6	0	For-Profit	150	2 stars
Garden Gate Healthcare Facility	000294	Erie	25	10	0	For-Profit	184	3 stars
Ghent Rehabilitation & Nursing Center	004551	Columbia	14	2	0	For-Profit	120	
Glen Arden INC	007016	Orange	2	2	1	Not-for-profit	40	3 stars
Glen Cove Center for Nursing and Rehabilitation	000493	Nassau	11	13	1	For-Profit	154	4 stars
Glen Island Center for Nursing and Rehabilitation	001078	Westchester	3	0	0	For-Profit	182	2 stars
Glendale Home-Schdy Cnty Dept Social Services	000846	Schenectady	6	0	0	Public-County	200	3 stars
Glengariff Rehabilitation and Healthcare Center	000491	Nassau	6	14	18	For-Profit	262	3 stars
Glens Falls Center for Rehabilitation and Nursing	001009	Warren	19	4	5	For-Profit	117	3 stars
Gold Crest Care Center	001226	Bronx	4	15	7	For-Profit	175	1 star
Golden Gate Rehabilitation & Healthcare Center	001757	Richmond	14	17	4	For-Profit	238	2 stars
Golden Hill Nursing and Rehabilitation Center	000998	Ulster	21	8	0	For-Profit	280	2 stars
Good Samaritan Nursing and	003041	Suffolk	21	1	0	Not-for-profit	100	3 stars

Rehabilitation Care Center								
Good Shepherd Village at Endwell	009135	Broome	5	1	0	Not-for-profit	32	4 stars
Good Shepherd-Fairview Home INC	000049	Broome	5	0	0	Not-for-profit	54	4 stars
Grand Manor Nursing & Rehabilitation Center	000856	Bronx	3	2	0	For-Profit	240	2 stars
Grandell Rehabilitation and Nursing Center	000497	Nassau	14	9	17	For-Profit	278	
Granville Center for Rehabilitation and Nursing	001022	Washington	1	1	0	For-Profit	122	2 stars
Greene Meadows Nursing and Rehabilitation Center	000350	Greene	18	8	0	For-Profit	120	2 stars
Greenfield Health & Rehab Center	007711	Erie	18	2	0	Not-for-profit	160	3 stars
Groton Community Health Care Center Residential care	002550	Tompkins	3	3	0	Not-for-profit	80	
Gurwin Jewish Nursing and Rehabilitation Center	003989	Suffolk	34	10	19	Not-for-profit	460	3 stars
Guthrie Cortland Medical Center	004799	Cortland	4	0	0	Not-for-profit	80	
Hamilton Park Nursing and Rehabilitation Center	004285	Kings	2	12	12	For-Profit	200	3 stars
Harlem Center for Nursing and Rehabilitation	001604	New York	4	4	29	For-Profit	200	2 stars
Harris Hill Nursing Facility, LLC	003455	Erie	117	19	2	For-Profit	192	2 stars

Haven Manor Health Care, LLC	003256	Queens	4	5	5	For-Profit	240	1 star
Haym Solomon Home for the Aged	001361	Kings	7	2	40	For-Profit	240	2 stars
Hebrew Home for the Aged at Riverdale	001212	Bronx	21	19	40	Not-for-profit	843	2 stars
Hempstead Park Nursing Home	000508	Nassau	2	12	10	For-Profit	251	2 stars
Henry J. Carter Skilled Nursing Facility	001601	New York	0	1	0	Public-Municipality	164	3 stars
Heritage Green Rehab & Skilled Nursing	002574	Chautauqua	12	1	0	Not-for-profit	134	2 stars
Heritage Village Rehab and Skilled Nursing, INC	000112	Chautauqua	8	0	0	Not-for-profit	120	2 stars
Highfield Gardens Care Center of Great Neck	000547	Nassau	25	10	0	For-Profit	200	2 stars
Highland Care Center	001711	Queens	5	27	24	For-Profit	320	2 stars
Highland Park Rehabilitation and Nursing Center	000041	Allegany	19	3	0	For-Profit	80	1 star
Highland Rehabilitation and Nursing Center	000691	Orange	8	10	3	For-Profit	98	2 stars
Highpointe on Michigan Health Care Facility	003182	Erie	4	1	0	Not-for-profit	300	4 stars
Hilaire Rehab & Nursing	000917	Suffolk	7	0	2	For-Profit	76	4 stars
Hill Haven Nursing Home	000479	Monroe	48	16	0	Not-for-profit	288	4 stars
Hillside Manor Rehab & Extended Care Center	001714	Queens	24	15	11	For-Profit	400	3 stars
Hollis Park Manor Nursing Home	003258	Queens	1	2	7	For-Profit	80	3 stars
Holliswood Center for	001712	Queens	21	6	42	For-Profit	314	1 star

Rehabilitation and Healthcare								
Hope Center for HIV and Nursing Care	004329	Bronx	0	2	0	For-Profit	66	4 stars
Hopkins Center for Rehabilitation and Healthcare	005546	Kings	5	38	15	For-Profit	288	2 stars
Horizon Care Center	001731	Queens	5	9	23	For-Profit	280	1 star
Hornell Gardens, LLC	000871	Steuben	11	4	1	For-Profit	114	
Houghton Rehabilitation & Nursing Center	000651	Allegany	16	1	0	For-Profit	160	
Hudson Park Rehabilitation and Nursing Center	000021	Albany	11	1	0	For-Profit	200	2 stars
Hudson Pointe at Riverdale Center for Nursing and	001232	Bronx	3	6	12	For-Profit	159	2 stars
Hudson Valley Rehabilitation & Extended Care Center	001003	Ulster	15	17	0	For-Profit	203	3 stars
Humboldt House Rehabilitation and Nursing Center	000244	Erie	6	6	0	For-Profit	173	2 stars
Huntington Hills Center for Health and Rehabilitation	007786	Suffolk	35	6	36	For-Profit	320	3 stars
Huntington Living Center	004286	Seneca	28	17	0	Not-for-profit	160	
Ideal Senior Living Center	000059	Broome	11	3	0	Not-for-profit	150	3 stars
Ira Davenport Memorial Hospital SNF/HRF	004156	Steuben	28	4	1	Not-for-profit	120	
Iroquois Nursing Home INC.	004555	Onondaga	43	5	0	Not-for-profit	160	2 stars
Isabella Geriatric Center INC.	001569	New York	25	34	43	Not-for-profit	705	3 stars
Island Nursing and Rehab Center	006324	Suffolk	7	11	16	Not-for-profit	120	3 stars

Jamaica Hospital Nursing CO INC.	001710	Queens	3	34	1	Not-for-profit	228	3 stars
James G. Johnston Memorial Nursing Home	003242	Broome	3	1	0	Mot-for-profit	120	4 stars
Jefferson's Ferry	006313	Suffolk	11	2	1	Not-for-profit	60	5 stars
Jennie B. Richmond Chaffee Nursing Home Company INC.	000281	Erie	0	1	0	Not-for-profit	80	
Jewish Home of Central New York	000647	Onondaga	8	4	0	Not-for-profit	132	Not available
Jewish Home of Rochester	003385	Monroe	2	0	0	Not-for-profit	328	4 stars
Katherine Luther Residential Health care and	000604	Oneida	27	10	0	Not-for-profit	280	1 star
Kendal on Hudson	006745	Westchester	2	1	0	Not-for-profit	26	5 stars
King David Center for Nursing and Rehabilitation	001364	Kings	9	2	25	For-Profit	271	3 stars
King Street Home INC.	001093	Westchester	2	7	0	For-Profit	120	4 stars
Kings Harbor MultiCare Center	001250	Bronx	54	3	8	For-Profit	720	2 stars
Kingsway Arms Nursing Center	000841	Schenectady	4	1	0	For-Profit	160	3 stars
Kirkhaven	003164	Monroe	37	7	4	Not-for-profit	147	3 stars
Laconia Nursing Home	001248	Bronx	1	12	8	For-Profit	240	1 star
Latta Road Nursing Home East	000475	Monroe	3	13	0	For-Profit	40	4 stars
Latta Road Nursing Home West	000473	Monroe	1	2	0	For-Profit	40	3 stars
Lawrence Nursing Care Center INC.	001707	Queens	5	3	1	For-Profit	200	1 star
Leroy Village Green Nursing	002974	Genesee	23	9	0	For-Profit	140	2 stars

and Rehabilitation Center								
Lewis County General Hospital Nursing Home Unit	0003884	Lewis	1	3	0	Public-County	160	3 stars
Linden Center for Nursing and Rehabilitation	007685	Kings	7	1	19	For-Profit	280	2 stars
Living Center at Geneva- North	000672	Ontario	11	1	0	Not-for-profit	160	
Living Center at Geneva- South	000674	Ontario	6	2	0	Not-for-profit	103	
Livingston County Center for Nursing and Rehabilitation	000390	Livingston	5	5	0	Public-County	266	
Livingston Hills Nursing and Rehabilitation Center	000156	Columbia	1	2	0	For-Profit	120	1 star
Lockport Rehab & Health Care Center	000568	Niagara	19	3	0	For-Profit	82	3 star
Long Beach Nursing and Rehabilitation Center	000498	Nassau	14	10	5	For-Profit	150	
Long Island Care Center INC.	001685	Queens	20	4	5	For-Profit	200	3 stars
Long Island State Veterans Home	003421	Suffolk	77	35	8	Public-State	350	5 stars
Loretto Health and Rehabilitation Center	000648	Onondaga	41	5	0	Not-for-profit	583	3 stars
Lutheran Center at Poughkeepsie, Inc.	007643	Dutchess	13	7	0	Not-for-profit	160	2 stars
Luxor Nursing and Rehabilitation at Mills Pond	000953	Suffolk	7	8	20	For-Profit	250	1 star
Luxor Nursing and Rehabilitation at Sayville	004552	Suffolk	10	5	15	For-Profit	180	2 stars
Lynbrook Restorative	000520	Nassau	10	9	0	For-Profit	100	2 stars

Therapy and Nursing								
M.M. Ewing Continuing Care Center	000681	Ontario	1	1	0	Not-for-profit	178	
Manhattanville Healthcare Center	003993	Bronx	6	22	2	For-Profit	200	2 stars
Maplewood Nursing Home INC	000462	Monroe	15	0	0	For-Profit	72	5 stars
Margaret Tietz Nursing and Rehabilitation Center	001669	Queens	16	13	6	For-Profit	200	3 stars
Maria Regina Residence INC	006334	Suffolk	23	4	10	Not-for-profit	188	4 stars
Martine Center for Rehabilitation and Nursing	001059	Westchester	9	12	18	For-Profit	200	2 stars
Mary Manning Walsh Nursing Home CO INC.	001571	New York	34	2	4	Not-for-profit	362	3 stars
Masonic Care Community of New York	000606	Oneida	9	4	0	Not-for-profit	320	3 stars
Massapequa Center for Rehabilitation and Nursing	000881	Suffolk	9	11	21	For-Profit	320	2 stars
Mayfair Care Center	000509	Nassau	3	1	2	For-Profit	200	2 stars
Mcauley Residence	000268	Erie	2	2	0	Not-for-profit	160	5 stars
Meadow Park Rehabilitation and Health Care Center LLC	001687	Queens	1	5	0	For-Profit	143	2 stars
Meadowbrook Care Center INC.	006009	Nassau	25	9	19	For-Profit	280	2 stars
Meadowbrook Healthcare	000140	Clinton	7	1	0	For-Profit	287	3 stars
Medford MultiCare Center for Living	006462	Suffolk	8	12	7	For-Profit	320	2 stars

Menorah Home & Hospital for Aged & Infirm	002539	Kings	22	30	48	Not-for-profit	436	3 stars
Methodist Home for Nursing and Rehabilitation	001221	Bronx	11	3	0	Not-for-profit	120	3 stars
Middletown Park Rehabilitation & Healthcare Center	002533	Orange	12	17	0	For-Profit	230	3 stars
Midway Nursing Home	001704	Queen	2	10	18	For-Profit	200	2 stars
Momentum at South Bay for Rehabilitation and Nursing	000934	Suffolk	31	3	0	For-Profit	160	3 stars
Monroe Community Hospital	000440	Monroe	6	6	0	Public-County	566	2 stars
Montgomery Nursing and Rehabilitation Center	000710	Orange	10	9	14	For-Profit	100	2 stars
Morningside Nursing and Rehabilitation Center	001252	Bronx	9	26	11	For-Profit	314	3 stars
Morris Park Rehabilitation and Nursing Center	001235	Bronx	3	10	20	For-Profit	191	1 star
Mosholu Parkway Nursing and Rehabilitation Center	001236	Bronx	1	6	18	For-Profit	122	2 stars
MVHS Rehabilitation and Nursing Center	006057	Oneida	11	3	0	Not-for-profit	202	1 star
Nassau Rehabilitation & Nursing Center	005710	Nassau	1	2	34	For-Profit	280	1 star
Nathan Littauer Hospital Nursing Home	000331	Fulton	2	0	0	Not-for-profit	84	3 stars
New Carlton Rehab and Nursing Center LLC	001379	Kings	1	12	1	For-Profit	148	1 star

New East Side Nursing Home	001578	New York	2	8	1	For-Profit	58	3 stars
New Glen Oaks Nursing Home, INC	001697	Queens	5	9	5	For-Profit	60	2 stars
New Gouverneur Hospital SNF	001606	New York	20	4	3	Public-Municipality	295	5 stars
New Paltz Center for Rehabilitation and Nursing	001001	Ulster	4	2	0	For-Profit	77	3 stars
New Roc Nursing and Rehabilitation Center	000448	Monroe	10	5	0			
New Vanderbilt Rehabilitation and Care Center INC	001752	Richmond	3	2	24	For-Profit	320	1 star
New York Center for Rehabilitation & Nursing	006384	Queens	2	19	27	For-Profit	280	4 stars
New York State Veterans Home at Montrose	006300	Westchester	15	9	23	Public-State	252	5 stars
Newark Manor Nursing Home INC	001031	Wayne	7	0	0	For-Profit	60	
Newfane Rehab & Healthcare Center	000586	Niagara	23	3	7	For-Profit	165	
Niagara Rehabilitation and Nursing Center	000580	Niagara	5	5	0	For-Profit	160	2 stars
North Gate Health Care Facility	001583	Niagara	9	6	0	For-Profit	200	3 stars
North Shore LIJ Orzac Center for Rehabilitation	004066	Nassau	1	16	0	Not-for-profit	120	5 star
North Westchester Restorative Therapy and Nursing	001150	Westchester	11	8	4	For-Profit	120	3 stars
Northeast Center for Rehabilitation and Brain Injury	007758	Ulster	0	1	0	For-Profit	280	2 stars
Northern Dutchess Res	000193	Dutchess	1	1	0	Not-for-profit	100	4 stars

Health Care Facility								
Northern Manhattan Rehabilitation and Nursing Center	005907	New York	16	20	12	For-Profit	320	2 stars
Northern Manor Geriatric Center INC	000784	Rockland	7	9	7	Not-for-profit	231	2 stars
Northern Metropolitan Residential Health Care Facility	000797	Rockland	4	4	0	Not-for-profit	120	3 stars
Northern Riverview Health Care Center, INC.	000774	Rockland	3	12	8	Not-for-profit	180	2 stars
Northwell Health Stern Family Center for	004089	Nassau	7	6	0	Not-for-profit	256	5 stars
Norwegian Christian Home and Health Center	001374	Kings	1	7	6	Not-for-profit	135	3 stars
Norwich Rehabilitation & Nursing Center	004522	Chenango	1	1	0	For-Profit	80	
NY Congregational Nursing Center Inc	001369	Kings	4	23	32	Not-for-profit	200	2 stars
Nyack Ridge Rehabilitation and Nursing Center	000786	Rockland	1	11	8	For-Profit	160	2 stars
NYS Veterans Home	000133	Chenango	6	2	0	Public-State	242	
NYS Veterans Home in NYC	004815	Queens	11	8	24	Public-State	250	5 stars
Oak Hill Rehabilitation and Nursing Care Center	0000982	Tompkins	10	3	0	For-Profit	60	
Oasis Rehabilitation and Nursing, LLC	000910	Suffolk	12	22	0	For-Profit	100	3 stars
Oceanside Care Center INC	000537	Nassau	7	6	1	For-Profit	100	2 stars

Oceanview Nursing & Rehabilitation Center, LLC	001688	Queens	2	12	3	For-Profit	100	2 stars
Oneida Center for Rehabilitation and Nursing	005790	Oneida	3	5	0	For-Profit	120	4 stars
Oneida Health Rehabilitation and Extended Care	000398	Madison	2	0	0	For-Profit	160	
Ontario Center for Rehabilitation and Healthcare	000683	Ontario	6	12	0	For-Profit	98	
Orchard Rehabilitation & Nursing Center	000721	Orleans	20	7	1	For-Profit	160	
Our Lady of Consolation Nursing and Rehabilitative Care	000935	Suffolk	41	27	1	Not-for-profit	345	3 stars
Our Lady Mercy Life Center	004755	Albany	11	2	1	Not-for-profit	160	3 stars
Our Lady of Peace Nursing Residence	006528	Niagara	22	3	0	Not-for-profit	250	2 stars
Oxford Nursing Home	001391	Kings	5	0	6	For-Profit	235	1 star
Ozanam Hall of Queens Nursing Home INC	001670	Queens	35	7	29	Not-for-profit	432	4 stars
Palatine Nursing Home	000489	Montgomery	6	3	0	For-Profit	70	2 stars
Palm Gardens Center for Nursing and Rehabilitation	001392	Kings	3	9	1	For-Profit	240	2 stars
Park Avenue Extended Care Facility	007823	Nassau	3	10	11	For-Profit	240	
Park Garden Rehabilitation & Nursing Center LLC	001238	Bronx	4	15	2	For-Profit	200	2 stars
Park Nursing Home	001689	Queens	1	4	0	For-Profit	196	2 stars

Park Ridge Nursing Home	000474	Monroe	2	1	0	For-Profit	120	5 stars
Park Terrace Care Center	001698	Queens	0	31	3	For-Profit	200	3 stars
Parker Jewish Institute for Health Care & Rehab	001671	Queens	83	32	0	Not-for-profit	527	4 stars
Parkview Care and Rehabilitation Center, INC.	000557	Nassau	1	4	11	For-Profit	169	1 star
Peconic Bay Skilled Nursing Facility	003826	Suffolk	20	0	0	Not-for-profit	60	5 stars
Peconic Landing at Southold	006518	Suffolk	6	2	3	Not-for-profit	60	5 stars
Pelham Parkway Nursing Care and Rehabilitation Facility	001245	Bronx	3	8	12	For-Profit	200	1 star
Penfield Place	000478	Monroe	1	0	0	For-Profit	48	2 stars
Peninsula Nursing and Rehabilitation Center	001672	Queens	4	22	3	For-Profit	200	2 stars
Penn Yan Manor Nursing Home INC	001162	Yates	9	2	0	Not-for-profit	46	
Pine Haven Home	000152	Columbia	7	6	4	For-Profit	120	
Pine Valley Center for Rehabilitation and Nursing	000778	Rockland	4	5	8	For-Profit	160	4 stars
Pinnacle MultiCare Nursing and Rehabilitation Center	001260	Bronx	2	16	0	For-Profit	480	2 stars
Pontiac Nursing Home	000732	Oswego	10	3	0	For-Profit	80	2 stars
Premier Genesee Center for Nursing and Rehabilitation	000344	Genesee	13	0	0	For-Profit	160	
Presbyterian Home for Central New York INC	000621	Oneida	16	10	1	Not-for-profit	236	2 stars

Promenade Rehabilitation and Health Care Center	001690	Queens	3	10	12	For-Profit	240	2 stars
Providence Rest, INC.	001216	Bronx	11	0	10	Not-for-profit	200	2 stars
Putnam Nursing & Rehabilitation Center	000754	Putnam	14	7	0	For-Profit	160	2 stars
Putnam Ridge	006171	Putnam	5	2	0	For-Profit	160	3 stars
Quantum Rehabilitation and Nursing LLC	000912	Suffolk	11	3	1	For-Profit	120	3 stars
Queens Boulevard Extended Care Facility	005904	Queens	4	19	3	For-Profit	280	3 stars
Queens Nassau Rehabilitation Center	001702	Queens	2	3	4	For-Profit	200	3 stars
Rebekah Rehab and Extended Care Center	001223	Bronx	5	9	19	Not-for-profit	213	1 star
Regal Heights Rehabilitation and Health Care Center	007875	Queens	9	20	5	For-Profit	280	3 star
Regeis Care Center	001242	Bronx	3	7	6	For-Profit	236	2 stars
Regency Extended Care Center	001103	Westchester	5	13	32	For-Profit	315	3 stars
Rego Park Nursing Home	001693	Queens	21	22	1	For-Profit	200	2 stars
Renaissance Rehabilitation and Nursing Care Center	000203	Dutchess	8	13	0	For-Profit	120	2 stars
Resort Nursing Home	001694	Queens	3	14	2	For-Profit	280	3 stars
Richmond Center for Rehabilitation and Specialty	004823	Richmond	1	13	12	For-Profit	372	3 stars
River Ridge Living Center	000485	Montgomery	14	3	0	For-Profit	120	2 stars
River View Rehabilitation and	000976	Tioga	11	8	0	For-Profit	77	Not available

Nursing Care Center								
Riverdale Nursing Home	001241	Bronx	1	13	4			
Riverside Center for Rehabilitation and Nursing	000767	Rensselaer	3	6	0	For-Profit	80	3 stars
Robinson Terrace Rehabilitation and Nursing Center	000169	Delaware	15	7	0	For-Profit	120	
Rockaway Care Center	001666	Queens	2	30	1	For-Profit	228	2 stars
Rockville Skilled Nursing & Rehabilitation Center, LLC	000517	Nassau	0	1	1	For-Profit	66	2 stars
Rome Memorial Hospital, Inc-RHCF	000590	Oneida	15	3	1	Not-for-profit	80	4 stars
Rosa Coplon Jewish Home and Infirmary	004772	Erie	17	3	0	Not-for-profit	180	3 stars
Rosewood Rehabilitation and Nursing Center	003920	Rensselaer	1	3	0	For-Profit	80	2 stars
Ross Center for Nursing and Rehabilitation	000932	Suffolk	7	0	7	For-Profit	120	2 stars
Rutland Nursing Home, INC.	001316	Kings	16	18	33	Not-for-profit	466	3 stars
Safire Rehabilitation of Northtowns, LLC	000266	Erie	4	6	5	For-Profit	100	3 stars
Safire Rehabilitation of Southtowns, LLC	003084	Erie	11	1	0	For-Profit	120	2 stars
Saint Joachim & Anne Nursing and Rehabilitation Center	004418	Kings	0	0	27	Not-for-profit	200	2 stars
Salamanca Rehabilitation & Nursing Center	000081	Cattaraugus	0	1	0	For-Profit	120	2 stars
Salem Hills Rehabilitation and Nursing Center	003765	Westchester	12	16	3	For-Profit	126	2 stars

Samaritan Senior Village, INC.	009472	Jefferson	2	2	0	Not-for-profit	167	Not available
San Simeon By the Sound Center for	000892	Suffolk	1	3	0	Not-for-profit	120	2 stars
Sands Point Center for Health and Rehabilitation	000546	Nassau	12	12	2	For-Profit	180	3 stars
Sans Souci Rehabilitation and Nursing Center	001106	Westchester	1	4	9	For-Profit	120	3 stars
Sapphire Center for Rehabilitation and Nursing of Central Queens, LLC	001680	Queens	4	1	50	For-Profit	227	2 stars
Sapphire Nursing and Rehab at Goshen	003407	Orange	15	5	4	For-Profit	120	2 stars
Sapphire Nursing at Meadows Hill	000696	Orange	15	16	0	For-Profit	190	2 stars
Sapphire Nursing at Wappingers	000191	Dutchess	0	1	0	For-Profit	62	2 stars
Schaffer Extended Care Center	001081	Westchester	4	7	0	Not-for-profit	150	5 stars
Schenectady Center for Rehabilitation and Nursing	000839	Schenectady	4	3	0	For-Profit	240	2 stars
Schervier Nursing Care Center	001224	Bronx	4	17	37	For-Profit	364	3 stars
Schervier Pavilion	005670	Orange	18	8	1	Not-for-profit	120	
Schoellkopf Health Center	000579	Niagara	25	2	0	Not-for-profit	120	2 stars
Schofield Residence	000269	Erie	26	3	0	Not-for-profit	120	3 stars
Schulman and Schachne Institute for Nursing and	001376	Kings	28	14	20	Not-for-profit	448	2 stars
Schuyler Hospital INC and Long Term Care Unit	000859	Schuyler	4	1	0	Not-for-profit	120	
Sea Crest Nursing and Rehabilitation	001401	Kings	14	27	10	For-Profit	305	3 stars

Sea View Hospital, Rehabilitation Center and Home	001749	Richmond	10	1	20	Public-Municipality	304	4 stars
Seagate Rehabilitation and Nursing Center	001373	Kings	5	0	31	For-Profit	360	1 star
Seneca Health Care Center	000300	Erie	14	6	0	For-Profit	160	3 stars
Seneca Hill Manor INC	007734	Oswego	18	0	0	Not-for-profit	120	
Seneca Nursing & Rehabilitation Center, LLC	000863	Seneca	2	2	0	For-Profit	120	3 stars
Seton Health at Schuyler Ridge Residential Healthcare	004826	Saratoga	4	2	0	Not-for-profit	120	3 stars
Shaker Place Rehabilitation and Nursing Center	000030	Albany	10	5	0	Public-County	250	3 stars
Sheepshead Nursing & Rehabilitation Center	001398	Kings	6	50	3	For-Profit	200	2 stars
Shore View Nursing & Rehabilitation Center	001399	Kings	28	29	2	For-Profit	320	3 stars
Silver Lake Specialized Rehabilitation and Care Center	001753	Richmond	2	6	37	For-Profit	278	2 stars
Silver Crest	004407	Queens	10	4	0	Not-for-profit	320	2 stars
Sky View Rehabilitation and Health Care Center, LLC	001120	Westchester	14	40	0	For-Profit	192	2 stars
Slate Valley Center for Rehabilitation and Nursing	004217	Washington	9	1	0	For-Profit	88	3 stars
Smithtown Center for Rehabilitation and Nursing Care	003433	Suffolk	24	8	4	For-Profit	162	2 stars

Sodus Rehabilitation & Nursing Center	001038	Wayne	2	2	0	For-Profit	124	
Soldiers and Sailors Memorial Hospital Extended Care	001159	Yales	5	3	0	Not-for-profit	150	
South Shore Rehabilitation and Nursing Center	000504	Nassau	5	12	3	For-Profit	100	3 stars
Split Rock Rehabilitation and Health Care Center	001243	Bronx	5	13	9	For-Profit	240	2 stars
Sprain Brook Manor Rehab	001114	Westchester	8	17	5	For-Profit	121	3 stars
Spring Creek Rehabilitation & Nursing Care Center	001400	Kings	2	4	11	For-Profit	188	1 star
ST Anns Community	000476	Monroe	17	4	0	Not-for-profit	470	2 stars
ST Anns Community	000477	Monroe	3	2	0	Not-for-profit	72	3 stars
ST Cabrini Nursing Home	001125	Westchester	16	9	8	Not-for-profit	304	2 stars
ST Camillus Residential Health Care Facility	000655	Onondaga	39	29	0	Not-for-profit	284	3 stars
ST Catherine Laboure Health Care Center	000252	Erie	2	2	0	Not-for-profit	80	4 stars
ST Catherine of Siena Nursing and Rehabilitation Care	003422	Suffolk	5	23	0	Not-for-profit	240	4 stars
ST Johnland Nursing Center, INC	000951	Suffolk	20	3	21	Not-for-profit	250	3 stars
ST Johns Health Care Corporation	000442	Monroe	35	7	0	Not-for-profit	455	4 stars
ST Luke Residential Health Care Facility INC	000735	Oswego	21	4	0	Not-for-profit	200	2 stars
ST Mary Center INC	004533	New York	0	2	0	Not-for-profit	40	5 stars

ST Patricks Home	001217	Bronx	26	0	14	Not-for-profit	264	3 stars
ST Vincent Depaul Residence	004543	Bronx	22	12	0	Not-for-profit	120	Not available
ST James Rehabilitation & Healthcare Center	000950	Suffolk	31	14	0	For-Profit	230	2 stars
ST Josephs Place	003914	Orange	7	1	1	Not-for-profit	46	
ST Peter's Nursing and Rehabilitation Center	000017	Albany	15	0	0	Not-for-profit	160	
Staten Island Care Center	001756	Richmond	2	4	16	For-Profit	300	1 star
Suffolk Center for Rehabilitation and Nursing	000888	Suffolk	2	9	1	For-Profit	120	2 stars
Sullivan County Adult Care Center	000963	Sullivan	5	1	0	Public-County	146	
Sunhabor Manor	000548	Nassau	26	17	10	For-Profit	266	4 stars
Sunnyside Care Center	000664	Onondaga	4	0	0	For-Profit	80	
Sunrise Manor Center for Nursing and Rehabilitation	000931	Suffolk	3	16	3	For-Profit	84	2 stars
Sunset Nursing and Rehabilitation Center, INC.	000613	Oneida	9	1	0	For-Profit	120	
Surge Rehabilitation and Nursing LLC	000909	Suffolk	9	4	4	For-Profit	149	3 stars
Susquehanna Nursing & Rehabilitation Center, LLC	000060	Broome	16	3	1	For-Profit	160	2 stars
Sutton Park Center for Nursing and Rehabilitation	001080	Westchester	7	17	7	For-Profit	160	3 stars
Syracuse Home Association	004323	Onondaga	2	1	0	Not-for-profit	120	4 stars
Tarrytown Hall Care Center	001115	Westchester	3	7	0	For-Profit	120	3 stars

Ten Broeck Center for Rehabilitation & Nursing	004710	Ulster	32	0	0	For-Profit	258	2 stars
Terence Cardinal Cooke Health Care Center	003089	New York	24	23	9	Not-for-profit	559	3 stars
Teresian House Nursing Home CO INC	000023	Albany	21	7	0	Not-for-profit	300	3 stars
Terrace View Long Term Care Facility	001739	Erie	7	6	0	For-Profit	390	4 stars
The Amsterdam at Harborside	009186	Nassau	3	0	0	Not-for-profit	56	5 stars
The Baptist Home at Brookmeade	000195	Dutchess	8	0	0	For-Profit	120	2 stars
The Brightonian, INC	000463	Monroe	11	1	0	For-Profit	54	1 star
The Brook at High Falls Nursing Home and Rehabilitation	000434	Monroe	2	3	0	For-Profit	28	Not available
The Chateau at Brooklyn Rehabilitation and Nursing	001383	Kings	9	4	20	For-Profit	189	3 stars
The Citadel Rehab and Nursing Center at Kingsbridge	001234	Bronx	9	3	49	For-Profit	385	2 stars
The Commons on St. Anthony, A Skilled Nursing & Short	000092	Cayuga	48	9	0	Not-for-profit	300	2 stars
The Cottages at Garden Grove, A Skilled Nursing	000657	Onondaga	1	0	0	Not-for-profit	156	3 stars
The Emerald Peek Rehabilitation and Nursing Center	001042	Westchester	3	8	2	For-Profit	96	1 star
The Enclave at Rye Rehabilitation and Nursing Center	001094	Westchester	4	7	17	For-Profit	160	

The Five Towns Premier Rehabilitation & Nursing Center	000539	Nassau	8	10	2	For-Profit	280	3 stars
The Friendly Home	000464	Monroe	14	1	0	Not-for-profit	200	3 stars
The Grand Pavilion for Rehab & Nursing at Rockville	000516	Nassau	19	15	14	For-Profit	158	2 stars
The Grand Rehabilitation and Nursing at Barnwell	000154	Columbia	13	9	0	For-Profit	236	2 stars
The Grand Rehabilitation and Nursing at Batavia	000343	Genesee	6	1	0	For-Profit	62	
The Grand Rehabilitation and Nursing at Chittenango	000403	Madison	3	0	0	For-Profit	80	2 stars
The Grand Rehabilitation and Nursing at Great Neck	000521	Nassau	18	10	9	For-Profit	214	3 stars
The Grand Rehabilitation and Nursing at Guilderland	000033	Albany	3	7	0	For-Profit	127	2 stars
The Grand Rehabilitation and Nursing at Mohawk	000357	Herkimer	11	3	0	For-Profit	120	2 stars
The Grand Rehabilitation and Nursing at Pawling	000189	Dutchess	4	6	8	For-Profit	122	3 stars
The Grand Rehabilitation and Nursing at Queens	001675	Queens	3	21	0	For-Profit	179	2 stars
The Grand Rehabilitation and Nursing at River Valley	006232	Dutchess	3	0	0	For-Profit	160	2 stars

The Grand Rehabilitation and Nursing at Rome	000593	Oneida	9	5	7	For-Profit	160	2 stars
The Grand Rehabilitation and Nursing at South Point	000564	Nassau	1	3	0	For-Profit	185	
The Grand Rehabilitation and Nursing at Utica	000609	Oneida	12	6	0	For-Profit	220	Not available
The Grove at Valhalla Rehabilitation and Nursing Center	007605	Westchester	5	6	5	For-Profit	160	2 stars
The Hamlet Rehabilitation Healthcare Center at	003230	Suffolk	8	7	8	For-Profit	240	2 stars
The Hamptons Center for Rehabilitation and Nursing	006871	Suffolk	7	1	14	For-Profit	280	2 stars
The Heritage Rehabilitation and Health Care Center	001393	Kings	1	5	2	For-Profit	79	2 stars
The Highlands at Brighton	005538	Monroe	21	5	0	Not-for-profit	145	4 stars
The Hurlbut	000465	Monroe	10	0	7	For-Profit	160	3 stars
The Knolls	006519	Westchester	0	1	1	Not-for-profit	20	5 stars
The New Jewish Home, Manhattan	001603	New York	48	6	13	Not-for-profit	514	2 stars
The New Jewish Home, Sarah Neuman	001113	Westchester	51	4	0	Not-for-profit	300	3 stars
The Osborn	001134	Westchester	8	2	6	Not-for-profit	84	5 stars
The Paramount at Somers Rehabilitation and Nursing	001148	Westchester	14	11	20	For-Profit	300	2 stars
The Pavilion at Queens Rehabilitation & Nursing	007298	Queens	4	15	11	For-Profit	302	1 star

The Phoenix Rehabilitation and Nursing Center	001405	Kings	29	7	37	For-Profit	400	2 stars
The Pines at Catskill Center for Nursing & Rehabilitation	000349	Greene	11	7	3	For-Profit	136	2 stars
The Pines at Glens Falls Center for Nursing &	001010	Warren	5	2	2	For-Profit	120	4 stars
The Pines at Poughkeepsie Center for Nursing &	000186	Dutchess	13	15	1	For-Profit	200	3 stars
The Pines at Utica Center for Nursing & Rehabilitation	000608	Oneida	5	2	0	For-Profit	117	3 stars
The Pines Healthcare & Rehabilitation Centers Machias	000083	Cattaraugus	0	1	0	Public-County	115	3 stars
The Plaza Rehab and Nursing Center	001225	Bronx	27	12	49	For-Profit	744	2 stars
The Riverside	001370	New York	50	16	18	For-Profit	520	1 star
The Shore Winds, LLC	000437	Monroe	20	1	1	For-Profit	229	
The Valley View Center for Nursing Care and	000702	Orange	53	16	3	Public-Country	360	2 stars
The Villages of Orleans Health and Rehabilitation	000716	Orleans	23	7	1	For-Profit	120	
The Wartburg Home	001068	Westchester	22	11	13	Not-for-profit	210	3 stars
The Willows at Ramapo Rehabilitation and Nursing	000780	Rockland	8	1	18	For-Profit	203	
Throgs Neck Rehabilitation & Nursing Center	004814	Bronx	7	1	36	For-Profit	205	1 star
Tolstoy Foundation	000785	Rockland	7	3	3	Not-for-profit	96	Not available

Rehabilitation and Nursing Center								
Townhouse Center for Rehabilitation & Nursing	006050	Nassau	10	5	8	For-Profit	280	2 stars
Triboro Center for Rehabilitation and Nursing	001249	Bronx	3	16	12	For-Profit	405	2 stars
Troy Center for Rehabilitation and Nursing	000762	Rensselaer	5	5	0	For-Profit	78	3 stars
Union Plaza Care Center	006037	Queens	21	6	29	For-Profit	280	2 stars
United Hebrew Geriatric Center	001077	Westchester	5	0	6	Not-for-profit	294	4 stars
United Helpers Canton Nursing Home	000810	Saint	13	3	0	Not-for-profit	96	
United Helpers Nursing Home	000802	Saint	21	1	0	Nott-for-profit	180	
Unity Living Center	003392	Monroe	5	6	0	Not-for-profit	120	4 stars
University Center for Rehabilitation and Nursing	001244	Bronx	2	1	2	For-Profit	46	3 stars
Upper East Side Rehabilitation and Nursing Center	001582	New York	18	51	11	For-Profit	499	3 stars
Utica Rehabilitation & Nursing Center	000607	Oneida	6	2	0	For-Profit	120	2 stars
Valley Health Services INC	003170	Herkimer	10	0	0	Not-for-profit	160	3 stars
Valley View Manor Nursing Home	000131	Chenango	10	0	0	For-Profit	82	
Van Duyn Center for Rehabilitation and Nursing	000650	Onondaga	45	8	1	For-Profit	513	2 stars
Van Rensselaer Manor	000761	Rensselaer	2	3	0	Public-County	362	2 stars
Verrazano Nursing Home	001754	Richmond	7	1	13	For-Profit	120	2 stars

Vestal Park Rehabilitation and Nursing Center	009514	Broome	7	2	2	For-Profit	160	2 stars
Victoria Home	001090	Westchester	2	4	4			
Villagecare Rehabilitation and Nursing Center	001599	New York	2	0	0	Not-for-profit	105	5 stars
Warren Center for Rehabilitation and Nursing	001008	Warren	5	2	0	For-Profit	80	2 stars
Washington Center for Rehabilitation and Healthcare	001026	Washington	5	1	0	For-Profit	122	2 stars
Waters Edge Rehab & Nursing Center at Port Jefferson	000899	Suffolk	6	8	2	For-Profit	120	2 stars
Waterview Hills Rehabilitation and Nursing Center	001144	Westchester	11	9	1	For-Profit	130	3 stars
Waterview Nursing Care Center	001677	Queens	2	2	5	For-Profit	200	2 stars
Waterville Residential Care Center	000618	Oneida	4	1	0	For-Profit	92	2 stars
Wayne Center for Nursing & Rehabilitation	001257	Bronx	0	1	0	For-Profit	243	2 stars
Wayne County Nursing Home	001034	Wayne	2	2	0	Public-County	192	
Wayne Health Care	001029	Wayne	15	2	0	Not-for-profit	180	
Wedgewood Nursing and Rehabilitation Center	000457	Monroe	2	1	0	For-Profit	29	Not available
Wells Nursing Home Inc	000335	Fulton	2	2	0	For-Profit	100	4 stars
Wellsville Manor Care Center	002589	Allegany	9	8	0	For-Profit	120	2 stars
Wesley Garden Corporation	000449	Monroe	3	5	0	For-Profit	200	4 stars
Wesley Health Care Center INC	000822	Saratoga	29	4	0	Not-for-profit	342	3 stars

West Lawrence Care Center LLC	001726	Queens	8	20	2	For-Profit	215	1 star
Westchester Center for Rehabilitation & Nursing	001069	Westchester	5	14	0	For-Profit	240	2 stars
Western New York State Veterans Home	005751	Genesee	18	5	0	Public-State	126	
Westhampton Care Center	005638	Suffolk	23	10	0	For-Profit	180	2 stars
White Oaks Rehabilitation and Nursing Center	003872	Nassau	33	13	8	For-Profit	200	2 stars
White Plains Center for Nursing Care	001058	Westchester	5	0	0	For-Profit	88	Not available
Wilkinson Residential Health Care Facility	000483	Montgomery	15	4	0	Not-for-profit	160	4 stars
Williamsbridge Center for Rehabilitation and Nursing	001247	Bronx	2	6	1	For-Profit	77	2 stars
Williamsville Suburban LLC	001378	Erie	8	15	0	For-Profit	220	2 stars
Willow Point Rehabilitation and Nursing Center	000064	Broome	35	15	0	Public-County	300	2 stars
Windsor Park Nursing Home	001699	Queens	9	3	0	For-Profit	70	2 stars
Wingate at Beacon	006237	Dutchess	19	2	0	For-Profit	160	3 stars
Wingate at Dutchess	005760	Dutchess	3	4	0	For-Profit	160	3 stars
Wingate at Ulster	007064	Ulster	7	3	0	For-Profit	120	4 stars
Woodcrest Rehabilitation & Residential Health Care	001700	Queens	5	18	0	For-Profit	200	2 stars
Woodhaven Nursing Home	000908	Suffolk	6	12	0	For-Profit	143	2 stars
Woodland Pond at New Paltz	009136	Ulster	0	1	0	Not-for-profit	40	5 stars
Workmen's Circle Multicare Center	001219	Bronx	17	36	12	For-Profit	524	2 stars

Wyoming County Community Hospital SNF	001154	Wyoming	4	3	0	Public-County	138	
Yonkers Gardens Center for Nursing and Rehabilitation	001109	Westchester	7	8	12	For-Profit	200	3 stars
Yorktown Rehabilitation & Nursing Center	0003630	Westchester	7	6	5	For-Profit	125	2 stars

The numbers displayed are provided by ACF and NH facilities and capture COVID-19 presumed deaths at NHs and ACFs, and COVUD-19 confirmed out of facility (hospital/other) deaths of NH facility residents, as reported by NHs. Retrospective data reporting fates back to March 1, 2020 and data is updated as fatality reports are confirmed and validated by DOH.

Sources: NYS Department of Health, Center for Medicare and Medicaid Services.

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PROPOSED COMMENTS UPON TASK FORCE ON NURSING HOMES

AND LONG-TERM CARE

As Co-Chair of the Committee on Disability Rights I strongly applaud the comprehensive analysis performed by the Task Force on Nursing Homes and Long-Term Care. The report demonstrates not only the breath of the impact from the pandemic, but how a progressive institutionalization system has been created over decades that was ill-equipped for the pandemic as a result of living environments that had an almost equal detrimental effect upon quality of life. Frank discussions are now occurring about how we live as we die that have been avoided for decades and are now being addressed forthrightly. The Task Force has bravely advanced these discussions and on behalf of the Committee on Disability Rights I am grateful to the Task Force members and our representatives Sheila Shea, Mary Morrissey and Simeon Goldman.

Recognition must be given to Association leadership and particularly President Karson for expeditiously creating the Task Force to address ramifications from the pandemic. The work of the Task Force was clearly a collaborative effort. Special mentioned must be given to Chair Hermès Fernandez. After one brief voicemail message asking for the CDR to be included Hermes' response was immediate and meaningful. This is merely an example of the foresightful efforts of the Task Force to have diversity inclusion which is reflected throughout the Report.

This Task Force report has been a pinion in moving forward to address the problems and create a format to discuss solutions. None of the members involved had expertise in all areas addressed but collaboratively created a report addressing the broad dynamic and coalescing similarities instead of solely being focused on criticism and differences.

The nursing home industry, or indeed all large-scale congregate care, are not "villains" in the least. This system has been a societal creation and for some reason our society has repeatedly created these systems. State Hospitals are a living memory and were deconstructed to a community-based system. The pandemic has exposed similar systemic fractures in congregate care which may have similar solutions.

The Report provides an excellent analysis of the broad similarities in how our "system" addresses disabilities based upon age, type, program and payor source and the need to redirect towards appropriate community-based residences with supports and services to facilitate quality of life in the least restrictive living environment regardless of age.

There are many community programs that can be extended and enhanced to provide oversight and assistance as they currently do in programs for different types of persons with disabilities. Examples are Community Medicaid; Home and Community Based Services; "Open Door" (Money Follows the Person); Nursing Home Transition and Diversion; TBI; and Mental Health Enriched Housing. Note these examples further demonstrate the segmentation and silos that exist despite all have the same ultimate purpose.

The Report demonstrates the stark contrast between how we address aging related developmental disabilities and other types of disability, particularly where the age onset is as a child instead of as an adult. People with disabilities largely age in place. Group Homes are an example that includes persons who are part of the Willowbrook Class and continue to reside in place despite now developing age related disabilities. However, our aging population is shuffled between home, Adult Homes, Senior Housing, Assisted Living, Nursing Homes and Hospice. All occurring while they are least capable to control their destiny and while they are aware of their decreasing physical and mental capabilities. The lack of psychological supports and mental health services are abysmal.

Part of the reason why large-scale congregate care has been created is a result of the need to create housing that can accommodate disability and provide appropriate services. Many primary homes and residences are unsuitable as a result of the curse of stairs and small bathrooms or that a person needs 24-hour care requiring "overnights". While the Report correctly points out most New Yorkers continue to live home, they also correctly point out the severe staffing problems with historically low wages and no benefits have deterred individuals from performing these often-demanding jobs. Who can blame a staff member without benefits refusing work during the height of the pandemic? Yet, as this legislative session ends that problem will necessarily persist. Care givers continue to have low wages and no benefits despite the physical, emotional and very personal demands of the job.

The Report first and foremost recommends we "Rethink the Delivery of Long-Term Care" and provides examples how this can be accomplished. The Report demonstrates how our system of caring for people with disabilities, regardless of age, arises from a lack of accommodative community housing with appropriate service delivery.

The attached Proposal began in concept amongst an ad hoc group of disability and elder professionals including attorneys looking for solutions while learning Zoom. From there, the collaborative network branched out and continues to grow. NYSBA was instrumental in the development and should take pride in the professionalism and collegiality among our members. The Proposal is non-proprietary and a work in progress. Like this Report, it is an effort to meaningfully address the crisis and inspire solutions not only to the current environment but the embedded pre-existing challenges.

As the Report demonstrates, solutions exist but are unrecognized. Already a majority of the older persons are aging in place. We already have community-based service delivery. We have existing programs that provide for congregate care avoidance. While the Proposal is not unique in method or manner, it appears unique as there is no similar program that allows primary residence condominium home ownership as a Community Medicaid exempt asset; utilizing Community Exempt income to maintain monthly expenses while remaining qualified to receive licensed and appropriate care services. Importantly, people can live with their spouse, child or caregiver and never have to move. They will remain in their home with an appropriate and comforting living environment through their passing.

Continuing discussions need to occur among the diverse perspectives reflected by the Task Force membership and resulting Report. It has been a privilege for CDR to have participated in the creation of this report and we look forward to continuing collaborations.

I WHOLLY RECOCOMMEND ACCEPTANCE OF THE REPORT WITH GRATEFUL APPRECIATION.

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Joseph J. Ranni
Co-Chair Committee on Disability Rights

The opinions expressed are those of the author and do not reflect endorsement or position of the Association or any Section or Committee.

Accommodative Residences Utilizing Community Medicaid Exemptions for Older Persons and Persons with Disabilities

A Multi-Disciplinary Collaborative Effort

Executive Summary Overview

The singular goal of the following non-proprietary proposal is to provide a person centered cost-effective alternative approach for individuals who may not need to be or can avoid being in a skilled nursing facility. Embodied in the Nursing Home Medicaid system, there are predispositions toward congregate care when daily care exceeds 12 hours and are directed towards Nursing Homes instead of being provided supportive assistance that would enable them to remain at home or in alternative accommodative housing fully interwoven into the fabric of community living.

A significant reason people can't remain home are architectural barriers such as stairs and small bathrooms. A lack of accommodative housing for older persons and persons with disabilities is historic and largely the reason people with disabilities, regardless of age are compelled to large scale congregate care. Medicaid thereby ultimately became the payor while the individual becomes impoverished. In effect, a disability penalty and a living environment few choose.

Community Medicaid, a quite different program from Nursing Home Medicaid, was originally developed as a nursing home and congregate avoidance program – patterned from the Willowbrook Decree that deinstitutionalized state hospitals. In that instance, scaled-down community-based group homes were developed as an alternative to permanent institutional confinement, creating an array of modestly sized residences supported by an elaboration of integrated programs and services.

The congregate care system evolved over centuries in an attempt to address the complex and presumptively 'burdensome' issues commonly associated with aging and disability. The need for changes in both policy and practice is undeniable as events over the recent year have caused many of us to rethink the reasons and economies for the existing system. In fact, there are many programs that currently exist with the same purpose. Essentially, this proposal provides a method for an individual to choose and provide for their own accommodative housing without the need to depend on public funds for their housing and monthly support. The individual preserves their assets or uses their money otherwise lost to Medicaid impoverishment requirements for a primary home-like residence in their local community. Medicaid will save money as they are no longer responsible for room and board as well as

solving the "overnights" problem and fluid care delivery with small economies of scale.

This proposal offers an alternative that is humane and cost effective, that restores connection, dignity, and hopefulness to our most vulnerable citizens. It develops accommodative housing that embraces a holistic, person-centered approach to addressing the long-term care needs identified by each individual, one that focuses on core health determinants, leverages the strength of existing health care and social service providers (consistent with existing Community Medicaid, Nursing Home Waiver, Redirection and Avoidance programs). Importantly the proposal preserves personal resources and yields Medicaid savings through the benefits of co-located individuals requiring care. Regardless, as congregate facilities are being challenged by the costs of maintaining large facilities, this proposal provides an opportunity for integrating accommodative environment options consistent with or beyond those currently being provided.

We are all familiar with the seemingly hopeless progression from home… to senior housing… to assisted living… to nursing home… to hospice, yet little attention is given to the transfer trauma. Virtually no one likes to move from safe familiar surroundings yet doing so has become an integral part of aging in our state and nation. As a state and nation, we have willingly if reluctantly embraced this shuffle as unalterable, a march towards death that strips us of our freedom, our sense of purpose and our connections with family and community. They are replaced with a pattern of institutional diversions designed to provide momentary distractions and to cajole loved ones into thinking they have made the right decision.

Health care providers and systems are becoming increasingly aware of the importance of caregiving approaches that promote continuing wellness by addressing both medical needs and social determinants of health – conditions directly associated with where people live, learn, work, and play that affect a wide range of health and quality-of-life risks and outcomes. Often, these are a key driver to ensuring health equity, where everyone can attain their full wellness potential regardless of social position or other socially determined circumstance. Moreover, multiple studies have found that approximately 60 percent of the factors that influence health and wellness are nonmedical social, behavioral, and environmental, while only 20 percent are genetic, and the remaining 20 percent are associated with health care. The studies are numerous that demonstrate appropriate transitions between hospitals and homes reduce readmissions and health care costs, increases satisfaction with care, and achieve better outcomes.

Revealing the limitations inherent in the nursing home model of care is not intended as a challenge to the dedication of caregivers, medical professionals and administrators caught up in a broken system. They more

than anyone have personally witnessed the tragedy imposed by the pandemic. Instead, this proposal is an opportunity to revisit the question of care for older persons and people with significant disabilities. Collaboratively we can find transformational solutions that redefine how best to apply our resources to the challenge of "building back better"; to replacing isolation with family and community contact, despair with hope, distraction with purposeful activity, and to make aging in place a reality for members of our community at all stages of life.

Proposal Description

The proposal is to develop a community condominium residence consisting of 10-12 fully accessible suites with accompanying amenities, each being connected directly with interior and exterior common areas. The direct access to interior common areas could be through a foyer, but not a hallway. Suites would be large enough to accommodate an individual or couple; disabled child for whom an adult is a caregiver or adult child who is a caregiver to their parent; in-home service providers as needed; or visiting family members. The suite would be of universal design with private bedroom, possibly a second bedroom; accommodative bath, sitting area, and hazard-free kitchenette while exterior areas would include porches and patios, with easy access to secure courtyards offering lawn and garden areas, a playground (for visiting children) and barrier-free walkways.

All homes would be resident owned, enabling them to preserve financial resources permissible through the Community Medicaid primary residence exemption of $906,000. The suite and common non-care services would be sustained through the monthly income exemption of $884 and potentially additional exempt excess income expended consistent with existing Community Medicaid regulations through currently well utilized Pooled Trusts.

Medicaid requires near complete impoverishment since a person is only allowed non-exempt assets of $15,750 and $884 of income per month. If a spouse also requires Medicaid, then non-exempt assets are $23,400 and income limit of $1,300. If the spouse does not need Medicaid, they are entitled to a supportive Minimum Monthly Needs Allowance of at least $3,259.50 or maintain their own income and contribute 25% of the excess above $3,259.50 for the care and support of their spouse. The spouse is also able to retain non-exempt resources up to $130,380.

For the individual, "excess income" which most people have beyond $884 (pensions, 401ks, IRAs, annuities; etc.) can be deposited in a "pooled" trust that is professionally managed consistent with Medicaid guidelines and pays for supports, services, and luxuries Medicaid does not. The categories are very broad and can include any self-benefitting expense. For example, proper expenses for art or music "therapy"; appropriate furniture; or lightweight wheelchairs and other durable medical equipment to facilitate not only the person but those who assist them. The individual retains maximum independence and enjoys the benefit of using *their own* money as long as they personally benefit from the expenditure. In fact, *all of the money* to create and operate the residence is using the persons own resources and income. Public benefits would provide the same service delivery as currently exists for persons on Community Medicaid and residing home. Medicaid should experience *decreased expenditures* from not having to provide housing and benefitting from small economies of scale to deliver care. Congregate care does have its benefits and few would argue different as long as it is a personal choice and amongst options that aren't Hobson's Choices. However, as we now see, the large economies of scale are now dis-economic and there is a clear policy and demand shift away from what was previously acceptable.

A person is eligible and qualifies for Community Medicaid when they are below the above asset and income thresholds and need "hands-on" or "arm's reach" with at least three (3) Activities of Daily Living and a *filed* application. The "spend downs" and elder planning *must* be done before the application.

An assessment is performed through a state designated entity which evaluates the needs, care and supports as well as personal assistance resources available (ex. family members). From the care plan established, services can be obtained either through a MLTCP or CDPAS as the individual may choose. If a person chooses a MLTCP they typically have a choice amongst several companies who perform another assessment and "offer" what services, they will provide.

Most people receive services based upon "hours a day" correlated to need and a schedule to address those needs. Requiring more than 12 hours (overnights) is a logistical challenge to remain home. While most advocates argue the "per capita" rate paid MLTCPs encourages them to compel "high needs" transfer to congregate care, there is also the reality of industry-wide staff shortages. Small congregate care as proposed provides the opportunity to achieve a small economy of scale.

Notably, as CDPAS programs allow people to self direct care providers who are providing the needed services, traditional "licensing" of aides is not required. Consequently, the program provides the opportunity to expand the labor pool. All care givers under CDPAS must be properly vetted with payments monitored through a Fiscal Intermediary (FI). The FI is responsible to make sure the person is trained, able to perform the services and actually performs the services. While government costs are not increased by persons utilizing this program compared to Managed Long Term Care Plans (MLTCP), the ability to "self-direct" the care services and person providing them facilitates more appropriate care.

As previously stated, typical elder planning occurs *prior* to the filing of Medicaid application regardless of whether the planning is for Nursing Home or Community Medicaid. Both Medicaid programs were created to provide necessary supports and services for poor people. Elder planning seeks to protect assets while rendering individuals "poor" to qualify for benefits. If the assets aren't protected, they indeed will lack necessary resources due to the very low Medicaid limits and often drag their spouse with them into poverty. Beyond calculating the different "lookback periods" for Nursing Home Medicaid and Community Medicaid related to "gifting" money away from the person are strategies to "spend down" a person's assets to get under the Medicaid "resource" limit and preserve assets consistent with Medicaid guidelines.

For Community Medicaid planning, the primary home is always the initial "go to" for spending money on an exempt asset that provides an appropriate and comfortable environment that is then preserved through the primary residence exemption. Typical planning seeks to provide accommodative housing that will facilitate the needs of the individual through death and preserve assets to access in times of need.

Any money not properly preserved or transferred will be lost to Medicaid to pay for the services Medicaid provided during life. Most are familiar with spousal refusal where a spouse protects assets by refusing to make those resources available to the needy spouse. Upon the Medicaid individual's death, Medicaid has a right to recover those expenses from remaining assets with certain exemptions. Contrary to popular belief, the primary goal of elder law is *preserving* assets for an individual's benefit and preparing for the most difficult transition we have in life. Regardless, most of us have witnessed the depression and discouragement of a couple facing the loss of their life's savings and the evaporation of their hopes of providing for progeny.

Special note should be made of the impact the current system has upon the "well" spouse, often compromised as well. First, our system separates spouses and the lack of appropriate housing is the primary reason. They both can't be where they are and can't be together where the other has to go. Additionally, they are compelled to "refuse" their spouse and a notably sickening elder planning strategy of divorce. This proposal addresses these issues as spouses will never have to part; be rendered poor; or struggle without assistance because they will not separate.

Amazingly, despite older persons and persons with disabilities facing the most challenging aspects of life there is a dearth of psychological supports, services, or treatment. There are few things more disturbing to witness than a person with a dementia realizing their loss of mental acuity. Yet, what assistance exists? In the community there are mental health programs, peer supports, family, friends, religious and social communities.

During the discussions in the crowdsourcing of this proposal staffing and workforce issues came up continuously. Indeed, the lack of available workforce was a chronic problem before the pandemic and worse now as many caregivers have left the industry, some tragically. Of course, nursing home occupancy rates have been drastically reduced, and more people are remaining home requiring substantial assistance. It would be to deny the obvious that 24-hour at home care stretches the available workforce even thinner.

The proposal can expand the workforce available to perform this important work as some non-caregiving services are being provided by the residence, the most important being fresh food, security and housekeeping of common areas. Additionally, there would be a reduced need for some services as family, friends and community relationships are more readily available. Community Medicaid currently considers available informal, volunteer and family services as part of their assessment. Current community service programs can be expanded for support, assistance, and oversight.

Optimally, Community Medicaid would waive any right of recovery against the primary residence providing a further incentive so that suite occupant/owners could pass the primary residence value to beneficiaries. Notwithstanding, this proposal is not dependent upon such a waiver and traditional elder planning could still occur.

Some have commented on the potential desirability for a non-disabled person to want to reside in a residence. For some residences, that may be true and desirable creating a more integrated setting. However, for

residences dominated by older persons, compelled to move there from home, and the serious care giving most would be receiving, it is doubtful the issue would be a problem though it would be a testament that the goal of the proposal was achieved for the persons to whom it is directed.

Additionally, there is the potential that community residences could be established for separate purposes that individuals would find attractive to invest their personal funds, such as for young disabled adults or parents with disabled children. Hopefully, these residences wouldn't necessarily be standalone structures or clustered but integrated with affordable housing, workforce housing or perhaps even a golf community.

How creative might the free market be? The proposal would not require any more capital to develop than a small housing development. There is not the need for the capital-intensive system and basic utilitarian environment that exists due to a dependency upon the Medicaid monthly billing and large numbers of "beds" to create the necessary large economies of scale.

Developing a condominium plan per project would impose significant costs that would inhibit development of single residences in rural areas where there is the most need. In Western NY for instance the closest nursing home could be more than 30 miles away. The goal of this proposal is to reach all communities and the legal expenses are daunting relative to a single project. Consequently, additional collaborative efforts are needed to address how to streamline costs and approval. An acknowledgement needs to be made to the NYS Attorney General's Office who have been informative and gracious.

Small economies of scale demonstrably exist. While this proposal can certainly provide an alternative to Group Homes, Group Homes demonstrate small economies of scale are achievable. Viability is further demonstrated by alternative community-based housing innovations such as the Green House Project (https://thegreenhouseproject.org/) which is based upon being a small-scale nursing home of design consistent with this proposal. However, there is no reason this small community based accommodative residence couldn't be created and operated consistent with Community Medicaid exemptions described above with services provided through existing long term care programs. Another notable current grassroots example is people renovating their large homes to accommodate several similarly situated persons and achieve a small economy of scale to receive more appropriate services. A common planning practice in elder law is to co-locate family members who need services. Additionally, religious

communities facing the issues of aging are also good examples of truly aging in place.

This community-based solution seeks to provide permanent long-term housing for older persons and people with disabilities that would offer the array of collateral benefits typically associated with providing fully accessible home ownership. First, unlike the current system, spouses would remain together. Certainly, there are enhanced opportunities for contact with friends, family members and religious communities. Expanded services can be provided by community-based, multi-sector organizations that include individually aligned health and social interventions aimed at addressing the whole person.

This proposal seeks to achieve a better overall quality of life, providing the least restrictive living environment and promoting the self-management of chronic health conditions – which is particularly important as the health care sector transitions to value-based payment models.

Smaller economies of scale can provide for the overnights economically and provide more appropriate service delivery over the course of a day instead of a rigid schedule often currently required for home care. Additionally, as MLTCP benefit from providing services to people co-located there would be the greater potential of obtaining more or better-quality services than would be available at home.

With the goal of creating and sustaining independent environments that comprehensively facilitate aging in place, the residence would be supported by a number of on-site services including building management, food services, housekeeping, and maintenance services of common areas. The monthly excess income exemption allowed by Community Medicaid could be used to offset non-Medicaid housing and cost of living related expenses. Regardless, the home's equity could still be accessed for any purpose, sufficient funds would need to be available to offset monthly common charges, perhaps mortality + 5 years to determine necessary reserves.

Questions arose in collaboration as to what type of licensing, if any, would be appropriate. While a detailed analysis of the scope of existing licensing provisions for nursing homes, assisted living, adult homes, enhanced adult homes and Continuing Care Retirement Communities is beyond the scope of this Overview, simplistically it is a tiered hierarchy based upon the functional needs of the individual and insuring appropriate personal care services are provided by licensed individuals. In the proposal, those care giving services are provided not by the residence but by licensed care givers as would occur

if they lived at home. The residence would be providing services more aligned with the hospitality industry which also provides food, common facilities and housekeeping with the oversight and inspections common to that industry.

Notwithstanding, oversight is also enhanced as the residence would be located within or close to the community of their choice, assumedly close to family and friends. Additionally, community programs exist that could be expanded. There are many innovative proposals in NY and nationwide to expand community services and oversight.

Proposal Development

The proposal is designed to serve all populations who may need any long-term services and supports. At its core, this proposal embodies a new vision… one that acknowledges and respects the right of all individuals to live with dignity in the home of their choosing, and to play *the* central role in decision-making that effects where they reside, the care they receive as well as their participation in family and community living.

There is also opportunity to integrate with existing "self-help' and supported living initiatives that have long existed in assisting persons with disabilities. The potential exists for a person on public benefits to invest exempt assets, which like Community Medicaid typically exist in these types of programs, in an exempt primary residence which facilitates the economic ability to transition out of a supported program. The studies are numerous as to the uplifting effect of home ownership for persons in transition.

There is no reason that persons with assets should be inhibited from accessing a viable option as their economic situation may provide. A common denominator of poverty is abhorrent. Our society is full of talented builders, architects and entrepreneurs who can exercise creativity in development. One benefit *is* that this proposal provides a local solution, whether urban or rural, and is not dependent upon financing large complexes. Notwithstanding, existing programs for the economically disadvantaged can be expanded consistent with this proposal with similarly potential reduced government expenditures.

There is near universal recognition of the demand and policy shifts away from large scale congregate care and institutionalization towards small community-based housing. This proposal provides a free market non-

governmental solution that will allow people to live with their spouse in an accommodative environment of their choosing in their local community. They will never be shuffled or transferred while preserving their resources and liquidity. Medicaid will save money through small economies of scale and more appropriate service delivery. Halcyon? Not at all, this proposal could be developed tomorrow and should be. This a combination of existing programs, nothing in it is truly unique.

Conclusion

The time has come to move away from the institutional model that has governed the way people live as they are dying. How WE will live as we die. The pandemic has created a tragic opportunity to address long standing festering issues at their root and create appropriate and accommodative living environments for all persons.

Respectfully Submitted,

Joseph J. Ranni, Esq.

May 28, 2021

The opinions expressed are those of the author and do not reflect any endorsement or position of any person, legal or professional Association, Organization, or entity.

Joseph Ranni is the Co-chair of the Disability Rights Committee, a member the Health Law Section Long Term Care Planning Committee and Public Health Committee, and the Elder Law/Special Needs Section and Committee on Long Term Care Reform. He is also Board President of the non-profit Independent Living, Inc. He received his JD from Brooklyn Law School (’87) and LL.M.- Elder Law from Stetson College of Law (’15)

Doug Hovey, a Contributing Editor, is the Founder and Executive Director of Independent Living Inc. (ILI) which provides community supports, services and accommodative housing in the Hudson Valley. He is a noted statewide advocate and testifies frequently before the NYS Legislature.

Assistance in drafting by A.J. Abrams is gratefully acknowledged.

Additional Recognition

Substantial feedback, guidance and encouragement from members of the New York State Bar Association Health Law Section, Public Health Committee and Long Term Care committee; the Elder Law/Special Needs Section and Long Term Care Reform Committee and the Committee on Disability Rights which were critical to the development of this proposal. Notwithstanding, contributions from elder rights advocates; Independent Living Organizations and grassroots disability rights organizations are recognized as well.

Accommodative Residences Utilizing Community Medicaid Exemptions for Older Persons and Persons with Disabilities

Executive Summary

May 11, 2021

PROPOSAL: Facilitate the development of accommodative housing for persons with disabilities regardless of their age. Personal resource preservation and service delivery would occur concurrently with existing Community Medicaid, Nursing Home Waiver, Redirection and Avoidance programs. Medicaid savings would occur though small economies of scale and expanded community-based service programs currently existing.

CONCEPT: Purpose built small condominium community residences with 10-12 suites of accommodative design for persons with disabilities to age in place with spouses while preserving financial resources exemption for primary home ownership consistent with the Community Medicaid Resource Exemption. The Community Medicaid monthly income exemption (and excess income) allows for the payment of monthly common charges for food, utilities, housekeeping, maintenance, landscaping etc.

PURPOSE: Provide home ownership for individuals from which they would never have to move who are otherwise eligible for congregate care. The community residence would provide maximum independence for residents regardless of physical or mental health challenges throughout the remainder of their lives. As the residence could be in any small town or urban neighborhood, access for family and friends can be maximized. Additionally, existing community supports, and services programs can be expanded.

METHOD: Utilizing Community Medicaid resource and income exemptions to allow the purchase and provide monthly expenses of a residential suite with fully accommodative direct access to common interior and exterior areas. Personal care services would be provided through existing Consumer Directed Personal Assistance Services (CDPAS) programs and/or licensed Managed Long Term Care Plan entities (MLTCP's). Medicaid costs are reduced through smaller service delivery economies of scale and nursing home avoidance. Additionally, "overnights" and more fluid care delivery for residents can occur as service delivery would be shared by Consumer Directed program residents or MLTCP's who would be able to provide services to multiple clients.

COMPOSITION: Small community residence condo apartments consisting of suites directly opening to common interior and exterior areas. Suites would be of universal design with private bedroom, accommodative bath, sitting area, and hazard-free kitchenette. The suites could also have 2 bedrooms such that a parent, child, or caregiver could co-reside. Exterior spaces would include porches and patios, grass and gardens, a playground, and walkways.

OWNERSHIP: Condominium residence ownership in a structure built consistent with nursing home construction specifications. The ownership interest is an exempt resource asset under Community Medicaid eligibility rules. While Medicaid has many rules and some exemptions, preserving assets through home investment is a typical "spend down" strategy in current elder planning to preserve resources in the primary residence otherwise lost pursuant to Nursing Home Medicaid poverty requirements. Unfortunately, many people live in homes that cannot accommodate their disabilities and must move. Since Community Medicaid allows a principal residence up to $906,000 to be exempt, residences could be simple or complex, and the purchase funds preserved. A significant incentive would be for Medicaid to waive any right of recovery against the primary residence asset. Notwithstanding, current financial Medicaid planning strategies would apply to protect assets according to existing law.

Residents retain all exclusive ownership rights and responsibilities typical of primary homeownership for their individual condo suite. At any time, the resident can sell their interest as is typical of any condominium interest. Notwithstanding, while the equity may be accessed for any purpose, sufficient balances must be preserved to provide an uninterrupted income stream (ex. SSI, SSDI, pension, 401(k) etc.) such that monthly common charges through the age of mortality +5 years can be paid.

MONTHLY EXPENSES: The residence would have a building manager, cook, housekeeping, maintenance, and common environmental non-care services. Community Medicaid allows an individual a monthly income exemption of $884 with excess income to be used for non-Medicaid housing and costs of living. Consequently, the typical SS, pension, IRA etc. income can be used to pay a monthly expense that would be utilized for the maximum benefit and discretion of the individual.

ADDITIONAL EXEMPT RESOURCES:

Again, Medicaid has many rules concerning "allowable" exempt resources beyond the home. An individual is allowed assets of only $15,900; with

Medicaid dependent spouse, $23,400; and non-Medicaid spouse is permitted up to $130,380 of assets. Consequently, while the individual limits are very low, an individuals with or without their spouse would be able to provide for their needs suitably as the residence provides for basic "room and board".

SERVICE DELIVERY: Currently, people living home on Community Medicaid receive services inside the home through either a Managed Long Term Care Plan (MLTCP) or Consumer Directed Personal Assistance Services (CDPAS) programs as they may choose. They typically have a choice amongst MLTCPs who perform an assessment and "offer" a menu of services. Most people receive services based upon "hours a day" correlated to need. Requiring more than 12 hours (overnights) is a logistical challenge to remain home.

Smaller service delivery economies of scale can provide for the overnights and provide more appropriate service delivery over the course of a day instead of a rigid schedule often currently required for home care. The concept would provide greater flexibility to facilitate care needs for persons over the course of a day. Additionally, as MLTCPs benefit from providing services to people co-located, there would be the greater potential of obtaining more or enhanced services than would be available at home.

Each resident would have the right to choose their care services provider or arrange services through a CDPAS as currently exists. Notwithstanding, all care givers must be properly trained, licensed if necessary, and compliant with the obligations consistent with any program pursuant to which services are provided.

LICENSING and INSPECTIONS: All care giving through MLTCP or CDPAS would be through licensed or approved entities, however, no licensing for the residence specifically would be necessary except usual and customary hospitality industry inspections and oversight for the common services and facilities that would be provided. The residence is providing accommodative design and services that if currently being provided to someone in their home would not need separate licensing.

COMMUNITY SUPPORTS and SERVICES: Currently there are broad community supports and services for persons with disabilities across a wide spectrum. These include transportation, peer counseling services, visitation and linking people to community-based services. There would also be greater access to faith-based services. Notwithstanding, innovative community-based programs are aggressively being considered and would dovetail well with this proposal by providing oversight and services access.

BROAD APPLICATION: While the proposal can be most helpful to the current middle class, there are also possibilities for low-income individuals through a set aside program whereby 20% of units may be available as rentals using subsidies from a sponsoring agency. Perhaps an individual could use exempt resources to invest in the exempt residence and "buy-out" the state which can provide a bootstrap to transition out of the public program.

Since these are small residences, they could be built for special purposes for which people may *want* to socialize in their living situation. Whether religious reasons, disability related or just similar interests they can accommodate personal independence of choice for people in need of accommodative housing.

Low or no interest loans could be offered to non-profits for build-out. There are many possibilities using current programs. There are existing and new policy efforts for greater community integration with other types of affordable or workforce housing into which the concept could easily be incorporated. While the residences can be operated standalone, optimally they would be integrated into every community seamlessly. There is no reason a residence could not be included in retirement or recreational communities as well.

POSSIBLE INCENTIVE:

Medicaid Waiver of Recovery. NYS Medicaid currently retains a right of recovery against the primary residential resource after the death of the resident and potentially the surviving spouse. Should Medicaid waive such right, and allow the resource to pass to beneficiaries, a significant financial incentive would be created for this type of nursing home avoidance.

ADDITIONAL FEATURES

To provide the most integrated setting, no more than 5 residences should be grouped on any building lot unless co-located with other forms of housing with the residence comprising no more than 20% of the total units on the lot.

Maximum 12 units per suite of accommodative design which must at minimum consist of a bedroom, sitting area, kitchenette (hazard-free) and bathroom. The sitting area must be large enough to provide for a pull-out queen bed if no second bedroom.

Each suite must open directly to the common area. While the suite entry can be a foyer, it should not be a hallway, though recognizing urban design may require otherwise.

Each residence shall maintain common exterior spaces directly accessible from the common areas into which each suite opens directly and exterior areas are accessible directly from an elevator.

Each residence should provide suitable space for use by visiting medical professionals; therapists; and telehealth.

Each residence should provide residence based freshly prepared meals and food service available a minimum of 12 hours per day and accessible 24/7.

Each residence would provide common area security, housekeeping services and premises maintenance.

Each residence would provide for all common charges for utilities, water, sewer, physical plant (not including interior suites), common areas both interior and exterior.

CONCLUSION: The proposal provides an opportunity for individuals with disabilities regardless of age, whether living in rural or urban settings, to enjoy an appropriate living environment with improved quality of life while having their support and care needs met. Most importantly they will continue to reside in the community with their spouse, parent, child with a disability or caregiver with direct access to friends and family. Lastly, Medicaid will save money though more appropriate economies of scale while also providing more appropriate community-based care.

There is nothing truly unique about this proposal. The goal is to provide a transitional plan allowing people to live in the community rather than be displaced. It seeks to incorporate existing programs across the elder and disability spectrums, all of which have the same purposes and goals to create supportive environments. Utilizing free market principles that will facilitate local solutions can benefit communities throughout the state both humanistically and economically. The question is not whether this proposal is achievable, but how it may be developed aggressively now and improved and refined over time.

Respectfully Submitted.

Joseph J. Ranni, Esq

Lead Collaborator

From:	New York State Bar Association
To:	O"Clair, Melissa
Subject:	Steven Richman commented on the "Report and recommendations of the Task Force on Nursing Homes and Long-Term Care" library entry
Date:	Wednesday, May 19, 2021 2:56:27 PM

Steven Richman commented on the 'Report and recommendations of the Task Force on Nursing Homes and Long-Term Care' library entry

I recommend that Section H of the Recommendations be modified to refer to State and Local Governments (page 121) as well as the Federal Government. Pending allegations under review by both the NYS Attorney General and the State Assembly Impeachment Inquiry include that politics played a significant role in the State's response or lack thereof. I agree that political considerations should not play a role in these vital issues on any government level. The language should be revised to include... View More

MEMO

TO: NYSBA LONG TERM CARE TASK FORCE

FROM: ELDER LAW AND SPECIAL NEEDS SECTION

RE: REPORT FOR HOUSE OF DELEGATES

DATE: May 27, 2021

The Elder Law and Special Needs Section appreciates the opportunity to comment on the NYSBA Long Term Care Task Force (the "Task Force") report. We commend the Task Force on the time and effort that it devoted to these critical issues and wish to offer our commentary in the spirit of expanding the dialogue, as it certainly cannot end here. Rather than to look at the tragic consequences of the pandemic as the result of an anomaly, we consider the events to have exposed a system in desperate need of an overhaul.

While we appreciate the efforts that the Task Force clearly put into its report, the Section feels that the group in general did not do enough to develop recommendations to improve the quality of care and life for older adults and people with disabilities living in nursing homes and other settings such as adult care facilities. In our view, the Task Force issued general recommendations that fall short of offering concrete laws and regulations in New York State (or at the federal level) to "adequately protect vulnerable populations and guarantee equitable access to high quality care."

The Task Force declined to offer specific policy changes or comments on legislation and regulations. Compare, for example, the Federal Independent Coronavirus Commission for the Safety and Quality in Nursing Homes report.[1] *See also* the work the Elder Law & Special Needs Section's Task Force, and now Committee on Long-Term Care Reform.

Our comments pertaining to some of the recommendations and themes of the report are as follows:

March 25th DOH Advisory

We appreciate the focus on the March 25th DOH Advisory and its comparison to the CDC March 12, 2020 guidance document. However, the Task Force did not place any weight on the fact that nursing homes still had the authority to deny admission to new residents. While the Task Force refers to nursing homes as an extension of hospitals, nursing homes are not hospitals, nor are they emergency departments required to treat every resident that seeks admission. Nursing homes, if short staffed, short on PPE, and other supplies, could have denied admittance to new residents during the pandemic and the Task Force should have taken a stance on this point.

[1] https://edit.cms.gov/files/document/covid-final-nh-commission-report.pdf

Financial Situation of Operators

With respect to the funding of nursing homes and the financial stress before the pandemic, operators have been stating they have been underpaid for years. Yet, nursing homes continue to be purchased by for profit corporations, which we agree comes with problems. The Task Force missed an opportunity to take a hardline approach when it comes to financing. If more monies are needed, then this can and should be addressed. But nursing homes should first prove that they have a record of providing quality care and demonstrate how each government dollar is spent. We cannot continue to spend money on a system that often does not work well and can result in a serious lack of care and neglect to occur for older adults and people with disabilities.

Rethink the Delivery of Long-Term Care

We agree with the statement that nursing homes have been dangerous places for residents throughout the course of the COVID-19 pandemic. However, in its report, we feel that the Task Force missed an opportunity to directly acknowledge and address the long-standing quality of care issues and the failures of nursing homes in NYS. While the Task Force did not outrightly state there is a bias towards placing our older adults and people with disabilities into nursing homes (institutions), we appreciate the insinuation and we support the Task Force's recommendation to rethink the delivery of long-term care. We also support the recommendations of the Task Force, but again are concerned that the Task Force missed its opportunity to offer recommendations on specific laws and regulations.

Meaningful Agency Enforcement-Review Regulatory Standards

We respectfully disagree with the Task Force's statement that "regulation of nursing homes (and adult care facilities) by DOH is characterized by hundreds to thousands of standards that regulate the minutiae, and which have little to no impact on residents' quality of life or protection from contagion." First, regulation of nursing homes stems from the federal regulatory system, which sets forth minimum standards, and second, if the industry did a better job of self-regulating quality and resident rights, the regulations would not be needed. The laws and regulations exist because too many operators failed to ensure resident rights and meet quality care standards.

While we agree with the Task Force statement that "the focus of DOH surveyors is on the minutiae rather than on the big picture," we disagree with the Task Force's insinuation that the standards are too much on operators, and "stifle initiative from operators" when dealing with emerging threats. For example, while a pandemic such as COVID-19 was a shock/surprise to many, basic infection control protocols, procedures, and requirements have existed long before the pandemic (something the Task Force acknowledged.)

In addition, while we agree that DOH needs to look at the "big picture" when investigating nursing homes, it needs to do so at the operator level.

We also respectfully disagree with the Task Force's insinuation that DOH is 'too hard' on nursing home operators and is moving away from an advisory and supportive role. DOH is the enforcement entity of the federal and state nursing home laws and regulations. If anything, DOH routinely under enforces the laws and regulations. When discussing the role of DOH and whether it is 'too hard' on operators, the Task Force should have remembered that operators have the ability to appeal citations and fines. Residents, however, are not afforded an option to appeal a situation when the DOH fails to enforce the laws and regulations. The majority of residents are not harmed enough to pursue remedy/justice in the court system and many are prevented from accessing the court system due to pre-dispute arbitration agreements. As a result, it is imperative DOH does its job as the enforcement entity.

Furthermore, prior to and throughout the pandemic, DOH had meetings with industry representatives and issued numerous guidances to operators. Residents and their advocates however, were not, and are not, afforded such transparency.

Meaningful Agency Enforcement-Survey Process
Again, the Task Force missed its opportunity to offer constructive feedback to both the state and federal governments and regulators. The report nicely outlined the survey requirements and the role of federal oversight, but the Task Force's recommendations do not make any reference or comment on improving the process.

Meaningful Agency Enforcement-Address Under-Performance
We are disappointed that the Task Force used the word "under-performance**"** to describe serious deficiencies in the provision of substandard resident care and did not directly call out operators who routinely violate resident rights and safety conditions. Under-performance means neglect of older adults and people with disabilities who rely on staff to meet their basic care needs. In addition, DOH, even when occupancy rates exceeded 95% could have done more to ensure resident safety. Including, for example, more closely enforcing resident assessments and discharge planning to ensure that residents who do not want to live in a nursing home were prioritized to live in a lower level of care or the community with services.

In summary: the members of the Task Force clearly put in a lot of time and energy into the report, including an overview of the pandemic, responsibilities of government in responding to a pandemic, and the federal-state regulatory structure. However, the final product and recommendations are diluted and offer many excuses for the failures of nursing home operators. Older adults and people with disabilities have been inappropriately warehoused and harmed for years prior to the pandemic. While we recognize operating a nursing home, especially during the pandemic, is difficult, at the end of the day excuses are not acceptable and true reform is necessary. This report offered general statements but no specific reform recommendations.